# KNOWLEDGE OF WORKPLACE VIOLENCE AGAINST NURSES IN THE EMERGENCY DEPARTMENT OF PUBLIC SECTOR TERTIARY CARE HOSPITALS IN PESHAWAR, PAKISTAN

By

MUHAMMAD NASIR

*Aga Khan University, Karachi, Pakistan.*

https://doi.org/10.26634/jnur.14.2.20924

*Date Received: 25/06/2024* *Date Revised: 07/07/2024* *Date Accepted: 15/07/2024*

***ABSTRACT***

*This study delves into the critical issue of workplace violence against nurses, focusing on public sector tertiary care hospitals in Peshawar, Pakistan. Nurses play an indispensable role in healthcare delivery as the backbone of patient care. However, they face the challenge of workplace violence, which poses a significant threat to their well-being and compromises patient care quality. This paper contributes to the existing knowledge of workplace violence in healthcare settings. Through a cross-sectional survey design, data was collected from 384 registered nurses with a minimum of six months of experience in the emergency department. The data was collected between September and October 2023. The study provides comprehensive insights into various aspects of workplace violence, including training, exposure to incidents, reporting, investigation, and support mechanisms. The findings reveal that while training in workplace violence prevention is provided, there is room for enhancement, as indicated by a positive skewness in the data. Moreover, a concerning prevalence of workplace violence incidents within the last 12 months was reported, emphasizing the urgency for comprehensive measures to address this issue. The study highlights the diverse nature of violence experienced by nurses, emphasizing the need for tailored interventions.*

*Keywords: Workplace Violence Against Nurses, Healthcare System, Patient Care Quality, Well Being, Emergency Department, Public Sector, Tertiary Care Hospitals, Pakistan.*

## INTRODUCTION

Nurses serve as the cornerstone of healthcare, blending medical expertise with empathy to provide continuous support to patients. However, their indispensable role is marred by a growing concern about workplace violence. This issue encompasses acts of aggression, harassment, and physical assaults directed toward healthcare workers, posing a significant threat to their well-being and compromising patient care standards (Phillips, 2016; Ramacciati et al., 2015). This study aims to determine the incidents of workplace violence targeting nurses within the emergency departments of public sector tertiary care hospitals in Peshawar, analyzing the prevalence, identifying contributing factors, and assessing the impact of these occurrences.

i-manager Publications
Member of: SDG Publishers Compact

*This paper has objectives related to SDGs*

3 GOOD HEALTH AND WELL-BEING
16 PEACE, JUSTICE AND STRONG INSTITUTIONS

Understanding the historical roots of this problem reveals its enduring presence in the healthcare sector. Dating back to 1824, documented cases of violence against healthcare workers mark the beginning of a persistent challenge (Atan et al., 2013). From verbal abuse to tragic events causing severe harm, instances of violence have plagued healthcare settings, prompting a shift in perspective towards recognizing it as a systemic issue demanding comprehensive intervention (Eshah et al., 2024; Jiao et al., 2015).

This issue isn't confined by borders. It's a global challenge impacting healthcare workers universally. Research conducted across regions consistently highlights the prevalence of violence against healthcare workers, with nurses facing heightened vulnerability (Lipscomb & El Ghaziri, 2013). Statistics from various countries, including the United States, the United Kingdom, Australia, and Canada, underscore the widespread nature of this issue, particularly in high-stress environments like emergency departments (Arnetz et al., 2018; Carter et al., 2016; Kim et al., 2021; Shafran-Tikva et al., 2017).

In a bustling city like Peshawar, with its diverse population and unique healthcare challenges, contextual nuances play a pivotal role in understanding the dynamics of workplace violence in healthcare institutions. The city's varied demographics, coupled with its proximity to turbulent regions, add layers of complexity to an already challenging healthcare landscape (Hanson et al., 2015).

The consequences of workplace violence extend beyond immediate physical harm, deeply affecting both nurses and the quality of patient care. Nurses, pivotal in providing compassionate care, require a violence-free environment to deliver their services effectively. Violence-induced trauma impairs their focus, decision-making abilities, and mental health, leading to increased risks of conditions like PTSD, depression, and anxiety (Liu et al., 2018; Roche et al., 2010). While legislative measures exist in countries like Pakistan to protect healthcare workers, enforcement remains a significant challenge. Specific policies, especially in regions like Khyber Pakhtunkhwa, are crucial. These policies should encompass clear reporting mechanisms, rapid response teams, and comprehensive training for healthcare workers, necessitating collaboration between institutions, law enforcement, and relevant authorities for effective implementation (Al-Shaban et al., 2021; WHO, n.d.).

