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ORIGINAL ARTICLE

Patients' violence towards nurses: A questionnaire survey

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ABSTRACT

Background: Although nurses worldwide are experienced violence in their workplace, how nurses experiences violence in India remains unclear. ***Objectives:*** The objectives of this study were to (1) determine the occurrence of violence towards nurses. (2) compare the physical and verbal violence towards nurses. (3)find the association between the violence and selected variables.

Methods: A descriptive survey design ***Setting:*** Mental health hospital (A), Bangalore, Karnataka, India. ***Participants:*** Purposive sampling technique was used which includes the nurses (1) working in Hospital A, (2) having minimum 6 (Six) months of experience. (3) who were available during data collection. (4) who were willing to participate in the study. majority i.e. 165 (92.2%) of the subjects are females and 14 (7.8%) are males, data further show that 147 (82.1%) subjects are staff nurses. A validated and reliable self administered questionnaire developed by the investigator was administered from 24th April 2006 to 25th May 2006.

Results: Majority i.e. 156 (87.2%) of subjects experience violence, out of that 102 (57%) subjects experienced mild violence, whereas 23 subjects i.e. 12.8% never experienced violence, and fifty four (30.2%) experience moderate violence. The mean verbal violence score (5.40) is apparently higher than the mean physical violence score (1.55).

Conclusion: These results suggest that nurses need to be trained in therapeutic communication and nonviolence self-defence techniques.

Keywords: *Nurses; Violence; Occurrence*

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Introduction and Significance

India is one of the largest demographic countries in the world with the second largest population. Last ten years the economic growth of the nation is highly increasing than ever before. Health care is one of the fields growing along with the country's overall growth. In 2010, India will be world's largest mass health care provider. To meet the demand, India produces largest number of nurses in the world.

Violence in all its forms has increased dramatically worldwide in recent decades. Now concerns are wide spread over workplace violence against health workers. The problem of violence in health care is not new; it has probably always been a part of nursing (Paterson M, 1999). Violence has been defined as any aggressive behaviour "aimed at inflicting harm or discomfort on its victims" (Felton, 1997). Verbal abuse is a form of workplace violence that leaves no visible scars; however, the emotional damage to the inner core of the victim's self can be devastating (OSHA, 2004).

ICN report paper said that ninety five percent of nurses around the world are women. Attitudes towards women are reflected in interactions with the profession. A study showed that health care workers are more likely to be attacked at work than prison guards or police officers, nurses are the health care workers most at risk, with female nurses considered the most vulnerable, general patient rooms have replaced psychiatric units at the second most frequent area for assaults, physical assault is almost exclusively perpetrated by patients, 72% of nurses don't feel safe from assault in their workplaces, up to 95% of nurses reported having been bullied at work, up to 75% of nurses reported having been subjected to sexual harassment at work.

The continuous exposure to violence led many mental health nurses in the UK to accept it as a normal part of their work and they failed to demand better measures to protect them (Martin 1984). Altshul and Booking (1981) also warned of the deleterious effects of poorly trained staff and uncoordinated treatment interventions. Brennan (1997) found that 57% of nurses have been assaulted in last 2 years and 93% were verbally abused.

Verbal abuse from the physicians and patients accounts for the highest incidents of aggression towards nurses in health-care settings (Copper, 1996). Research has shown those nurses' experience high rates of verbal abuse, from 82% to 97% (Cameron, 1998 and Fernandes et al, 1999). Verbal abuse significantly impacts the workplace by decreasing moral, increasing job dissatisfaction, and creating a hostile work climate (Aiken et al, 2001 and Manderino et al, 1997). Furthermore, verbal abuse negates a caring organizational culture and threatens the organization itself by higher turnover rates, increase lawsuits, decrease productivity, increased errors, and overall decreased quality of care (Cox, 1987 and Bush,H & Gilliland, M. 1995). Failures to address verbal abuse places hospitals at risk to increased turnover and cost resulting from decreased productivity and job satisfaction(Aiken et al, 2001 and Nield-Anderson L, & Clarke J,T, 1996). Thus, this study was designed to describe the frequency and severity of verbal and physical violence towards nurses from patients, working in hospitals in India

Review of Literature

The review of literature of the present study consists of studies related to violence against nurses from various countries.

