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NURSES AND OCCUPATIONAL VIOLENCE: A SYSTEMATIC REVIEW

Joseph Ndovoyo*, Damaris Moraa[1], Sarah Makong'o[2], Peter Kiambuthi[3], Grace Kibet[4] and Dr. Jashon Nganyi[5]

*School of Nursing and Midwifery, Department of Community Health Nursing, Kaimosi Friends University, Kaimosi – Kenya.

[1]School of Nursing and Midwifery, Department of Medical Surgical Nursing, Kaimosi Friends University, Kaimosi – Kenya.

[2]School of Nursing and Midwifery, Department of Midwifery, Kaimosi Friends University, Kaimosi – Kenya.

[3]School of Nursing and Midwifery, Department of Clinical Services, Kaimosi Friends University, Kakamega – Kenya.

[4]School of Nursing & Midwifery, Department of Community Health Nursing, Moi University, Eldoret - Kenya.

[5]School of Education, Department of Science, Masinde Muliro University of Science and Technology, Kakamega – Kenya.

***Corresponding Author: Joseph Ndovoyo**

School of Nursing and Midwifery, Department of Community Health Nursing, Kaimosi Friends University, Kaimosi - Kenya.

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ABSTRACT

Violence at work, refers to instances where persons are abused, threatened, or assaulted in circumstances related to their employment, involving an explicit challenge to their safety and well-being. Aggression in the healthcare sector has been a concern for many years, especially among the nursing profession. Globally, one-third of the nursing population experience some form of workplace aggression in any 12-month period, where two-thirds of nurses' experience non-physical violence, and one-quarter experience sexual harassment. The aim of this systematic review was to determine the type of occupational violence acts against nurses. A systematic review, integrating themes emerging from relevant articles and comments from in-depth interviews from the previous studies was done. The researchers retrieved 60 but reviewed 40 of this articles that had similar objectives from CINAHL, COCHRANE and PubMed data bases. The data was organized thematically. Most of the articles 34 (97.1%) nurses experience high levels of physical abuse. Accident and Emergency department was the most common site for violence (75.7%). Delay in offering services due to shortage of resources was the most cited risk factor (75%), while burnout was the most experienced impact following an incidence of violence. The commonly highlighted strategy to prevent workplace violence to nurses is provision of adequate resources (40 %). In conclusion, nurses encounter workplace violence. Future research should try to determine the specific factors, including staff characteristics associated with the incidences of workplace violence to nurses.

KEYWORDS: Nurses, violence, Occupation Aggressiveness, Strategies, Workplace.

BACKGROUND

Aggression in the healthcare sector has been a concern for many years. Workplace violence in healthcare organizations is a significant global occupational health problem, and nurses are the occupational group at greatest risk (Chaiwuth et al., 2020). Globally, one-third of the nursing population experience some form of workplace aggression in any 12-month period, where two-thirds of nurses' experience non-physical violence, and one-quarter experience sexual harassment (Spector et al., 2014). These leads to serious consequences for Nurses, their patients, patient care and the institution as a whole. The reasons for this high incidence of aggression in general settings is unclear. While there is a plethora of research on this topic, there exists very minimal and unconvincing data that identifies types of aggression encountered, individuals perceived to be most at risk and strategies to reduce or prevent workplace aggression metered to nurses. There is therefore an urgent need for stronger evidence for system and service level interventions to prevent and minimize workplace aggression in health care settings.

Violence and aggressiveness are the quality of being likely to attack other people or behave in a violent or angry way towards them (English dictionary). According to the definition adopted by the European Commission in 1995, violence at work denotes incidents 'where persons are abused, threatened, or assaulted in circumstances related to their work, involving an explicit challenge to their safety, well-being, or health (Magnavita, 2012). A similar definition is from the National Occupational Health and Safety Commission of Australia: 'Occupational violence is the attempted or actual

exercise by a person of any force so as to cause injury to a worker, including any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk.' (Bowie, 2012).