The psychological toll of workplace violence on nurses is profound, resulting in fear, anxiety, and helplessness. This strain not only affects their professional lives but also impacts job satisfaction and contributes to high turnover rates among nurses (Mayhew & Chappell, 2007).

Notably, the emergency department emerges as a high-risk setting for workplace violence against nurses due to its fast-paced and unpredictable nature. Studies in Peshawar and globally highlight the prevalence of violence in these settings, predominantly instigated by patients' relatives or the patients themselves (Gacki-Smith et al., 2009; Kowalenko et al., 2013; Mobaraki et al., 2020).

Numerous risk factors, including unrealistic expectations, poor communication, substance abuse, mental illness, and staffing shortages, contribute to this issue. The resulting frustration can escalate, leading to violent incidents (Magnavita & Heponiemi, 2012).

The repercussions of workplace violence extend beyond nurses' well-being, affecting the quality of patient care. Nurses subjected to violence are at a higher risk of committing errors and providing lower-quality care (Chang & Cho, 2016).

Addressing workplace violence against emergency department nurses is imperative, not only for their well-being but also for upholding the standards of quality patient care. Focused efforts on prevention and intervention strategies are essential to mitigate these risks.

## 1. Methodology

An investigation of workplace violence against nurses in the emergency departments of public sector tertiary care hospitals in Peshawar was conducted using a face-to-face cross-sectional survey design. The variables include gender, age, marital status, education status, experience, training received, exposure to violent incidents, number of incidents exposed to, observed violence in colleagues, types of violent events in the past 12 months, occurrences of violence in the workplace, sources of violence, locations of violence, reactions to violence, reporting incidents to administrators, reasons for not reporting, investigations into the causes of violence, identification of causes, persons conducting investigations, consequences for aggressors, support received, handling of incidents in the hospital, and recommendations for preventing workplace violence.

The inclusion criteria include nurses employed in the emergency department of a public sector tertiary care hospital in Peshawar. Nurses with a minimum of six months of experience in the emergency department were also included. The exclusion criteria were nurses not working in the emergency department and nurses with less than six months of experience in the emergency department.

The sample size determination was based on the formula for estimating proportions. A study conducted in a comparable healthcare environment revealed that 47.8% of healthcare workers encountered workplace violence within the past twelve months (Harthi et al., 2020). This proportion was utilized to calculate a sample size of 384, considering a 95% confidence interval and a 5% margin of error. The calculated sample size stood at 384 subjects to achieve a 95% confidence interval with a 5% margin of error.

*1.1 Sampling Technique*

A multistage random sampling technique was employed. In the first stage, public sector tertiary care hospitals in Peshawar were randomly selected. Three tertiary care public sector hospitals were approached. In the second stage, the emergency departments within the selected hospitals were included. Finally, nurses from each selected department were sampled randomly.

*1.2 Data Collection*

Data were collected using a structured questionnaire. The questionnaire was designed to capture information on the prevalence, types, and impact of workplace violence experienced by nurses in the emergency department. It was administered in person.

*1.3 Ethical Considerations*

Informed consent was obtained from all participants before their involvement in the study. The participants were assured of the confidentiality of their responses, and no personally identifiable information was disclosed in any reports or publications resulting from this paper.

## 2. Results

### *2.1 Descriptive Statistics*

*2.1.1 Descriptive Statistics of Demographic Information*

Table 1 shows descriptive statistics for various variables related to demographic information among 384 individuals. The statistics include the number of observations, minimum and maximum values, mean, and standard deviation for each variable. The mean values and standard deviations provide insight into the central tendency and variability of the data for each variable, offering a comprehensive overview of the study's findings on workplace violence and related factors.

The descriptive statistics for the categorical variables from a sample of 384 individuals indicate that gender, age, marital status, and educational status each have three possible categories, while experience has two. The means for gender (1.2839), age (1.6797), marital status (1.4245), and educational status (1.7578) suggest distributions skewed towards the lower categories, particularly for gender and marital status. Experience has a mean of 1.5208, indicating a slight skew towards the higher category. The standard deviations, which range from 0.46288 to 0.73067 for the three-category variables and 0.50022 for experience, reflect varying degrees of dispersion, with lower values indicating responses are more tightly clustered around the mean. These statistics provide a snapshot of the central tendency and variability within the surveyed population's responses.

