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Assessment of Nurses' Knowledge Regarding the Workplace Violence at 250 Bedded Mohammad Ali Hospital, Bogura, Bangladesh

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Abstract

Background: Workplace violence in healthcare settings is a serious problem worldwide and in Bangladesh. It is becoming more common worldwide, and the recent trends confirm a high prevalence of occupational violence against nurses and physicians [1]. The International Labor Office, International Council of Nurses, World Health Organization, and Public Services International defined workplace violence as using physical or nonphysical power against another person or group that could harm the victims physically, mentally, spiritually, sexually, morally, or socially. About 1.6 million people died worldwide due to workplace violence, and many more became injured or suffered from physical and nonphysical health problems [3]. ***Objective:*** The aim was to assess nurses' knowledge regarding workplace violence at 250 Bedded Mohammad Ali Hospital, Bogura. ***Methodology:*** This was a descriptive cross-sectional study design used, and a sample size of 110 that was a purposive sampling technique followed those who met the inclusion criteria and assessed the nurses' knowledge regarding workplace violence. The study was conducted from July 2021 to December 2021. The instruments for data collection were a semi-structured questionnaire composed of two parts: Demographic variables and knowledge-based information on workplace violence. ***Results:*** The findings of the present study revealed that the highest age group, 40.91% were within 30-40 years, 86.36% were female, 4.55% were Muslim, 93.64% were married, and 47.27% were Diploma in nursing educational qualification among respondents. The average knowledge score of 68% was a good level of knowledge regarding workplace violence. It may be due to their cooperation. ***Conclusion*:** Workplace violence among nurses is a major problem in the workplace. It is also a common global problem, including Bangladesh. The major findings of 68% were good level of knowledge. The government plays an important role in minimizing workplace violence using different approaches.

Keywords*:* Knowledge, workplace violence.

INTRODUCTION

Workplace violence in healthcare settings is a serious problem worldwide and in Bangladesh. Among health care providers, nurses are at higher risk of victimization by violence. It is becoming more common worldwide, and the recent trends confirm a high prevalence of occupational violence against nurses and physicians [1]. Workplace violence refers to any harmful act, including physical assault and nonphysical behavior that occurs inside the workstations during the working period of the employee [2]. The International Labor Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) (2002) defined *workplace violence* as the use of physical or nonphysical power against another person or group that could harm the victims physically, mentally, spiritually, sexually, morally or socially. Among health care providers, nurses are at higher risk of victimization by violence. Nurses working in particular