The ventromedial prefrontal cortex plays an important role in modulating human response to stimuli or frustrating situations. The ventromedial prefrontal cortex is connected to areas of the brain that control the processes necessary to control our response to frustrating stimuli, such as the hippocampus (essential for memory), sensory areas, the amygdale (important to give an emotional sense to experiences). Possibly the importance of the ventromedial prefrontal cortex is determined by its connections with other areas. Some studies have found features in the brains of aggressive people that differentiate them from non-aggressive ones. Serotonin or 5-hydroxytryptamine (5-HT) is a monoamine neurotransmitter (CITE). Its biological function is complex and multifaceted, modulating mood, cognition, reward, learning, memory, and numerous physiological processes such as vomiting and vasoconstriction. When Frustrated or angry, humans normally feel like engaging in aggressive behaviour, but they control them and try to calm themselves down. Serotonin plays an important role in modulating aggressive behaviour. Specifically, it appears to inhibit this type of behaviour, so that low levels of serotonin would be related to aggressive behaviour and other types of antisocial behaviour. Taking drugs that increase serotonin levels may also decrease aggressive behaviour (Manchia, et, al., 2017). Researchers have however focused on relating violent behaviour to emotional regulation.

Human aggression can be classified as direct and indirect aggression, while the former is characterized by physical or verbal behavior intended to cause harm to someone, the latter is characterized by behaviour designed to damage the social relations of an individual or group. Almost all animal species carry out aggressive behavior, which range from intimidating behavior such as teeth grinding to direct attack, in the case of humans it can be both physical and verbal. There are a number of disorders in which the aggressive component is especially important; these are encompassed in DSM-5 within disruptive disorders of impulse control and behaviour. These disorders imply a problem in the control of the behavioural and emotional impulses. They are more frequent in men than in women and in extroverted and uninhibited people and appear from childhood. The first sphere affected by aggression is the psyche. For the victim, each interaction with the offender is a source of stress and, in long-term perspective, causes mental health disorders and stress-related somatic symptoms (Fafliora, 2016).

Workplace aggression in the health and care sectors is a major work health and safety and public health concern, worldwide. In Australia, rates of exposure to workplace aggression are consistent with those experienced by nurses internationally, and have not decreased over the past 35 years. The elevated risk of violence in this professional group (nurses) is related to the specific character of work itself. In these sector, permanent contact with clients/patients is the important content of work duties. Moreover, work organization, staff shortages and many other limitations produce additional tensions and leads to feeling of frustration and anger in clients. A common feature of work-place violence is that it is concentrated on certain occupations including health care and social work occupations. Most cases of physical injury were caused in health care and particularly nursing occupations (Lähdesmäki, 2015). There's a growing recognition and concern that nurses, like employees in other settings, are subjected to high levels of interpersonal conflict at work. The Finnish victimization survey found that 5% of the employees were victims of work-place violence in the year 2003 (140,000 employees). Of the violent incidents, two-thirds were threats. In a pilot study that was done in Australia, nurses were asked to indicate in an open-ended question the types of behaviours they considered to be aggressive. In response to this question on what behaviours constitute aggression, 89.5% of nurses stated that it included any one or more of the three behaviours: verbal abuse, physical abuse and/or intimidation (O'Connell et al., 2000).

Women experience violence at work more often than men. According to the 2003 survey, 7% of the female and 4% of the male labour force had fallen victim to work-place violence or threats at work during the year preceding the survey date. The difference in victimization between men and women increased especially in the 2003 study. In the first Finnish national victimization survey in 1980, the majority of the victims were men (Berlanda, et al., 2019). Prevalence studies have found that 15–75% of survey respondents reported verbal aggression and 2–29% reported physical aggression in medical practice (Hills, 2013). According to Hills (2018), Victorian nurses, midwives and care personnel work in aggressive and violent workplaces. In a study that was done in 2016, 96.5% of respondents experienced workplace aggression, with 90.9% experiencing aggression from external sources and 72.3% from internal sources. A majority indicated they just accepted incidents of aggression, and most rarely or never took time off work, sought medical or psychological treatment, or sought organizational or other institutional support, advice or action. The incivility endemic in health care likely sets the climate for the generation of and exposure to so much explicit aggression and violence. It appears that any systems or processes instituted to protect health care personnel from harm are failing.