*2.1.2 Frequency Table of Gender*

Table 2 shows the frequency table of gender. Among the 384 participants, 279 (72.7%) identified as male, while 105 (27.3%) identified as female. These percentages reflect the proportion of each gender within the sample. The "Valid Percent" column shows the percentage of each gender category out of the total valid responses, which is 100% for both male and female categories. In terms of cumulative percentage, 72.7% of participants identified as male, while 100% of participants are accounted for

| Descriptive Statistics | N | Minimum | Maximum |
|---|---|---|---|
| Gender | 384 | 1.00 | 3.00 |
| Age | 384 | 1.00 | 3.00 |
| Marital Status | 384 | 1.00 | 3.00 |
| Educational Status | 384 | 1.00 | 3.00 |
| Experience | 384 | 1.00 | 2.00 |
| Valid N (Listwise) | 384 | | |

Table 1. Descriptive Statistics of Demographic Information

when considering both male and female categories. This breakdown provides insights into the gender composition of the study sample, highlighting a majority of male participants compared to female participants.

*2.1.3 Frequency Table of Age*

Table 3 and Figure 1 show the age distribution of the 384 individuals in the sample, categorized into three groups. "Under 30" constitutes 44.5% of the sample, "30-40" accounts for 43%, and "40 and above" represents 12.5%. These percentages are valid, and the cumulative percent illustrates that 44.5% of the sample is under 30, 87.5% is below 40, and 100% encompasses all age groups. This data highlights that the majority of respondents are either under 30 or between 30 and 40, with a smaller proportion being 40 years or older.

| Gender | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Male | 279 | 72.7 | 72.7 | 72.7 |
| Female | 105 | 27.3 | 27.3 | 100.0 |
| Total | 384 | 100.0 | 100.0 | |

Table 2. Frequency Table of Gender

| Age | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Under 30 | 171 | 44.5 | 44.5 | 44.5 |
| 30-40 | 65 | 43.0 | 43.0 | 87.5 |
| 40 and Above | 48 | 12.5 | 12.5 | 100.0 |
| Total | 384 | 100.0 | 100.0 | |

Table 3. Frequency Table of Age

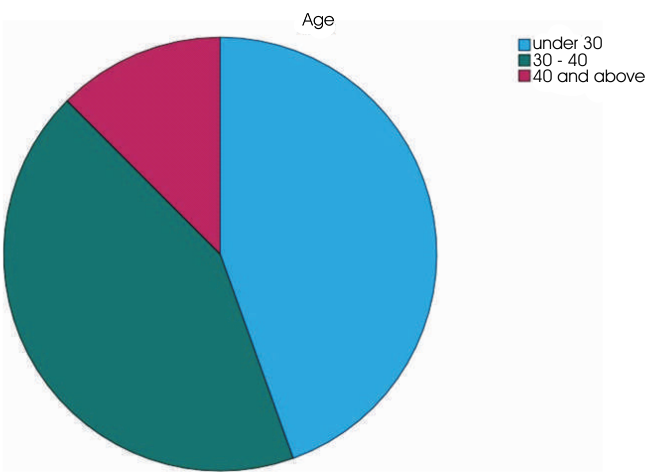


Figure 1. Frequency Table of Age

*2.1.4 Frequency Table of Marital Status*

Table 4 shows marital status in a sample of 384 individuals, categorizing them as "married" or "unmarried." Of the respondents, 60.4% are married, while 39.6% are unmarried. These percentages are accurate, indicating that 60.4% of the sample is married, and the remaining 39.6% are unmarried. This data highlights a majority being married, with a noteworthy portion being unmarried.

*2.1.5 Frequency Table of Education Status*

Table 5 and Figure 2 show the educational status of a sample of 384 individuals, classifying them into three groups: "diploma," "degree," and "master." Among the respondents, 41.7% possess a diploma, 40.9% hold a degree, and 17.4% have a master's degree. These percentages are accurate. The cumulative percent indicates that 41.7% have a diploma, 82.6% have either a diploma or a degree, and 100% encompass all three educational categories. This data shows that the majority of respondents in the sample have a diploma, with fewer holding a degree or a master's degree.

*2.1.6 Frequency Table of Experience*

Table 6 and Figure 3 show the distribution of work experience among a sample of 384 individuals, categorized into two groups: "0-5" and "6-9" years. Half of the respondents (47.9%) have 0 to 5 years of experience, while the other half (50%) have 6 to 9 years of experience. These percentages accurately represent the data, with 52.1% falling into each category. This data indicates an

| Marital Status | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Married | 232 | 60.4 | 60.4 | 60.4 |
| Unmarried | 152 | 39.6 | 39.6 | 100.0 |
| Total | 384 | 100.0 | 100.0 | |

Table 4. Frequency Table of Marital Status

| Educational Status | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Diploma | 160 | 41.7 | 41.7 | 41.7 |
| Degree | 157 | 40.9 | 40.9 | 82.6 |
| Master | 67 | 17.4 | 17.4 | 100.0 |
| Total | 384 | 100.0 | 100.0 | |

Table 5. Frequency Table of Education Status

equal split between those with less than 5 years of experience and those with 6 to 9 years of experience in the sample.