Ryan, P.E., Hart, V.S., Messick, D.L. Aarom, J., & Burnette, M. (2004) conducted a prospective study on assault against staff by youths in a state psychiatric hospital for children and adolescents to examine the frequency and nature of violence directed at staff. The study sample comprised all 111 patients who were hospitalized during the study period (December 3, 2001, to February 3, 2002) and 140 employees who had patient contact, including direct care staff, clinicians, and teachers (140 individuals). All staff who were involved in the direct care of patients were asked to complete a confidential questionnaire immediately after the assault. Of the 111 participants, the 37 (33 percent) who committed assaults during the course of the study were deemed to be assaultive. Most incidents (116 incidents, or 54 percent) against staff resulted in no detectable physical injury. However 99 incidents (46 percent) produced level 2 or 3 injuries: six assaultive incidents (3 percent) resulted in injuries that required medical attention. The results of this study indicate that physical assault against staff in child and adolescent psychiatric settings is frequent and problematic.

Winstanley,S., & Whittington,R.(2004) conducted a study on "Aggression towards health care staff in a UK general hospital: variation among professions and departments". This study extends existing research by evaluating physical assault, threatening behaviour and verbal aggression from patients/visitors towards general hospital staff in the context of different professions and departments. Results showed that aggression is widespread. Within the preceding year, 27% of the respondents were assaulted, 23% experienced threatening behaviour from patients and 15.5% experienced threatening behaviour from visitors. Over 68% reported verbal aggression, 25.7% experiencing it more regularly than monthly.

Staff nurses and enrolled nurses reported the most assaults (43.4%) and doctors, the fewest (13.8%). Other nursing grades and health care professions all reported levels of physical assault in excess of 20%.

Lin, Y., & Liu. (2005), conducted a study on "the impact of workplace violence on nurses in south Taiwan". The purpose of this study was to explore the prevalence of workplace violence (WPV) committed by patients and their family members against healthcare workers in south Taiwan. Two hundred and thirty nurses in a 400 bed hospital were sent surveys. Response rate was 94.8% (205). The Chinese workplace violence incident questionnaire with 32 items was designed by the researcher. The instrument was distributed to nurses by their head nurses. Completed questionnaire were returned within one week to the appropriate head nurse. Nearly two third of the nurses reported experiencing a WPV event (n = 127; 62%). A majority of the nurses representing a variety of clinical settings in nursing, reported experiencing WPV, including verbal (n = 111, 53.9%) and physical (n = 61; 29.6%). Many nurses reported experiencing more than one WPV event (n = 81; 39.3%). However, the experience of WPV significantly differed depending on the subject's education ($\chi 2$ = 2227.95; p = 0.00), Years of nursing practice at the time of WPV events (t = 0.68, p =0.49), age (t = -0.75, p =0.87), and training against violence ($\chi 2$ = 0.05; p = 0.82) were not found to be associated with WPV. Experience of WPV among nurses in Taiwan was common especially the verbal type and all settings were potentially high risk.

However the present study is unique in terms of population selected i.e. registered nurses working in hospitals in India and the study planned to explore the occurrence of violence in India.

Method

The purpose of the study

The purpose of this study is to determine the nature and extent of violence experienced by nurses working in hospitals, from patients. This will help the nurses to understand the sufferings they are tolerating at work and will prompt the nurses to take necessary actions to prevent and manage violence.

The objectives of this study were to

- determine the occurrence of violence towards nurses.
- compare the physical and verbal violence towards nurses.
- find the association between the violence and selected variables.

3.1. Design

A descriptive survey design was used for the study, with verbal and physical violence as dependent variables. The independent variables were the demographic variables such as age, gender, religion, marital status, professional qualification, designation, years of experience in present area, and total years of experience.

3.2. Sample size and method

A purposive sampling was used to select the sample from Mental health hospital (A) located in Bangalore, Karnataka, India. Two hundred and fifty questionnaire were distributed to the nurses through ward in-charges on April 2006. At the end of data collection period i.e. May 2006 the researcher got back 179 filled usable questionnaire with the response rate of 71.6%.

3.3. Measures

Since no standard tool was available on violence, the researcher developed the following tools for the study. The relevant research and non-research literature were reviewed and experts were consulted for opinion and suggestions in developing the tools. Investigator's own experience also helped in developing the tools.

1. Demographic proforma
2. Questionnaire on occurrence of violence

Tool – 1: Demographic Proforma

The demographic proforma consisted of items on background data of the participants. It included age, gender, religion, marital status, professional qualification, present area of work, designation, years of experience in the present area, and total years of experience as nurse. The items in this tool do not have scoring as it reflects factual information.