In a related study that was done in China, workplace violence against nurses was a significant problem in Hong Kong. In this study, where a total of 420 nurses participated, three hundred and twenty (76%) nurses

reported abuse of any kind—verbal abuse, 73%; bullying, 45%; physical abuse, 18%; and sexual harassment, 12%. Most nurses (82%) who experienced verbal abuse tended to confide in friends, family members, or colleagues. Some (42%) ignored the incident. Risk factors for workplace violence included working in male wards and in certain specialties such as the Accident and Emergency Department, Community Nursing Service, and the Orthopaedics and Traumatology Department (Li et al., 2006).

Methods

This was a systematic review that involved a search on multiple data base which included CINAHL, COCHRANE and PubMed. Emerging themes from comments in in-depth interviews were integrated.

Study group

The study comprised articles related to work place violence. The choice of those data/group was intentional. International data show that this sector is at risk of increased violent exposures (Merecz, 2009).

Data Analysis

Thematic analysis of data on combined comments in the articles that showed similarities was done. Review was done on 40 studies that met the inclusion criteria. The articles were related to the thematic areas of interest and over the same kind of violence that were experienced by nurses.

Ethical Consideration

The researchers presented data the way it was collected. No disclosure of the sources of data was done and had to abide by the sources that gave the data.

RESULTS AND DISCUSSION

A total of 60 articles were retrieved. Five thematic areas were identified.

Thematic areas

Most common forms of violence 35 (87.5%), Individual departments in which nurses were perceived to be most at risk of workplace violence 37 (92.5%), Risk factors related to violence to nurses 20 (50%), Impact of occupational aggressiveness to the nurses 15 (37.5%), and appropriate strategies to prevent occupational aggressiveness 10 (25%).

Table 1: Thematic Areas.

No	Thematic area	No of articles (n)
1	Most common forms of violence	35
2	Individual departments in which nurses were perceived to be most at risk of workplace violence	37
3	Risk factors related to violence to nurses	20
4	Impact of occupational aggressiveness to the nurses	15
5	Appropriate strategies to prevent occupational aggressiveness	10

Common forms of violence metered against nurses

According to O'Connell (2000), conducting research in the area of violence poses problems for researchers, as the definition of what constitutes a violent act varies from person to person. Additionally, the frequency of violent acts is reported in the literature using different time frames; hence, it is difficult to draw comparisons between populations. Under this thematic area, most research papers reported physical assault 97.1% (34) that included being grabbed, punched, pushed, kicked, pinched, scratched, spat on, bitten, hit, having hair pulled, choked and verbal 80% (32) including being abused and threatened as the commonest form of violence. Use of weapons was reported in 1(2.5%). Several studies both previous and current however report contrary findings. According to a report by the Joint Commission (2018), verbal abuse is the most common type of workplace violence. This is supported by a recent study among nurses (Bernardes et al., 2022) which revealed verbal abuse as the most form of abuse among nurses.

Previous studies have categorized violence into three areas: limited violence, assault and deadly violence. Limited violence was defined as 'verbal threats, arguments without hostile physical contact and physical contact with sexual intent but resulting in no physical harm to the victim'. Assault was defined as 'physical and sexual attack not involving lethal weapons such as knives and guns.' Sexual assault was defined as 'involving physical injury but no actual rape', while deadly violence included events such as 'shootings, knifings, hostage-taking, rape and robbery aided by physical force'. One could argue that the perception of what is an aggressive act can vary between groups and cultural settings as it is an internal personal construct. It is necessary therefore to take account of these individual, group and cultural differences in defining aggression.