The data indicates that respondents reported receiving training in workplace violence prevention. The positive skewedness suggests that some respondents reported more extensive training, causing the distribution to stretch towards the higher end.

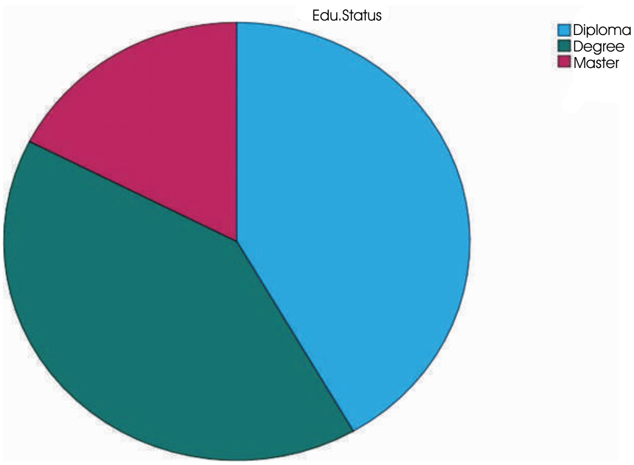


Figure 2. Frequency Table of Education Status

| Experience | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| 0-5 | 184 | 47.9 | 47.9 | 47.9 |
| 6-9 | 200 | 52.1 | 52.1 | 100.0 |
| Total | 384 | 100.0 | 100.0 | |

Table 6. Frequency Table of Experience

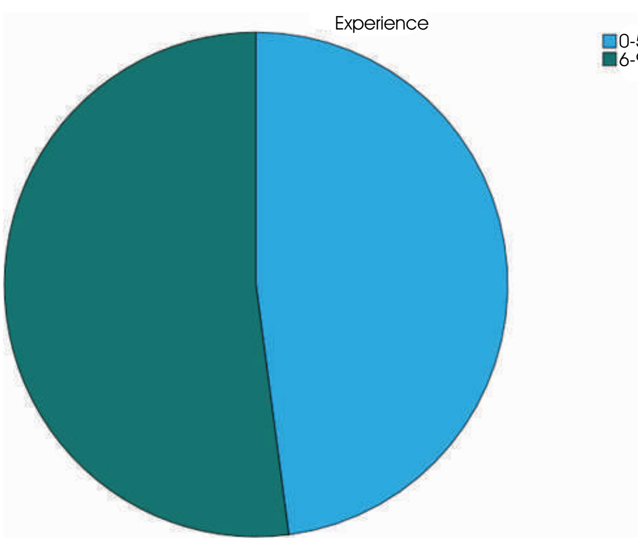


Figure 3. Frequency Table of Experience

Respondents reported experiencing exposure to violent incidents in the 12 months. The positive skewness suggests that some respondents reported higher levels of exposure. Respondents reported being exposed to violent incidents approximately 1-2 times in the 12 months on average. The positive skewness indicates that some respondents reported higher frequencies of exposure.

Respondents reported observing violence against their colleagues. The positive skewness suggests that some respondents reported higher frequencies of observation. Respondents reported that the source of the violence was moderately varied on average. Respondents reported that violence occurred in various locations within the workplace on average.

Respondents reported various reactions to workplace violence, with a relatively wide range of responses on average. On average, respondents reported a moderate inclination towards reporting incidents to administrators.

Respondents who did not report incidents provided various reasons, with the data indicating a range of factors influencing non-reporting. On average, some form of investigation was conducted to identify the cause of violence. Respondents reported a variety of identified causes of violence, indicating multiple contributing factors.

The investigation into the causes of violence was conducted by different parties, with the data showing a range of entities involved. The data suggests a range of consequences for aggressors, with some variability in the severity of outcomes.

Respondents reported receiving varying levels of support from management, with the data indicating a range of experiences. On average, respondents reported moderate satisfaction with the way incidents were handled in their hospital. Respondents provided a wide range of recommendations for preventing workplace violence, indicating diverse perspectives on potential solutions.

The data portrays a complex landscape of experiences related to workplace violence among nurses. Respondents reported a variety of experiences, reactions, and perceptions, highlighting the multifaceted nature of this issue in healthcare settings.