Tool – 2: Questionnaire on occurrence of violence

Structured four point Likert scale was developed to determine the occurrence of violence towards nurses. Violence towards nurses was broadly classified into two categories such as verbal violence and physical violence in this tool. Total number of items in this tool was 10 (Ten), out of that verbal and physical violence carries 5 (Five) of each.

Scoring of the tool

Total 10 items were considers for scoring. Each item was given options as: Never (A), 1-5 times (B), 6-10 times (C), and More than 10 times (D). The responses were scored as Never '0', 1-5 times as '1', 6-10 times as '2', and more than 10 times as '3'.

Violence score was classified arbitrarily as no violence, mild, moderate and severe violence for 0, 1-10, 11-20, and 21-30 respectively.

Content validity of the tools

To ensure content validity, the tools along with the blue print, objectives and criteria checklist were given to 13 experts in the field of psychiatry, psychiatric nursing and clinical psychologist. The experts were requested to give their opinion and suggestions on relevancy, accuracy and appropriateness of the items

Tool – 1: Demographic Proforma

There was 100% agreement by experts on eight out of ten items in the tool and the items number three and six got 91% and 81% agreement respectively. Item number 5 was modified by adding two more options i.e. Pc.B.Sc (Nursing), and Ph.D (Nursing) as per the experts' suggestion.

Tool – 2: Questionnaire to assess the occurrence of violence

There was 100% agreement for 7 items out of ten. Item number 1 and 4 got 82% of agreement and item number 3 got 91% of agreement.

Reliability of the Tools

The reliability of the tool on questionnaire on occurrence of violence was established by Cronbach's alpha.

The tool was administered to 20 nurses in Dr. TMA Pai Hospital, Udupi, Karnataka, India from 27.03.20056 to 01.04.2006. Responses were obtained and data were analyzed. The coefficient alpha was 0.94, hence the tool was considered reliable for the study. The participants told that items used in the questionnaire were clear and understandable.

3.4. Procedure

After obtaining formal administrative permission from the Dean, Manipal college of Nursing, MAHE, Manipal, and The Special Officer, Academic & Evaluation, NIMHANS, Bangalore, nurses were approached. Verbal consent was taken from the subjects and assured the confidentiality of the information and anonymity by the researcher. Data were collected from 24th April 2006 to 26th May 2006. The questionnaire took approximately 10-15 min to complete.

3.5. Data management and Analysis

Descriptive and inferential statistics (SPSS 10.0 for windows) was used for data analysis. All variables were evaluated using descriptive statistics. To examine the difference between verbal and physical violence, paired 't' test was used. To find the association between violence and selected variables χ^2 test was used. The significance level for this investigation was set a prior at $p<0.05$.

Results and discussion

4.1. Description of violence score

Data related violence were obtained by tool on occurrence of violence and the scores are presented in the Fig-1 and Table-1

Fig-1: Nurses' experience of violence

Table 1: Frequency and percentage distribution of total violence score. (N = 179)

Violence score	Range of score	Frequency	Percentage
No violence	0	023	12.8
Mild	1-10	102	57.0
Moderate	11-20	054	30.2
Severe	21-30	0	0

Data in Fig-1 show that, the majority 156 (87.2%) of subjects experienced violence. Data in Table-1 further show that majority i.e. 1O2 (57%) of subjects experienced mild violence, where as 23 subjects i.e. 12.8% never experienced violence, and fifty four (30.2%) experience moderate violence.

This is similar to the findings reported by Lin Y, Liu H (2005) who found that nearly two thirds of the nurses reported experiencing violence (n = 127, 62%).And Nolan P et al (2001) found that 71% English and 59% Swedish nurses had been exposed to violence.

4.2. Comparison of verbal and physical Violence

Data related verbal and physical violence were presented in the Table-1

Table 2: Mean, Mean difference, Standard deviation and 't' values of physical and verbal violence from patients. (N = 179)

Type of Violence	Mean	MD	SD	t
Verbal	5.40	3.85	4.61	12.439
Physical	1.55		1.29	

Table values of $t_{(178)} = 2.575$ ($p< 0.01$).