This lack of definition of the concept of violence could explain the under-reporting of violent acts cited in many publications. Other reasons given for this under-reporting were 'a fear of being blamed by supervisors' and a reluctance to 'rock the boat'. Consequently, many caregivers concealed the violent acts they encountered.

In Australia, very little research has been done on the nature and frequency of violence in general hospital

settings. The literature revealed violence occurring in metropolitan and country hospitals and community agencies throughout the state of Victoria in Australia. Results showed that 73% had been verbally abused, and 63% had been physically assaulted by patients. A large proportion of nurses (43%) indicated that aggressive incidents had occurred on between one and four occasions in the previous 12 months, while 16% had experienced such acts more than 25 times in the same period.

In a study that was done in Palestine, Jaradat, et. Al., (2016) reports that, ninety-three (27.1%) of the respondents reported exposure to workplace violence of any kind. Seventeen (5%) reported exposure to physical violence, 83 (24.2%) reported exposure to verbal violence, and 25 (7.3%) reported exposure to bullying.

Table 2: Most common forms of violence.

No	Type of violence	No of articles (n)%
1	Physical	34 (97.1%)
2	verbal	32 (91.4)

Individual departments in which nurses were perceived to be most at risk of workplace violence

Majority of the reviewed articles reported emergency department as the most notorious department 28 (75.7 %) that carried the most risk of metering violence to nurses. Others included, Psychiatry 4 (10.8 %), pediatric department 2 (5.4 %), General (Surgical and Medical wards) 3(8.1%) as some of the departments in which nurses were perceived to be most at risk of workplace violence. Acts of aggression have, to some extent, been seen as inevitable in mental health and accident and emergency settings, due to patients' medical conditions and accompanying levels of anxiety and stress. According to Karen (2014), Physical aggression was found to be most frequent in mental health, nursing homes and emergency departments while verbal violence was more commonly experienced by general nurses. In a related study, Tan (2014) noted that emergency department nurses commonly experienced physical injuries.

Some studies speculate that this increased violence in hospitals has occurred as a function of increasing levels of violence in the general population and use of aggression as a means to solve problems. Dafiny, (2021), in a study of verbal and physical abuse towards nurses across teaching, psychiatric and community hospital settings, reported that 33% of nurses had experienced an incident of physical or verbal abuse in the past five working days. In another study, which included data from an accident and emergency department, it was reported that 50% of nurses had experienced verbal abuse, 27% had experienced physical assault and 25% had experienced threats within the past year.

A survey conducted by Bigham, (2014) on exposure to violence in the workplace revealed that 37% of nurses had experienced a violent episode, though this rate was lower in general hospitals. This trend seems to be changing as nurses working in general medical and surgical wards voice concerns about being subjected to increasing levels of aggression in the workplace. Although there is a perception that this is occurring in general settings, the actual nature and frequency of aggression in these areas is not fully understood for a number of reasons. However, according to Farrell (2001), different clinical settings have their own profiles of aggression towards nurses. In a study that was carried out in Australia, the emergency department was noted as a high-risk area for workplace aggression. Emergency nurses reported 110 episodes of violence within a 5-month period, with 37% occurring on the evening shift (Hogarth, 2016).

According to a research study in Australia, the five most common sites where these aggressive acts occurred were reported as medical (22.9%) and surgical wards (22.6%) followed by accident and emergency departments (19.7%), geriatric wards (15.8%) and intensive care units (11.3%). These findings illustrate that incidents of aggression are not solely confined to mental health settings (Dafny, 2021).

Studies consistently reported emergency department (76.4%), followed by psychiatric units (10.6%), general wards (5.0%), and then paediatric units (3.52%) as most sites of reported violence. This is supported by Berlanda (2019), who reported that 85.8% of nurses had experienced some form of violence from patients in the emergency unit, 41.9% had experienced violence from psychiatric unit and 30.9% from the general ward.