*2.1.7 Descriptive Statistics of Violence*

The descriptive statistics for various variables related to workplace violence among 384 individuals reveal the insights (Table 7). The mean for training R.V.P. (1.1693) and exposed violent incidents (1.2917) suggest most respondents have low exposure, with standard deviations of 0.37548 and 0.47752 indicating moderate consistency. The number of exposed violent incidents (mean 1.9193, SD 1.04531) and observed violence in colleagues (mean 1.8464, SD 0.88199) show higher variability. Types of violent events in the past 12 months (mean 1.9375, SD 0.56091) and the occurrence of workplace violence (mean 2.5156, SD 0.81421) indicate moderate levels. The source of violence has a higher mean (3.5859, SD 1.04615), suggesting diverse sources, while the location of violence (mean 2.6615, SD 1.11481) and reactions to violence (mean 3.6693, SD 2.21613) show significant variability. Reporting incidents to administrators (mean 1.3776, SD 0.61370) and reasons for not reporting (mean 1.9167, SD 1.02620) show lower means with some variability. Investigations about violence (mean 2.1094, SD 1.02375) and identified causes (mean 3.3958, SD 1.59620) indicate moderate engagement. The person conducting investigations (mean 2.9974, SD 0.81915) and consequences for the aggressor (mean 4.2708, SD 1.47373) vary more. Support from risk management (mean 1.5391, SD 0.75343) and how incidents are handled in the hospital (mean 2.6172, SD 1.09440) show moderate values. Recommendations for preventing workplace violence (mean 5.1885, SD 2.11323) among 366 respondents show significant variability.

***2.2 Analysis of Variances (ANOVA)***

Table 8 shows an analysis of the occurrence of workplace violence (Workplace.V.occur) across different groups using the ANOVA table.

In the ANOVA table, the total sum of squares (253.906) is divided into two components: between groups (23.073) and within groups (230.834). The degrees of freedom (df) are 2 for between groups and 381 for within groups. The mean square, which is the sum of squares divided by the

| ANOVA Workplace Violence occur | Sum of Squares | df | Mean Square | F | Sig |
|---|---|---|---|---|---|
| Between Groups | 23.073 | 2 | 11.536 | 19.041 | .000 |
| Within Groups | 230.834 | 381 | .606 | | |
| Total | 253.906 | 383 | | | |

Table 8. ANOVA Analysis of the Occurrence of Workplace Violence

| Descriptive Statistics | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Training R. V. P. | 384 | 1.00 | 2.00 | 1.1693 | .37548 |
| Exposed Violent Incident | 384 | 1.00 | 3.00 | 1.2917 | .47752 |
| No. of Exposed V. I. | 384 | 1.00 | 4.00 | 1.9193 | 1.04531 |
| Observed Violence in Colleagues | 384 | 1.00 | 4.00 | 1.8464 | .88199 |
| Types of V. E. in 12 Months | 384 | 1.00 | 3.00 | 1.9375 | .56091 |
| Workplace V. Occur | 384 | 1.00 | 5.00 | 2.5156 | .81421 |
| Source Violence | 384 | 1.00 | 5.00 | 3.5859 | 1.04615 |
| Location of Violence | 384 | 1.00 | 8.00 | 2.6615 | 1.11481 |
| React to violence | 384 | 1.00 | 8.00 | 3.6693 | 2.21613 |
| Report of the Incident to Administrator | 384 | 1.00 | 5.00 | 1.3776 | .61370 |
| If No | 384 | 1.00 | 5.00 | 1.9167 | 1.02620 |
| Investigation about the Cause of Violence | 384 | 1.00 | 7.00 | 2.1094 | 1.02375 |
| Identified Causes of Violence | 384 | 1.00 | 7.00 | 3.3958 | 1.59620 |
| Person Conducted Investing | 384 | 2.00 | 6.00 | 2.9974 | .81915 |
| Consequences of Aggressor | 384 | 1.00 | 6.00 | 4.2708 | 1.47373 |
| Support R. M. | 384 | 1.00 | 4.00 | 1.5391 | .75343 |
| Incident Handle in Hospital | 384 | 1.00 | 6.00 | 2.6172 | 1.09440 |
| Any Recommendations Preventing Workplace Violence | 366 | 2.00 | 9.00 | 5.1885 | 2.11323 |
| Valid N (Listwise) | 366 | | | | |

Table 7. Descriptive Statistics of Violence

respective degrees of freedom, is 11.536 for between groups and 0.606 for within groups. The F-statistic, which tests the ratio of the between-group variance to the within-group variance, is 19.041. The significance level (Sig.) is less than 0.001, indicating a statistically significant difference in the occurrence of workplace violence between the groups. This suggests that the groups have different mean levels of workplace violence occurrence, and the observed differences are unlikely due to random chance.