Hence the't' value in Tbale-2 was higher than the table value, the null hypothesis was rejected and the research hypothesis was accepted. Further the data reveal that the mean verbal violence score (5.40) was apparently higher than the mean physical violence score (1.55), indicating that the nurses experience more verbal violence than physical violence.

This is similar to findings reported by Lin Y, Liu H (2005) who found that majority of the nurses, reported experiencing violence including verbal (n = 111; 53.9%) and physical (n = 61, 29.6%) violence. And Ergun, S.F., & Karadakovan, A. (2005) reported that Verbal violence was reported to have been experienced by 98.5% of the respondents, and 53.8% had been verbally violated more than 15 times in their professional career.

Table 1: Frequency and percentage distribution of total violence score. (N = 179)

Selected Variables		Violence Score From Patients			$\chi 2$
		No Violence	Mild Violence	Moderate Violence	
Age	Below Median	20	62	25	**11.191***
	Above Median	03	40	49	
Gender	Male	00	13	01	**8.051***
	Female	23	89	53	
Religion	Hindu	16	54	25	3.508
	Other	07	48	29	
Marital Status	Married	08	21	18	3.953
	Unmarried	15	81	36	
Qualification	Diploma	14	76	33	3.704
	Degree	09	26	21	
Designation	Staff Nurse	22	83	42	3.601
	Ward in-charge	01	19	12	
Experience in present area	Below Median	19	69	27	**8.661***
	Above Median	04	33	27	
Total experience	Below Median	19	63	23	**11.594***
	Above Median	04	33	27	

* - significant Table value of t (2) = 5.991($p< 0.05$)

The findings on Table-3 show that the chi square values between violence score of nurses from patients and the selected variables such as age, gender, experience in present area & total years of experience ($\chi 2$= 11.191 8.501, 8.661, 11.594, $p<0.05$) are significant. And other variables such religion, marital status, qualification and designation ($\chi 2$= 3.508, 3.953, 3.704, 3.601, p,0.05) are not significant.

This is similar to the findings reported by Mc. Kenna, G.B., Smith, A.N., Poole, S.J., & Coverdale, J.H. (2003) who found that no significant differences in demographic variables such as gender, current work place setting and geographical location except ethnicity ($\chi 2 = 9.2$, df = 4, p = 0.03). This is contradicted to the findings reported by Lin Y, Liu H (2005) who found that the experience of violence significantly differed depending on the subject's education ($\chi 2 = 227.95$, p = 0.000), and marital status ($\chi 2$= 36.07, p = 0.000).

Limitations

The limitations of the study were

- Study was conducted in only one hospital, which limits the generalization of study findings
- The questions in the Questionnaire on occurrence of violence were recall questions, which would completely depend on the memory level of the subjects

Implications

6.1. Nursing practice

Nurses can understand the existing level of violence towards them. There are actions that can be taken by nursing staff to address this growing concern. Some of the actions include:

Education for staff which could include communications skills training, and assertiveness training. Communication skills training should include empathic limit setting styles and therapeutic communication and stress the importance of involving clients in making decisions that involve their treatment.

Nurses should be taught coping skill for anger and stress management.

Complete assessments should be performed on every client on admission to inpatient. These assessments must include the individual characteristics. The findings should be documented and clearly communicated to other staff members. This will help the staff nurses to take precaution regarding each client's violence threshold. Inform clients on admission that there is zero tolerance for violence.

Education for staff could include nonviolent self-defense training, use of protective devices and restraining.

Provision of seclusion rooms and restrain team will help the staff to protect themselves from the aggressive clients.

Emotional support to be provided for health care workers who have been assaulted.

6.2. Nursing education

Nursing students have to be trained in various areas such as communication skills, assertiveness training and leadership roles. Nonviolent self-defense, restraining, seclusion etc have to be incorporated in the nursing curriculum. These changes will help the forth-coming nurses to protect themselves from the workplace violence.

6.3. Nursing administration

Nursing administrators have to create a safe and secure environment for their staff to work in peace. Adequate staffing will give support to the existing staff to protect themselves from violence. Provision of seclusion rooms, restrains, and other facilities will help the staff to deliver their duty at their level best.

Advocating for legislation to protect health care workers. For example, four bills were introduced before the Massachusetts legislature addressing workplace violence in health care settings. The bills included mandatory violence prevention programs and employee counseling an assault, safe staffing ratios, and mandating a felony chare for any health care worker who is assaulted. Introducing the OSHA guidelines for Preventing Workplace Violence for Health care and Social Service Workers (1998) to management as a basis for violence prevention activities.