According to Farrell (2006), in a study that was done in Australia, a majority of respondents (63·5%) had experienced some form of violence (verbal or physical abuse) in the four working weeks immediately prior to the survey. Patients/clients or their visitors were identified as the main perpetrators, followed by medical and nursing colleagues.

In most of the studies, patients were the most frequent source of both verbal and physical aggression reported by nurses. However, a large proportion of nurses reported that they had experienced incidents involving relatives who were also verbally aggressive. Intimidation from medical staff was reported, while intimidation from peers and the nursing hierarchy were also reported.

Table 3: Individual departments in which nurses were perceived to be most at risk of workplace violence.

Departments in which nurses were perceived to be most at risk of workplace violence		
No	**Department**	**No of articles n (%)**
1	General (Surgical, Medical)	3 (8.1%)
2	Psychiatry	4 (10.8%)
3	Accident and Emergency	28 (75.7%)
4	Pediatric	2 (5.4)

Risk factors related to aggressiveness to nurses

Delay in offering services due to shortage of staff and lack of commodities 75% (15) was the most document risk factor in violence towards nurses. Other risks featured in some of the articles reviewed include; Integration of psychiatric patients into the general wards 50%, large amount of drug and alcohol abuse 15% (3), limited knowledge in early identification and management of this cases associated with inadequate training 25% (5).

Findings in a related qualitative study revealed the growing recognition and concern that nurses, like employees in other settings, are subjected to high levels of interpersonal conflict at work. The nurses work in an environment of a team that comprise other colleagues both nurses and non-nurses putting them at high risk (Farrell, 1999). Increased illicit drug use puts nurses at the sharp end in managing patients admitted with drug-related problems. Such people are often resistant to healthcare intervention, and often have associated disorders, including mental illness (Farrell, 2006). Further, according to Tan (2014), Nurses were concerned about their perceived inability to predict patients' behaviours and future violent incidents.

The nurses were able to identify potentially-aggressive people when they factored the patient's medical or non-medical presentation into account. Alcohol intoxication, the use of drugs/drug overdose, as well as the presence of mental illness were cited by nurses as contributing to aggressive incidents. Similarly, nurses cited medical conditions as biomedical cues to determine the aggression risk of patients. Health service-related reasons, such as long waiting times or patients seeking emergency department admission due to socioeconomic reasons, could also result in patients exhibiting aggressive behaviour. Previous research has reported similar findings, where nurses perceived that people who could not tolerate the long waiting times were potential aggressors.

Table 4: Risk factors related to violence to nurses.

No	Risk factor	No of articles n (%)
1	Integration of psychiatric patients into the general wards	10 (50)
2	Large amount of drug and alcohol abuse	3 (15)
3	Limited knowledge in early identification and management of this cases associated with inadequate training	5 (25)
4	Delay in offering services due to shortage of resources (staff & commodities)	15 (75)

Impact of occupational aggressiveness to the nurses

Some researchers have reported that staff who have encountered aggressive acts experience emotional trauma. Findings from the reviewed articles revealed that after an aggressive incident, nurses resorted into taking sick leave 7 (46.6 %) thus leaving the needy patients at risk of missing nursing care. A good percentage of articles reported nurses resorting to taking alcohol or drugs 2 (13.3%). Burnout was the most felt impact 8 (53.3 %) after experiencing an aggressive act as reported in these articles while 4 (26.6 %) felt like exiting their job. Some articles 3 (20 %) stated that despite the violent acts, nurses remained on duty. Only 1 (6.6 %) of the articles reported about a nurse who had gone to seek for emotional support but majority 2 (13.3 %) did not take any action as they did not know where to get assistance from.

Common emotional reactions included anger, anxiety, helplessness, fear and resentment. These findings are supported by some research articles which noted that following an aggressive act nurses cited depression, self-blame, apathy and fear of returning to the site of the incident (Ding et al., 2023). Further, researchers have highlighted some difficulties associated with returning to work, which included fear of other patients and a possible change in relationships with co-workers. Some authors have also observed that nurses who were exposed to verbal or physical abuse often experienced a negative psychological impact post incident (Karen, 2014). In Singapore, anecdotal evidence suggests that nurses are concerned about managing aggressive incidents in the emergency department where more often nurses experience physical aggression resulting in psychological effects, such as anger, burnout, stress, anxiety, and fear (Tan, 2014).

