



Contents lists available at ScienceDirect

Asian Nursing Research

journal homepage: [www.asian-nursingresearch.com](http://www.asian-nursingresearch.com)

## Research Article

## Experience of Violence from the Clients and Coping Methods Among Intensive Care Unit Nurses Working in a Hospital in South Korea

Hye Jin Yoo, RN, MSN,<sup>1</sup> Eunyoung E. Suh, RN, FNP, PhD,<sup>2,\*</sup> Soon Haeng Lee, RN, MA,<sup>3</sup> Jin Hee Hwang, RN, BS,<sup>4</sup> Ji Hye Kwon, RN, BS<sup>4</sup><sup>1</sup> College of Nursing, Seoul National University, Seoul, South Korea<sup>2</sup> College of Nursing and Research Institute of Nursing Science, Seoul National University, Seoul, South Korea<sup>3</sup> Performance Improvement Unit, Asan Medical Center, Seoul, South Korea<sup>4</sup> Intensive Care Unit, Asan Medical Center, Seoul, South Korea

## ARTICLE INFO

## Article history:

Received 27 November 2017

Received in revised form

25 January 2018

Accepted 23 February 2018

## Keywords:

family  
intensive care units  
nurses  
patients  
violence

## ABSTRACT

**Purpose:** It is difficult to develop a good defense system that can prevent nurses from experiencing physical and verbal violence from patients and families in intensive care units, which are closed spaces. This study aimed to identify intensive care nurses' experience of violence from patients and families and investigate their coping methods, if there are any, in a tertiary hospital in South Korea.

**Methods:** This study used a mixed methods design using both a survey for collecting quantitative data and individual interviews for a qualitative one. A total of 200 intensive care nurses participated in the survey, with 30 of them taking part in individual interviews. Survey data were analyzed using SPSS 21.0 program, and qualitative data were analyzed by qualitative content analysis method.

**Results:** In the survey, 99.5% of the nurses reported that they had experienced violence from the patients, and 67.5% of the nurses reported that they had experienced violence from their visitors (families or relatives). Verbal violence were reported more than physical ones. They showed moderate or severe responses to violence, scoring an average of  $2.98 \pm 0.63$  of 5. The qualitative data were analyzed to draw four themes, eight categories, and 17 subcategories. The four themes were perception of violence, coping with violence experience, coping resources, and caring mind after violence experience.

**Conclusion:** While intensive care nurses experience unpredicted violence from patients and their visitors, they fail to cope well with the experience. The safe working environment of intensive care units is expected to contribute to quality care and an improvement of expertise in nursing.

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## Introduction

According to the world report on violence and health, violence is defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, psychological harm, mal-development, or deprivation.” [1]. One of the causes of possible violence on nurses, i.e., patient and visitor violence (PVV) is an issue being reported around the globe [2–4]. Other health-care providers were about 50% less frequently exposed to PVV than nurses [2]. Most nurses experienced violence in the hospital, and the most frequent

offenders were patients, followed by their families and health-care providers [4,5]. It seems that nurses interacting most frequently with patients and their families are more likely to become primary victims of PVV than other occupational groups not only because of more complicated disease treatment and hospital systems but also because of patients' and families' demand for higher quality of healthcare [2,3].

PVV often occurs when patients' conditions suddenly become worse. Other causes of PVV reportedly include misunderstandings and distrust between health-care providers and patients and their families, uncertainty of the future, anxiety, stress, noises within hospital, and lack of manpower [6,7]. Although PVV is found in lots of departments within a hospital, intensive care units (ICUs) are especially vulnerable to PVV. This is because ICUs are meant to physically care for patients in a critical condition, and the patients and their families are physically and psychologically unstable,

\* Correspondence to: Suh Eunyoung E., RN, FNP, PhD, Jonrogu Daehackro 103, Seoul National University College of Nursing, Rm 513, 06080, South Korea.  
E-mail address: [esuh@snu.ac.kr](mailto:esuh@snu.ac.kr)

<https://doi.org/10.1016/j.anr.2018.02.005>

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which can easily lead to extreme stress and verbal and physical violence.

Nurses who need to cope rapidly with any change in the health state of seriously ill patients in a closed space of an ICU are exposed to excessive job stress accompanied by keeping themselves more alert than those at any other department [8,9]. Intensive care nurses who perceive violence while giving care may fail to cope with the violence and keep working due to rapid workflow [10]. They also experience difficulty in making initial responses because their violence experience is hardly known externally due to the spatial characteristics of ICUs: being closed and isolated [11].