areas in health care settings are more vulnerable to experiencing violent incidents. This area includes psychiatric departments, long-term care departments, intensive care units, and other high-risk areas in emergency departments [3]. Workplace violence may be categorized based on the nature of the perpetrators, which may consist of physical and nonphysical violence such as threats, verbal abuse, bullying, and sexual harassment [2]. Workplace violence is an area of rising concern. Though violence can occur in any environment, this problem has become a high-profile issue in healthcare. Violence occurs more often in healthcare than in other industries [4]. Growing evidence suggests that nurses experience disproportionate levels of violence compared to other healthcare workers and high-risk occupations outside the healthcare system [5]. Despite these findings, it is widely accepted that violence-related incidents in healthcare are underreported, and the actual prevalence is grossly underestimated [6]. Previous studies in several countries indicated that 50% of nurses have experienced violent incidents with verbal abuse, the most common type of violence [7- 11]. Nurses working in particular areas in health care settings are more vulnerable to experiencing violent incidents. These areas include psychiatric departments, long-term care departments, intensive care units, and other high-risk areas in emergency departments [7- 14]. Therefore, most nurses feel unsafe in emergency departments [10]. Furthermore, aggression in emergency departments can negatively impact nurses and health care services. Emergency departments are the entry point for health care services at hospitals, so violence in emergency departments can be very disruptive and threaten the image of health care services. Furthermore, violence can negatively impact emergency nurses' personal and professional lives and the quality of care they provide. Nurses report moderate anxiety, intrusion, avoidance, hyper-arousal, anger, and post-traumatic stress disorder symptoms after experiencing violence [9- 15]. About 1.6 million people died worldwide due to workplace violence, and many more became injured or suffered from physical and nonphysical health problems. Recently, a study found that the prevalence of workplace violence in healthcare was >50%, ranging from 36.0% to 92.0% among nurses in developed and developing countries [2]. In Iraq, a study was conducted to determine the rate and sources of different types of violence. Some characteristics of violent incidents and nurses' reactions towards violent incidents reported that about 90.5% were exposed to workplace violence. Exposure to workplace violence rate among males (93.85%) was higher than among females (86.1%). Exposure to workplace violence rate was lower among those younger than 30 (77.81%) than older participants (71.1%) of the participants were exposed to verbal violence. Relatives of the patients were the major source of violence, and the main time of exposure to violence was during the night shift [16]. A study including 169 nursing staff working in Indonesian emergency departments related that Ten percent of emergency nurses reported experiencing physical violence perpetrated mostly by patients. In contrast, more than half of emergency nurses (54.6%) reported experiencing nonphysical violence with patients' relatives as the main perpetrators. 55.6% of nurses were not encouraged to report workplace violence, and 10.1% had not received any information or training about workplace violence. This study revealed the seriousness of violence in the Indonesian emergency departments [3]. In a study including 444 nurses working in Palestine hospitals, 76.1% experienced a type of workplace violence in the past 12 months: 35.6% exposed to physical and 71.25 to nonphysical assaults. Perpetrators of physical and nonphysical were mainly patients' families or visitors; waiting times, lack of prevention measures and unmet expectations of patients and their families are the main reasons for workplace violence [17]. Many studies have shown that nurses are more vulnerable to workplace violence than doctors and other health care. Earlier research conducted by Shahjalal *et al*. (2021) showed that workplace violence among healthcare workers in Bangladesh Formal guidelines for reporting and managing workplace violence are urgently needed at the individual, hospital, and national levels [18]. Most reports on workplace violence and healthcare workers have appeared in the media through newspapers and electronic media in Bangladesh but without systematic research on the prevalence and effects of workplace violence. Although there is no unified definition of workplace violence since it varies depending on countries and institutions, according to the European Risk Observatory Report, there is a growing concern about it in European countries and worldwide. Measures are being taken to curve the problem [19]. Under the umbrella of workplace violence, all forms of abuse are classified and studied. The European Risk Observatory Report also provides a list of different forms of harassment and workplace violence, which include, in addition to the previously listed ones, sexual violence and harassment, one-off incidents, or more systematic, and thus long- lasting, patterns of behaviour [20]. Workplace violence ranges from minor acts to homicide and can be perpetrated by peers, managers or supervisors, and clients/patients. This type of violence can also be called third-party violence. Unfortunately, Some nurses might cope by taking revenge on a patient and enjoying the pain caused by procedures [21]. Unhealthy coping methods include alcohol, smoking, over-eating, and drug abuse [21]. Job dissatisfaction caused by workplace violence and administrators' insufficient support and action to relieve the situation cause nurses to contemplate leaving their workplace or profession [21]. Therefore, this study sought to assess nurse's knowledge of workplace violence, and the study's result would help guide future research in identifying strategies that could effectively reduce workplace violence in Bangladesh.

METHODOLOGY & MATERIALS

This is a descriptive cross-sectional study; 110 participants were enrolled and analyzed. This study was conducted at 250 Bedded Mohammad Ali Hospital, Bogura, Bangladesh. The study duration was six months, from July 2021 to December 2021. All selected participants were registered nurses at 250 Bedded Mohammad Ali Hospital, Bogura, Bangladesh. The sample was selected from the medicine department, surgery department, gynaecology and obstructs department, pediatric department, and emergency department at 250 Bedded Mohammad Ali Hospital, Bogura. Before collecting data, a written consent form was taken from every participant, and the data were kept confidential. The ethical committee of Bogura Nursing College, Bogura, Bangladesh, approved the study.

Inclusion Criteria

- Nurses are those who work in the selected area of the hospital.
- Nurses who were willing to participate.
- Respondents who were available on duty during the data collection period.

Exclusion Criteria

- Nurses who were not willing to participate.
- Respondents who were not available during the data collection period.
- Nurses who work less than 6 months in the selected hospital.

A purposive sampling technique was followed to complete data collection in this study. The researchers developed a Semi-structured questionnaire according to the objectives and variables of the study. Research instruments consisted of two parts for collecting data. The questionnaire consisted of two parts: Part A covered the demographic information about the respondents, and Part B contained a related questionnaire on workplace violence, including seven items of multiple responses questions and "yes" and "No" options.