## 3. Discussion

Harthi et al. (2020) conducted a study in Saudi Arabia and presented valuable findings aligning with several observed trends in this paper. The high response rate of 85% from the distributed questionnaires reinforces the comprehensive data collection efforts, mirroring the robustness of the data collection strategies employed in this study. The prevalence of violent incidents experienced by healthcare workers, accounting for almost half of the respondents (47.8%), corresponds closely with the prevalent experiences of violence reported in this study. Moreover, the breakdown of violence incidents into verbal abuse, physical violence, and sexual harassment parallels the multifaceted nature of violence observed among participants in this current research. The identification of factors such as lack of encouragement to report incidents and specific demographics like Saudi nationality associated with workplace violence resonates with the barriers to reporting and certain demographic vulnerabilities highlighted in this study. This alignment underscores the consistent challenges faced in reporting incidents and the importance of addressing cultural or systemic factors contributing to workplace violence within healthcare settings.

Both the study on workplace violence among nurses in Italy and this study shed light on the prevalence of workplace violence, indicating a significant proportion of nurses encountering physical or verbal violence (Ramacciati et al., 2015). While this study shows a 43% prevalence among nurses, aligning closely with a 34% prevalence among nursing students in reference number 2, distinctions arise in the types and sources of violence. Nurses faced external violence primarily from patients or relatives, contrasting with students' experiences of internal violence from colleagues, staff, and supervisors. The findings emphasize the impact of verbal violence on nurses' mental health and its associations with job strain and social support, particularly among students. These comparative insights underscore the multifaceted nature of workplace violence, calling for tailored interventions addressing varied sources and implications within healthcare settings.

The operational definition proposed in a comprehensive review on violence towards nurses in healthcare workplaces delineates workplace violence experienced by nurses as encompassing acts or threats of verbal or physical violence, harassment, intimidation, or disruptive behavior aimed at abusing or injuring the target (Ferri et al., 2016). This definition aligns with the multifaceted experiences highlighted in this study, where nurses reported a range of incidents, including verbal and physical violence, threats, and harassment. Adopting this operational definition establishes a cohesive framework for identifying and categorizing diverse manifestations of workplace violence encountered by nurses, reinforcing the broad spectrum of behaviors constituting workplace violence within healthcare settings.

The study conducted in the United States provides insights into workplace violence among healthcare workers in acute care settings, mirroring the prevalence and circumstances identified in this study (Chakraborty et al., 2022). Their findings reveal a 39% twelve-month prevalence of type II violence, echoing the widespread nature of such incidents within healthcare environments. The reported occurrences of physical assaults, threats, and verbal abuse align with the range of encounters reported by nurses in this study. Similarly, the identification of direct care providers being at significant risk and factors contributing to violence, like altered mental status and dissatisfaction with care, resonate with these findings. Additionally, the common fear for safety among victims and low reporting rates mirror concerns identified in this paper. This alignment underscores persistent challenges faced by healthcare workers, highlighting the need for comprehensive interventions and improved reporting mechanisms to address workplace violence effectively.

The findings in reference echo patterns observed in this study, revealing widespread exposure to workplace violence among healthcare professionals (Kitaneh & Hamdan, 2012). The high prevalence (80.4%) aligns with the findings, highlighting the multifaceted nature of violence encountered in healthcare settings. While no statistical difference in exposure between physicians and nurses was found, gender-specific disparities in physical violence were evident, consistent with these observations. Moreover, lower experience levels and education were associated with increased vulnerability, echoing this study's demographic vulnerabilities. The assailants, mainly patients' relatives or coworkers, align with this study, as do the considerable consequences and underreporting of incidents due to various barriers, underscoring persistent challenges in addressing workplace violence effectively.

The findings highlighted by a study in Turkey echo global trends, indicating that nurses in Turkey, much like their counterparts worldwide, face workplace violence from patients, visitors, and health staff (Atan et al., 2013). The prevalence of nurses subjected to verbal or physical violence, encompassing 60.8% of participants, mirrors the substantial experiences of violence reported by nurses in this study. Furthermore, the negative impact on the physical and psychological health of nurses and the detrimental effects on work performance reported by those experiencing violence align with the implications identified in this study. However, the low percentages of nurses seeking professional help, making reports, or contacting hospital authorities underscore the challenges in response mechanisms and reporting systems, aligning with the barriers to reporting identified in this study. The resonance between these findings and global patterns emphasizes the pervasive nature of workplace violence against nurses, underscoring the need for comprehensive interventions and improved support structures to address and mitigate the impact of such incidents.