The United States has more than 5,000 nurses experiencing PVV every year and spends 4.2 billion dollars annually in dealing with this issue [4]. Workplace violence can exert long-term physical and mental injuries, which are hard to forget, on nurses. It is reported that nurses experiencing violence can have less compassion and be more vulnerable to burnout and posttraumatic stress. Undoubtedly, it can then lower the quality of their professional life and even affect their job satisfaction, moral senses, and turnover intention [4,12,13]. This can cause long-term fatal problems in their physical and mental health and, consequently, make the organization less efficient and less productive [14,15]. In addition, nurses' failure to regard their working environment as safe can lower the quality of their service and make patients and families less satisfied with health-care service in the long run [8]. No statistical research has been conducted on the accurate state of PVV in ICUs of about 80 medical institutions with over 500 beds in South Korea, and few PVV cases have been reviewed because of different systems and types of violence among hospitals.

In short, although it is certain that intensive care nurses' PVV experience is a phenomenon to study, it is difficult to understand violent situations and its specific status on the basis of the findings from literature review alone. Identifying through qualitative methods by targeting a small number of nurses in an ICU [10], research results have been drawn from a survey of workplace violence [5,11,20]. However, violence occurring in a clinical setting cannot be understood in detail through quantitative methods, and hence, one cannot generalize workplace violence in an ICU as only by identifying small number of violence experience through the qualitative methods alone. Because it is necessary to measure qualitative factors such as courses and situations of the PVV on intensive care nurses and their post-PVV responses and quantitative factors such as frequency, type, and intensity of violence, a mixed method of quantitative and qualitative ones seems to be desirable [16]. Therefore, this study aimed to use a mixed method to analyze PVV on nurses in an ICU.

## Methods

### Study design

This study used a mixed method of a quantitative survey and qualitative data analysis. As for the state of PVV that intensive care nurses experienced and their coping behavior, quantitative research was conducted on violence type, their responses to violence, and their coping methods. In addition, qualitative research was conducted on the nurses' experience of violence through in-depth personal interview, with the findings from the two methods combined and presented [16].

### Setting and samples

The 205 intensive care nurses at a single general hospital in Seoul who understood the purpose and methods of this study and voluntarily consented to the research participated in this study. The

inclusion criteria for gender were limited to females, and it is based on previous studies assuming that most of nurses are young females [2,10]. The data from a total of 200 of 205 participants, with the exception of 5 with missing answers, were finally analyzed. The nurses who participated in the survey and showed interest in additional talk about the theme were presented with a qualitative in-depth interview. As responses to and coping with violence experience were expected to depend on the length of service, stratified convenience sampling was performed among the nurses: < 3 years, 3–7 years, 7–10 years, and ≥ 10 years of clinical career. Interviewees were selected for each group, and they were sampled possibly until saturation with no more new item. As a result, a total of 30 nurses participated in the qualitative research.

### Ethical considerations

This study was approved by the institutional review board of a hospital (approval no. AXX 2016-0554). Before starting data collection, the participants were given full explanation of the purpose and methods of the study, and those willing to participate voluntarily were asked to sign the "research participation consent form." They were given explanation that the collected data would be used for the purpose of the study, be coded to prevent leakage of personal information, and be kept in a site which only the researcher could access. They were given another explanation that the records and copies of data would be destroyed permanently after completing the research.

## Measurements

### Types of violence

Park et al's [5] questionnaire was revised and complemented to determine violence type. This tool was composed of four items concerning verbal abuse, six items concerning physical threat, and seven items concerning physical violence, with offenders divided into patients and their families. Cronbach  $\alpha$  was 0.85 in Park et al's research [5] and 0.92 in this study.

### Responses of violence

The Korean version of the Assault Response Questionnaire (ARQ-K) developed by Jang and Lee [17] was used to measure responses to violence. This tool is the Korean translation of Lanza's [18] ARQ in four subareas: immediate emotional responses, delayed emotional responses, biophysical responses, and social responses. It is a five-point Likert scale with a total of 26 items, with a higher score meaning a higher level of negative responses. This study measured responses within 4 weeks after violence experience [17]. As for the subareas of ARQ-K in this study, Cronbach  $\alpha$  was 0.91 for immediate emotional responses, 0.85 for delayed emotional responses, 0.88 for biophysical responses, and 0.78 for social responses.

### Coping method and effect

A questionnaire with 11 items was developed to determine types of coping methods with violence experience on the basis of literature review [5,10,11]. Five people, including four nurses who have been working at an ICU for more than 10 years and one nursing faculty at a university, have examined the content validity, and CVI was reported as 0.92. In this tool, each item is a yes/no question, and the degree of effects on each coping type is measured with a five-point Likert scale, with scores ranging from 1 (totally

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