Researchers collected data after getting approval, and researchers met with the Hospital Authority and Nursing superintendent and then explained the purpose of this study for educational requirements. After obtaining permission, researchers asked for the cooperation of authority. Then, they explained the purpose of the study and asked for consent as their willingness. Researchers provided them with questionnaires and explained how to complete the questionnaire based on their understanding. The investigators collected data through a semi-structured questionnaire and face-to-face interviews with the respondents. Data was collected for three days (morning and evening). Collected data was checked, organized, coded, edited, and analyzed manually and computer-assisted by the researcher. The results were interpreted using descriptive statistics like frequency, percentage, and mean with the help of a scientific calculator. The important variables were considered and analyzed to fulfill the study's objectives. The results were calculated from the tabulated column. After the interpretation of data, a table and graph (bar chart, pie chart, etc) presented the study findings.

RESULT

Table 1 provides an overview of the study population's demographic characteristics. Among the respondents, 24.55% were aged 30 or younger, 40.91% were between 30 and 40 years old, 25.45% were in the 41-50 age group, and 9.09% were over 50. The mean age of respondents was 41.5 years. Regarding gender, 13.64% of the study population were male, while 86.36% were female. Examining religious affiliation, 93.64% identified as Muslim, 4.55% as Hindu, and 1.82% as Christian. Marital status distribution among respondents was 5.45% single, 93.64% married, and 0.91% divorced. Table 1 also presents educational backgrounds, where 47.27% had a Diploma in nursing level education, 32.73% had a BSc in nursing/PHN level education, and 20% held MSc/MPH level professional education. Regarding their working areas, 23% worked in the Current working area/Department, 31.82% in the surgery ward, 18.18% in the emergency ward, 16.36% in the labor ward, and 10.91% in other wards. Regarding working experience, 59.09% had less than 10 years of experience, 27.27% had 11-20 years, and 13.64% had more than 20 years of experience in their current roles. The distribution of working shifts showed that 80.91% worked morning shifts, 18.18% were on evening shifts, and 0.91% were on night duty. Concerning special training, 59.09% responded affirmatively, while 40.91% answered negatively (Table 1). Table 2 reveals that 97.27% of respondents agreed with the idea of workplace violence, while 2.73% disagreed. Categories of workplace violence included 2.73% experiencing physical force, 6.36% facing harmful acts, 30.91% enduring harassment, 60% dealing with threats, and 54.55% encountering aggressive behavior. Within the study population, 1.82% attributed workplace violence to Nurses' non-responsibility, 20% to Lack of coordination, 9.09% to Lack of medicine, and 69.09% to Shortage of workforce. Additionally, 44.55% experienced violence from Unstable people, 29.09% from Conflicts with co-workers, 16.36% from working late night or early morning hours, and 10% from working in areas with high crime rates. Concerning perceptions of doctors harassing nurses, 60.91% answered affirmatively, while 39.09% disagreed (Table 2). Table 3 provides information on the source of workplace violence, with 6.36% coming from patients, 79.09% from patient relatives, 1.82% from doctors, 6.36% from colleagues, and 6.36% from authorities. Measures taken to address workplace violence included creating policies to prevent harassment (18.18%), establishing effective lines of communication (36.36%), managing visitors and providing security monitoring (40%), and encouraging reporting of violent incidents (5.45%). Additional actions included encouraging reporting (18.18%), collecting reports on

workplace violence (26.36%), establishing follow-up procedures (17.27%), and identifying contributing factors to workplace violence (38.18%). Regarding personal experiences of being bullied at work, 66% responded affirmatively, while 34% answered negatively. Responses to workplace violence incidents included 47.27% receiving verbal warnings, 1.82% reporting to the police, 47.27% reporting to authorities, and 3.64% taking no action. Concerning worry levels, 4.55% were not worried, 22.73% were a little worried, 20% were worried, and 52.73% were sometimes worried. In response to taking action to investigate violent incidents, 46.36% responded affirmatively, 41.82% negatively, and 11.82% were unsure. Frequency of workplace violence occurrences showed that 51.82% experienced it once, 24.55% twice, 10% three or more times, and 13.64% never. Regarding the timing of violence, 14.55% occurred during violence, 52.73% immediately after violence, 17.27% within 24 hours, and 15.45% after one day. Finally, 61.82% received administrative support against violence, while 38.18% did not (Table 3). In Table 3, it's also shown that 29.09% of respondents provided training, 43.64% informed nurses about violence, 26.36% provided security for nurses, and 0.91% engaged in advocacy with lawyers. Table 4 outlines the distribution of the study population based on their levels of knowledge regarding workplace violence. Among respondents, 3.64% had very good knowledge, 13.64% had good knowledge, and 2.73% had poor knowledge.

Table 1: Socio-demographic information of the study participants (n=110).