The collective evidence from various studies underscores the pervasive and multifaceted nature of workplace violence experienced by nurses globally. Whether in Italy, Palestine, or Turkey, nurses face a spectrum of verbal and physical violence from patients, visitors, and colleagues, impacting their well-being and work performance. The consistent challenges in reporting incidents, seeking help, and addressing systemic factors highlight the urgent need for robust interventions and supportive measures tailored to the diverse contexts in which these incidents occur. Addressing workplace violence demands collaborative efforts, emphasizing the importance of comprehensive strategies to safeguard the safety and well-being of nurses in healthcare settings worldwide.

## Conclusion

This study highlights workplace violence against nurses in Peshawar's public sector tertiary care hospitals. Urgent, comprehensive strategies are needed. Implementing targeted interventions can create safer environments, enhancing patient care. Further diverse research is recommended for evidence-based interventions.

Workplace violence against nurses demands immediate attention. A multi-faceted approach is crucial, including training, reporting mechanisms, support systems, and consequences for aggressors. These measures should be integrated into institutional policies for a culture of safety and respect. Healthcare institutions should collaborate for change, including legislative reforms and supportive work environments. Addressing workplace violence improves patient care and system efficiency. This study urges action for nurse safety. By listening to frontline experiences, this study can drive meaningful transformation, creating a healthcare system marked by compassion and professionalism.

### *Limitations*

Potential bias in self-reported data and absence of qualitative perspectives for deeper insights into nurses' experiences and perceptions.

### *Future Research Directions*

Future research could employ mixed-methods approaches for a more comprehensive understanding of workplace violence against nurses, combining qualitative experiences and perceptions with quantitative data. Longitudinal studies could also assess the lasting impacts on nurses' well-being and retention.

**References**

**[1]. Al-Shaban, Z. R., Al-Otaibi, S. T., & Alqahtani, H. A. (2021).** Occupational violence and staff safety in health-care: A cross-sectional study in a large public hospital. *Risk Management and Healthcare Policy,* 1649-1657.

https://doi.org/10.2147/RMHP.S305217

**[2]. Arnetz, J., Hamblin, L. E., Sudan, S., & Arnetz, B. (2018).** Organizational determinants of workplace violence against hospital workers. *Journal of Occupational and Environmental Medicine,* 60(8), 693-699.

https://doi.org/10.1097/JOM.0000000000001345

**[3]. Atan, Ş. U., Arabaci, L. B, Sirin, A., Isler, A., Donmez, S., Guler, M. U., & Tasbasi, F. Y. (2013).** Violence experienced by nurses at six university hospitals in Turkey. *Journal of Psychiatric and Mental Health Nursing,* 20(10), 882-889.

https://doi.org/10.1111/jpm.12027

**[4]. Carter, E. J., Wyer, P., Giglio, J., Jia, H., Nelson, G., Kauari, V. E., & Larson, E. L. (2016).** Environmental factors and their association with emergency department hand hygiene compliance: An observational study. *BMJ Quality & Safety,* 25(5), 372-378.

https://doi.org/10.1136/bmjqs-2015-004081

**[5]. Chakraborty, S., Mashreky, S. R., & Dalal, K. (2022).** Violence against physicians and nurses: A systematic literature review. *Journal of Public Health,* 30(8), 1837-1855.

https://doi.org/10.1007/s10389-021-01689-6

**[6]. Chang, H. E., & Cho, S. H. (2016).** Workplace violence and job outcomes of newly licensed nurses. *Asian Nursing Research,* 10(4), 271-276.

https://doi.org/10.1016/j.anr.2016.09.001

**[7]. Eshah, N., Al Jabri, O. J., Aljboor, M. A., Abdalrahim, A., ALBashtawy, M., Alkhawaldeh, A., & Rayan, A. (2024).** Workplace violence against healthcare workers: A literature review. *SAGE Open Nursing,* 10, 23779608241258029.

https://doi.org/10.1177/23779608241258029

**[8]. Ferri, P., Silvestri, M., Artoni, C., & Di Lorenzo, R. (2016).** Workplace violence in different settings and among various health professionals in an Italian general hospital: A cross-sectional study. *Psychology Research and Behavior Management,* 9, 263-275.

https://doi.org/10.2147/PRBM.S114870

**[9]. Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009).** Violence against nurses working in US emergency departments. *JONA: The Journal of Nursing Administration,* 39(7/8), 340-349.

https://doi.org/10.1097/NNA.0b013e3181ae97db

**[10]. Hanson, G. C., Perrin, N. A., Moss, H., Laharnar, N., & Glass, N. (2015).** Workplace violence against homecare workers and its relationship with workers health outcomes: A cross-sectional study. *BMC Public Health*, 15, 1-13.