Similarly, in Tan (2014) emergency department nurses reported that caring for aggressive people affected them psychologically and physically. The psychological

effects included feeling upset, not feeling appreciated, and having recurrent thoughts about what could be done better. The frequent exposure to aggression created job dissatisfaction, resentment, and regrets about initiating the interaction with the person. Some of the nurses also reported feeling burned out and wearisome about continuing with their work duties. Talking with colleagues was by far the most likely and most helpful response following verbal or physical abuse. 'Taking no action' and 'Talking with the abuser' were not considered to be particularly helpful (Farrell, 2006).

I was punched … it was quite painful. So, I kept thinking what can I do better? Why must I go and attend to that patient? Sometimes I feel like I should just ignore that person. (Participant 3)

Fracture was also reported as a consequence of aggression, and the majority of nurses were not always able to prevent aggressive incidents. As a result of the physical injuries sustained, nurses were not always able to complete their nursing duties and were required to take sick leave. Some nurses have reported that caring for aggressive people was deemed to be time intensive. As a result, the majority of nurses believed that they could not do what they should do for all persons in their care. In some instances, they were unable to maintain professionalism (Tan, 2014):

Of course, at the scene, we are very angry … We … shout at the patient: "Hey you don't – you must obey us". (Participant 3)

Abuse influenced nurses' distress, their desire to stay in nursing, their productivity and the potential to make errors, yet they were reluctant to make their complaints 'official'. As well as reporting high levels of verbal and physical abuse, nurses were distressed because they could not provide the appropriate care to meet patients' needs. As a result, high levels of attrition from the profession was experienced in the affected institutions. Further, Farrell (2006) reports that, of those who had experienced aggression, over two-thirds indicated it frequently or occasionally contributed to their potential to make errors, or to affect their productivity. More so, Jaradat, *et, al.,* (2016) acknowledges that Verbal aggression was associated with higher psychological distress. Workplace bullying was associated with lower job satisfaction. This resonates well with the findings of O'Connell (2000) that, it is certainly plausible for nurses to face dissonance when trying to uphold their duty of care given that patients are typically the ones that start aggressiveness in hospital settings.

Findings from these studies revealed that after an aggressive incident, nurses reported reacting in a variety of ways including taking sick leave while others reported taking alcohol or drugs after an incident. Over half stated that they felt 'burnt out' after experiencing an aggressive act, yet the majority stated that they remained on duty. Nurses in these studies reported bodily injuries (e.g. being hit, kicked, and pushed), and verbalized reluctance in caring for aggressive people, although acknowledging their professional obligation to care for such people. The findings regarding these negative effects resonate with the literature, including feeling burned out. The most frequently reported emotional responses to aggression in these studies were frustration and anger, followed by fear and emotional hurt.

Table 5: Impact of occupational aggressiveness to the nurses.

No	**Impact**	**No of articles** n (%)
1	Taking sick leave	7 (46.6)
2	Taking alcohol or drugs	2 (13.3)
3	Burnt out	8 (53.3)
4	Felt like exiting the job	4 (26.6)
5	Remained on duty	3 (20)
6	Emotional trauma	1 (6.6 %)
7	Did not take any action as they did not know where to get assistance	2 (13.3%)

Appropriate strategies to prevent occupational aggressiveness against nurses

Of the 30 articles that were reviewed, 10 (33.3%) articles reported on appropriate strategies to prevent occupational aggressiveness. About a quarter 3(30%) articles articulated that schools of nursing should include units on identification and management of violent patients in their curriculum, as nurses may be exposed to this behaviour in the course of their work. Most of the articles 4 (40 %) mentioned provision of adequate resources to reduce waiting time as an appropriate strategy to prevent occupational aggressiveness towards nurses. Formation of institutions peer-help group, multicomponent crisis response-management system to be made available to allow nurses to share their experiences and emotions as this had worked in Singapore was mentioned in 1 (10 %) article.