Characteristics	Frequency (n)	Percentage (%)
Age group (years)		
≤30	27	24.55
30-40	45	40.91
41-50	28	25.45
>50	10	9.09
Gender		
Male	15	13.64
Female	95	86.36
Religion		
Muslim	103	93.64
Hindu	5	4.55
Christian	2	1.82
Marital status		
Married	103	93.64
Single	6	5.45
Divorced	1	0.91
Higher professional education status		
Diploma in Nursing	52	47.27
BSC in Nursing/ PHN	36	32.73
MSC in Nursing /MPH	22	20.00
Working area		
Surgery Ward	35	31.82
Emergency	20	18.18
Labor	18	16.36
Others	12	10.91
Medicine Ward	25	22.73
Working experience (years)		
≤10	65	59.09
11-20	30	27.27
>20	15	13.64
Work shift		
Morning	89	80.91
Evening	20	18.18
Night	1	0.91
Special training		
Yes	65	59.09
No	45	40.91

Table 2: Distribution of the study population according to the knowledge of the idea, occurrence, type, cause, risk factor, etc., of workplace violence (n=110).

Knowledge on	Frequency (n)	Percentage (%)
Idea about workplace violence		
Yes	107	97.27
No	3	2.73
Occurred during the working period		
Physical force	3	2.73
Harmful act	7	6.36
Harassment	34	30.91
Threatening disruptive behavior	66	60.00
Common type of workplace		
Verbal	36	32.73
Threat	14	12.73
Aggressive behavior	60	54.55
Causes of violence in the workplace		
Nurses' non-responsibility	2	1.82
Lack of coordination	22	20.00
Lack of medicine	10	9.09
Shortage of manpower	76	69.09
Risk factors of workplace violence		
Unstable people	49	44.55
Conflicts with co-workers	32	29.09
Working late night or early morning hours	18	16.36
Working in areas with high crime rates	11	10.00
Response during violence		
By negotiation	32	29.09
Told the person to stop	31	28.18
Reported to a senior staff	14	12.73
Informed authority	33	30.00
Harassed by doctor		
Yes	67	60.91
No	43	39.09
Exposure of violence		
Patient	7	6.36
Patient relatives	87	79.09
Doctors	2	1.82
Colleagues	7	6.36
Authority	7	6.36

Table 3: Distribution of the study population according to the knowledge on reduction, prevention, consequences, worries, investigation, etc., of workplace violence (n=110).

Knowledge on	Frequency (n)	Percentage (%)
Violence reduction in the workplace		
Create a policy that prevents harassment	20	18.18
Create an effective line of communication	40	36.36
Manage visitors and provide security monitoring	44	40.00
Encourage everyone to report any and all violent incidents	6	5.45
Prevent workplace violence		
Encourage reporting	20	18.18
Collect reports on workplace violence	29	26.36
Establish follow up procedure	19	17.27
Identify contributing factors to workplace violence	42	38.18
Consequences for the offender		
Verbal warning	52	47.27
Reported to police	2	1.82
Reported to authority	52	47.27
None	4	3.64

Knowledge on	Frequency (n)	Percentage (%)
Worries about workplace violence		
Not worried	5	4.55
A little worried	25	22.73
Worried	22	20.00
Sometimes worried	58	52.73
Investigate the incidence of violence		
Yes	51	46.36
No	46	41.82
Don't know	13	11.82
Violence last 12 month		
One time	57	51.82
2 times	27	24.55
3 or more	11	10.00
Never happen	15	13.64
Report for violence		
During violence	16	14.55
Immediately after violence	58	52.73
within 24 hours	19	17.27
After one day	17	15.45
Administrative support against violence		
Yes	68	61.82
No	42	38.18
Management of violence		
Provide training	32	29.09
Informed the nurses about violence	48	43.64
Provide security for nurses	29	26.36
Advocacy with lawyer	1	0.91

Table 4: Distribution of the respondents by average level of knowledge

Parameter	Frequency (n)	Percentage (%)
Very good level of knowledge	4	3.64
Good level of knowledge	15	13.64
Poor level of knowledge	3	2.73
Total	22	20