https://doi.org/10.1186/s12889-014-1340-7

**[11]. Harthi, M., Olayan, M., Abugad, H., & Wahab, M. A. (2020).** Workplace violence among health-care workers in emergency departments of public hospitals in Dammam, *Saudi Arabia. Eastern Mediterranean Health Journal,* 26(12), 1473-1481.

https://doi.org/10.26719/emhj.20.069

**[12]. Jiao, M., Ning, N., Li, Y., Gao, L., Cui, Y., Sun, H., & Hao, Y. (2015).** Workplace violence against nurses in Chinese hospitals: A cross-sectional survey. *BMJ Open*, 5(3), e006719.

https://doi.org/10.1136/bmjopen-2014-006719

**[13]. Kim, S., Mayer, C., & Jones, C. B. (2021).** Relationships between nurses' experiences of workplace violence, emotional exhaustion and patient safety. *Journal of Research in Nursing,* 26(1-2), 35-46.

https://doi.org/10.1177/1744987120960200

**[14]. Kitaneh, M., & Hamdan, M. (2012).** Workplace violence against physicians and nurses in Palestinian public hospitals: A cross-sectional study. *BMC Health Services Research,* 12, 1-9.

https://doi.org/10.1186/1472-6963-12-469

**[15]. Kowalenko, T., Gates, D., Gillespie, G. L., Succop, P., & Mentzel, T. K. (2013).** Prospective study of violence against ED workers. *The American Journal of Emergency Medicine,* 31(1), 197-205.

https://doi.org/10.1016/j.ajem.2012.07.010

**[16]. Lipscomb, J. A., & El Ghaziri, M. (2013).** Workplace violence prevention: Improving front-line health-care worker and patient safety. *New Solutions: A Journal of Environmental and Occupational Health Policy,* 23(2), 297-313.

https://doi.org/10.2190/NS.23.2.f

**[17]. Liu, W., Zhao, S., Shi, L., Zhang, Z., Liu, X., Li, L. I., & Ni, X. (2018).** Workplace violence, job satisfaction, burnout, perceived organisational support and their effects on turnover intention among Chinese nurses in tertiary hospitals: A cross-sectional study. *BMJ Open,* 8(6), e019525.

https://doi.org/10.1136/bmjopen-2017-019525

**[18]. Magnavita, N., & Heponiemi, T. (2012).** Violence towards health care workers in a public health care facility in Italy: A repeated cross-sectional study. *BMC Health Services Research*, 12, 1-9.

https://doi.org/10.1186/1472-6963-12-108

**[19]. Mayhew, C., & Chappell, D. (2007).** Workplace violence: An overview of patterns of risk and the emotional/stress consequences on targets. *International Journal of Law and Psychiatry,* 30(4-5), 327-339.

https://doi.org/10.1016/j.ijlp.2007.06.006

**[20]. Mobaraki, A., Aladah, R., Alahmadi, R., Almuzini, T., & Sharif, L. (2020).** Prevalence of workplace violence against nurses working in hospitals: A literature review. *American Journal of Nursing,* 9(2), 84-90.

**[21]. Phillips, J. P. (2016).** Workplace violence against health care workers in the United States. *New England Journal of Medicine,* 374(17), 1661-1669.

https://doi.org/10.1056/NEJMra1501998

**[22]. Ramacciati, N., Ceccagnoli, A., & Addey, B. (2015).** Violence against nurses in the triage area: An Italian qualitative study. *International Emergency Nursing,* 23(4), 274-280.

https://doi.org/10.1016/j.ienj.2015.02.004

**[23]. Roche, M., Diers, D., Duffield, C., & Catling‐Paull, C. (2010).** Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13-22.

https://doi.org/10.1111/j.1547-5069.2009.01321.x

**[24]. Shafran-Tikva, S., Chinitz, D., Stern, Z., & Feder-Bubis, P. (2017).** Violence against physicians and nurses in a hospital: How does it happen? A mixed-methods study. *Israel Journal of Health Policy Research,* 6, 1-12.

https://doi.org/10.1186/s13584-017-0183-y

**[25]. WHO. (n.d.).** *Preventing Violence against Health Workers.* Retrieved from

https://www.who.int/activities/preventing-violence-against-health-workers

## ABOUT THE AUTHORS

*Muhammad Nasir is doing M.Sc. Nursing from the Aga Khan University, Karachi, Pakistan. He has 5 years of critical care area experience. His area of research is Maternal, Neonatal, and Child Health.*