Developing a workplace violence policy for the institutions, which explains the process that should occur after an employee has been assaulted. This policy should include how to report the incident, whom to report the incident, and legal options for the victim, as well as referrals for medical care and psychological support.

6.4. Nursing research

Since the occurrence of verbal violence is high, researches may be done by the nurse educators / nurse administrators on the types of verbal violence, nurses lived experience with violence situation, stress level of nurses due to violence and their coping strategies.

Conclusion

This study adds to the body of knowledge describing the type and frequency of violence experience by nurses working in hospitals India. Nearly half of the nurses experienced more verbal violence than physical violence. Gender and violence is significantly associated than other variables. Adequate staffing and proper training will reduce the occurrence of violence, improves confidence in patient care and provides emotional support to the nurses in India.

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References

1. Aiken, L.H., Clarke, S.P., Sloane D, M, Sochalski, J.A., Busse, R., Clarke, H., 2001. Nurses' reports on hospital care in five countries. Health affairs 20(3), 43-53.
2. Altschul, A., 1981. Issues in psychiatric nursing. In: Hockey, L. (Ed.), Current issues in nursing. Edinburgh: Churchill Livingstone, pp. 95-103.
3. Brennan, W., 1992. Pressure points. Nursing times 88, 46-48.
4. Bush, H., Gilliland, M., 1995. Caring for the nurse self: verbal abuse as a case in point. Journal of nursing care quality 9(4), 55-62.
5. Cameron, L., 1998. Verbal abuse: a proactive approach. Nursing management 29(8), 34-36.
6. Copper, A., Saxe-Braithwaite, M., Anthony, R., 1996. Verbal abuse of hospital staff. The Canadian Nurse, 31-34.
7. Cox, H.C., 1987. Verbal abuse in nursing: report of a study. Nursing management 21(11), 47-50.
8. Ergun, S.F., Karadakovan, A., 2005. Violence towards nursing staff in emergency departments in one Turkish city. International nursing reviews 52, 154- 160.
9. Felton, J.S., 1997. Violence prevention at the health care site. Occupational medicine 12, 701-715.
10. Fernandes, C.M.S., Bouthillette, F., Raboud, J., Bullock, M., Moore, C.F., Christenson, J.M., 1999. Violence in the emergency department: a survey of health care workers. Canadian medical association journal 161(10), 1245-1248.
11. Hilton, P.E., Kottke, J., Pfahler, D., 1999. Verbal abuse in nursing: how serious is it?. Nursing management 25(5), 90.
12. ICN report paper. Available from: URL http://www.icn.ch/matters_violence.htm
13. James, D.V., Fineberg, N.A., Shah, A.K.,1990. An increase in violence on a acute psychiatric ward-astudy of associated facorts. Journal of psychiatry, 846- 852.

14. Lin, Y., Liu., 2005. The impact of workplace violence on nurses in south Taiwan. International journal of nursing studies 42, 773-778.
15. Manderino, M.A., Berkey, N., 1997. Verbal abuse of staff nurses by physicians. Journal of professional nursing 13(1), 48-55.
16. Nabb, D., 2000. Visitors' violence: the serious effects of aggression on nurses and other. Nursing standard 14, 36-38.
17. Nield-Anderson, L., Clarke, J.T., 1996. De-escalating verbal aggression in primary care setting. Nurse practioner 21(10), 95-107.
18. Occupational Safety and Health Administration (OSHA). Workplace violence awareness and prevention. Retrieved 2004 may 16, from www.osha.slc.gov/workplace_violence/workplaceviolence.partl.html.
19. Paterson, M., Leadbetter, R., 1999. Managing physical violence. In Aggression and Violence (Turnball J. & Paterson B. eds), London: Machmillan press, pp. 124-141.
20. Ryan, P.E., Hart, V.S., Messick, D.L., Aarom, J., Burnette. M., 2004. A prospective study on assault against staff by youths in a state psychiatric hospital. Psychiatric services 55, 665-670.
21. Weisser, M., Levkowitch, Y., Shalom. S., Neuman. M., 1994. Emotional reactions of psychiatric staff to violent parents. Harefuah 126, 642-645
22. Winstanley, S., Whittington, R., 2004. Aggression towards health care staff in a UK general hospital: variation among professions and departments. Journal of Clinical Nursing 13, 3–10