Other strategies mentioned include frequent interaction with patients 2 (20 %) including providing information and updates to the patient and relatives on the appropriate course of management and service to be offered. Chemical and physical restraints 1 (10 %) were used to manage aggression to ensure safety and allow the healthcare staff to carry out important investigations and treatments. The issue of Nurses also resorting to seek help from the security department 1 (10 %) when they were unable to satisfactorily manage the aggressive situation was reported. Farrell (1999) posits that following incidents of aggression, nurses talk with colleagues and friends rather than with human resource or trade union personnel. While aggression-management training is recommended for nurses, evidence suggests that the implementation of a one-time aggression training program is inadequate, and that the content could be more practical (Tan, 2014). In Singapore, anecdotal

evidence suggests there is an absence of policy in support of an aggression-free workplace (zero-tolerance legislation, prevention strategies, and mandatory training in aggression management), which is the only way forward to control aggressiveness to nurses who are young and feminine (Pich *et al.,* 2010).

Researchers have reported underutilization of the strategies put in place to address psychological effects on nurses. In Singapore a peer-help, multicomponent crisis response-management system has been made available by the Ministry of Health to Singapore public general hospitals. Despite this effort, a multisite healthcare workers survey by Chan and Chan (2012) revealed that only 10.6% of nurses had used the system to seek emotional support for work-related aggression.

An integral part of managing aggression is the ability of nurses to employ various nursing-assessment strategies. During their clinical encounter with aggressive people, nurses used presenting information and previous history, as well as nurses' reflection on past experiences to assess the person. They also relied on the medical diagnoses like alcohol intoxication, and delirium to determine the possibility for aggressive behaviour. Nurses also attributed possible underlying medical conditions, such as sepsis, electrolyte imbalances, heat stroke, dementia, and seizures, to aggressive behaviour. Several nurses also reported that if they receive information on a patient admitted with a drug overdose or a risk of self-injury during the handover of care, they would consider these patients to be potentially aggressive. Nurses also used their observation skills as part of the routine assessment for potentially-aggressive people. Specifically, nurses observed body language, verbal cues, and signs of unhappiness or dissatisfaction via the content, tone, and volume of the patient's speech:

You can observe their behaviour is a bit abnormal when a patient starts to shout and (they) don't obey your commands. Potentially, they will be difficult to manage. (Participant)

I already know that this patient tends to be aggressive, because they already have a history, or I have already seen them being aggressive … we have regular patients, drunk patients, who regularly turn up in our department. (Participantt)

The nurses reported making quick judgements to categorize patients, as the use of chemical or physical restraints might be necessary to effectively manage aggressive incidents. According to Jaradat, *et al.,* (2016), increased awareness and preventive measures to address this problem among health care workers are warranted. Strategies to decrease waiting times was noted as a critical action in all of the settings. This problem is also attributed to the current setting in various studies, where waiting times to see a doctor could vary between 4 and 10 hours.

Frequent interaction with patients was deemed important to prevent aggression, including providing information and updates. This included using hospital translators if language was deemed a communication barrier. Chemical and physical restraints were used to manage aggression to ensure safety and allow the healthcare staff to carry out important investigations and treatments. Nurses also resorted to seeking help from the security department when they were unable to satisfactorily manage the aggressive situation (Fafliora, 2016):

We (nurses] call the security to come … You can't possibly sedate an alcohol-intoxicated patient because … they will get more sedated … you can't physically restraint them too, because they are … (still) conscious and they are quite strong. (Participant)

Nurses reported contacting the police if it was perceived to be a case of severe physical aggression or when the person threatened the nurse. Nurses urged for changes so that they were more supported:

I called (the police) to come and help me because it is a very violent patient in the department. So, after taking down my report … they asked me, "Do I want to pursue the matter?" … I was thinking … why am I given a choice to pursue this matter? Can't they choose to pursue them instead of me charging him for doing all these violence and vulgarities? Because if I pursue this matter, they told me, it is under civil law and I sue him accordingly. (Participant)

It was also noteworthy that other than managing aggressive incidents, nurses also needed strategies to be able to let go of negative emotions. Many nurses explained that their coping strategies had helped, and examples they gave included venting to colleagues and family, separating professional duties from one's personal life, and engaging in regular leisure activities. According to the emergency department nurses, debriefing sessions conducted after incidents were infrequent, and sometimes there were none at all. For incidents that were perceived as inconsequential, nurses reported that the nurse managers did not show concern or render support. Inconsequential incidents appeared to be justified and normalized by the high frequency of aggressive incidents. Most of the nurses sought support from colleagues – "counselling each other" – to cope with the emotional effects. They expected front-line leaders, such as senior nurses, to have the competency to manage aggressive incidents and to be their role models:

I need the help of my senior nurses to teach me … how to properly manage (aggressive patients) or how to decide what interventions to use (in aggression management). (Participant)

Some articles reported that besides senior nurses, male nurses tend to step forth to assist in aggressive incidents.

As part of the emergency department's protocol, it was mandatory for nurses to write incident reports for incidents of physical aggression. Similar to incidents of verbal aggression, nurses reported that the decision to complete a report was at their discretion. Across all interviews, nurses believed that incident reports were important and necessary to avert legal liabilities in the event of alleged negligence or complaints against the nurse:

Because the patient is threatening us … we really have to write something in the incident report … if ever the patient sues us or writes a complaint letter, we have this written report of what really happened that time, that day. (Participant)

Despite the importance of incident reporting, nurses found the process cumbersome. They also perceived that management rarely acted on reports or provided additional resources to support nurses in managing aggressive incidents.

Workplace education, preparation, and training were deemed important to prepare nurses in emergency department for their role in managing aggressive behaviours. Some nurses stressed the importance of actual workplace experience in gaining skills, knowledge, and confidence:

I think the experience gained from working here will help you … It is better than any course … there is no course that can teach you. It is just valuable experience. (Participant).

When asked who offered nurses the most support after experiencing an aggressive incident, a good number named peers, with a further lower percentage naming supervisor. It is of concern that 65% of nurses did not know about the extensive support mechanisms that are available in the hospital to assist them to deal with and recover from an aggressive episode. This indicates that there needs to be greater promotion of the resources available.

CONCLUSION

On the basis of the reviewed studies in this survey, nurses experience high levels of workplace violence with physical abuse (97.1 %) being the most experienced by nurses at their workplace.

The findings from this study have revealed that nurses working in emergency, psychiatric and general medical surgical wards experience high levels of aggression at work. These findings substantiate the claim that aggression in the workplace is widespread and not confined to any particular ward setting though the incidence is higher in the Accident and Emergency department (75.7 %).

Delays in offering services due to shortage of resources (staff & commodities) was ranked the highest (75 %) risk factor related to violence to nurses.

The most felt impact from violence against nurses was burnout (53.3 %) arising from psychological trauma that impacts negatively on nurses work output.

Provision of adequate resources including adequate staffing and commodities to reduce waiting time (40 %) was reported to be the most appropriate strategy to prevent occupational aggressiveness towards nurses.

Recommendation

There needs to be continuous education that reinforces all staff members' roles in providing peer support and trying to prevent or minimize the effects of aggression especially to the nurses working in the accident and emergency departments. Furthermore, provision of adequate resources should be a priority for the health care management system to bring down the cases of workplace violence to nurses. Future research should try to determine the specific factors, including staff characteristics and environment, associated with the high levels of violence reported in the 'hot spots', including in such areas as emergency departments and psychiatric settings.

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