DISCUSSION

A descriptive cross-sectional study assessed the nurses' knowledge regarding workplace violence at 250 Bedded Mohammad Ali Hospital Bogura. The study was conducted from July 2021 to December 2021. The instruments for data collection were a semi-structured questionnaire composed of two parts: Demographic-related variables and knowledge- based information on workplace violence. This section discusses the results of the variables and the specific objectives. The findings of the present study revealed that the socio-demographic characteristics of the nurses were 24.55% were within ≤ 30 years of age, 40.91% were within 30-40 years, 25.45% were 41-50 years, and 9.09% were >50 years of age. The mean age of respondents is 41.5 years. Moreover, 86.36% were female, 93.64% were Muslim, and 93.64% were married. Furthermore, 59.09% had <10 years of working experience, 80.91% were on morning shift duty, and 59.09% received special training. These findings are consistent with a study in Bangladesh conducted byAlam, Latif, Mallick, and Akter (2019) on workplace violence among nurses at public hospitals in Bangladesh [22]. The average age was 35.33 years with a range from 23-55 years, where most (59.2%) of the participants below 35 years among 120 respondents, the majority of them78.3% were female, 79.2% were Muslim, 88.3% were married, among all of the participants 57.5% of the nurses were Diploma in Nursing / Midwifery in Nursing, 35.8% were Bachelor degree, and 6.7% were Master degree in Nursing. Most of the nurses were young and newly appointed, like in other Bangladesh countries. The findings are nearly similar to the present study. Regarding knowledge-related information, the findings of the present study revealed that the average knowledge of workplace violence was 18%, which was a very good level of knowledge regarding workplace violence, 13.64% had a Good level of knowledge, and 2.73% were a poor level of knowledge among the respondents in the current study. This finding is consistent with the study, which showed that 88.5% of respondents mentioned physical force as the most common term of violence [23]. This finding is inconsistent with a study in Iraq, where the nurses' knowledge about the concept of violence as physical force was low [16]. This present study found

that nurses' knowledge regarding types of violence is 47.27% verbal. Was the common form of workplace violence among nurses in Bangladesh? This study agrees with the study conducted in Saudi Arabia, where verbal abuse was high, and disagrees with the study conducted in Nigeria, where verbal abuse was low [23, 24]. This study agrees with a study conducted in Southern Thailand, where causes of workplace violence and shortages of nurses were as high [25]. This study found that nurses' knowledge regarding workplace violence risk factors is 97.27%, which is consistent with the study conducted in Messina, Italy, where the risk factors of workplace violence in crime areas were as high [26]. This present study showed that nurses' knowledge regarding the management of workplace violence is 99.09% manage visitors and provide security monitoring, and 99.09% encourage everyone to report any violent incidents. This study is consistent with the study conducted in Nigeria, where most respondents mentioned managing workplace violence through reporting and managing visitors [23]. In Gambia, the understaffing, shortage of drugs and medical supplies, security vacuum, and lack of management attention to workplace violence are important factors aggravating violent occurrences at the workplace. A study evaluated the factors associated with workplace violence among nurses in Nepal and found that nurses' age and working stations were significantly associated with workplace violence. Recently, in Iran, researchers confirmed that gender, age, work experience, and nursing shifts played significant roles in workplace violence against nurses. For Chinese nurses, the most common risk factors for workplace violence against nurses were nurses' age, department, years of experience, and direct contact with patients. A Jordanian study aimed to assess the incidence of workplace violence and the predictors of violent behavior against emergency department staff working at hospitals in Jordan. The findings revealed that overcrowding, lack of resources, staff shortages, and ineffective anti-violence policies contributed to workplace violence.

Limitations of the Study

This is a small representation of nurses at 250 Bedded Mohammad Ali Hospital, Bogura, and, as such, the study's results may be limited to one particular area. The small sample size and selecting samples only from the limited population at 250 Bedded Mohammad Ali Hospital, Bogura, were the limitations of our study. Thus, large-scale studies with larger sample sizes selected purposively from all parts of society are recommended to obtain more generalizable results for further study in the health sector.

CONCLUSION AND RECOMMENDATIONS

Workplace violence among nurses is a major problem and concern in health care. It is also a common global problem, including Bangladesh. The present study's findings revealed that 68% had good knowledge regarding workplace violence. Verbal violence is common compared with physical abuse and sexual harassment in most hospitals. Nurses need to self-report the violent incidents that occur in their working environment. Violence prevention policies and strategies, safety measures, education and training, and adopting protective factors such as an adequate number of security guards, alarm systems, and restricted visiting times could reduce workplace violence among nurses in the hospital. The government plays an important role in minimizing workplace violence using different approaches, such as reviewing laws that protect healthcare workers' rights in a workplace environment. The study can be replicated on a large sample to validate and generalize the findings. The study can be conducted in different settings, like the national level. The study can be conducted on both genders in the community. The level of nurses' knowledge was assessed. A comparative study can be conducted to assess the nurses' knowledge regarding workplace violence at 250 Bedded Mohammad Ali Hospital, Bogura. A similar study can be undertaken on a large scale.

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