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Workplace Violence Against Nurses

Mary W. Stewart, PhD, RN

RESEARCH CAN HELP solve some of our biggest problems, regardless of their domain, for example, personal, professional, or sociopolitical. In this period of global attention to the #MeToo Movement, female empowerment stands at the precipice of revolutionary change. As a traditionally female-dominated profession, nursing can contribute to and benefit from solutions to abuse and violence against women. A team of Chinese researchers gives voice to clinical nurses who endure adverse consequences of workplace violence. Their work sheds light on a topic that, if we are honest, affects nurses internationally.

Workplace Violence Against Nurses: A Cross-sectional Study by Zhang L, Wang A, Xie X, et al. *Int J Nurs Stud*. 2017;72: 8-14.

Background and Purpose

Workplace violence can be classified as physical contact, verbal abuse, threats, sexual harassment, and bullying. Assailants to nurses consist of patients, family members, visitors, colleagues, and superiors. Furthermore, both environment and individual characteristics contribute to violence that can lead to negative patient outcomes and physician-patient tension. Other concerns include job satisfaction and performance, physical and mental health, and financial costs.

Reported rates of exposure to workplace violence vary by country and specialty, ranging from 3.9% to 88.9%, with nurses in emergency, geriatric, and psychiatric facilities facing the problem most often. China, like other countries, contends with variations in definition and exposure of violence. The present study represents the first nationwide effort to investigate the prevalence of workplace violence in China.

Risk factors contributing to violence in the nursing workplace may be situational, such as critical care units, uncertain patient outcomes, high workloads, frequent interruptions in workflow, and long waits. Organizational risk factors involve poor teamwork, distrust among colleagues, lack of administrative support or programs to manage aggression, and perceived or actual injustice. Finally, younger nurses, who are less experienced and lack communication and conflict resolution skills, suffer more workplace violence than veteran nurses who are highly empathetic.

These researchers identified two variables of particular interest: China's high rate of only children and Yinao–also known as organized health care disturbances. Criminal gangs disturb normal health care activities by coordinating loud disruptions, for example, setting off fireworks in hospitals, destroying medical equipment, creating physical barriers between patients and providers, and squatting in offices and nursing stations. Often hired by others, gang members aim to intimidate hospitals to pay undue compensation.

Nurses endure workplace violence that disrupts normal order, dulls morale, and contributes to high turnover. Nursing leaders lack understanding of the complexity of workplace violence and fail to reduce risk factors. Therefore, the purpose of this study was to determine the prevalence and risk factors of nursing workplace violence in China.

Methodology

As the title indicates, this was a cross-sectional study–nurses completed surveys at one point in time. After securing approval from their institutional ethics committee, the researchers distributed questionnaires to nurses throughout the seven regions of China over a period of 4 months. They randomly selected two cities from each

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Conflict of interest: None to report.

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region, and then two hospitals within each city. The study sample included 28 hospitals from 13 provinces.

To be included, one had to be a registered nurse employed by a participating hospital and working on selected units–medicine, surgery, emergency, intensive care, pediatric, obstetrics, or technical (laboratory, sterilization) services. Two members of the research team went to each hospital and recruited participants from department meetings. After acquiring oral and written consent, the researchers distributed the surveys. Although not explicit in the article, the researchers apparently waited on site for the nurses to complete and return the surveys.

The study survey consisted of a demographic questionnaire and three previously validated scales. First, the Workplace Violence Incident Survey, designed to measure workplace violence in the health area, assessed physical force against nurses, for example, kicking and biting; nonphysical violence, for example, verbal abuse and threats of physical harm; and sexual harassment or any unwanted words or actions of a sexual nature. Second, the researchers added a new section related to organized health care disturbance. The Jefferson Scale of Empathy–Health Professionals (JSE-HP) measured nurses' empathy, which covered perspective taking, compassionate care, and standing in the patient's shoes. Third, participants completed the Practice Environment Scale of the Nursing Work Index (PES-NWI) that addressed five dimensions: nurse participation in hospital matters; quality care; resources and staffing; collegial nurse-physician relationships; and nurse manager leadership, support, and skills.

Authors reported appropriate handling of missing or unreliable data, for example, providing the same response to every item. Descriptive statistics identified sample characteristics. Correlational tests evaluated associations with workplace violence. Finally, logistic regression analyzed significant variables to determine the best fit for factors predicting nursing workplace violence in China.

Results

Researchers distributed 4,165 surveys, consisting of 117 questions each, to registered nurses in the targeted hospitals. The response rate, 92.7%, was very high and likely due to the timing and location of recruitment. Of the 3,835 surveys returned, 3,004 were valid and included in the analyses. Participants ranged in age from 18 to 57 years (M = 29.37, SD = 6.18) with length of service averaging 7.98 years (range 0.5 to 37 years, SD = 6.81). Most were female (97.04%) with siblings (69.87%). Close to three-fourths (74%) worked on a rotating roster in a range of departments: medicine (36.02%), surgery (31.29%), intensive care (10.15%), emergency (7.66%), obstetrics (6.39%), pediatrics (6.36%), and technical services (2.13%). Only 216 or 7.19% of the sample were in head nurse or superintendent positions.

Verbal abuse was the most common experience (61.25%) of workplace violence, followed by threats (36.75%), physical abuse (25.90%), and sexual harassment (2.76%). Almost 12% (11.72%) of nurses reported organized health care disturbances. Overall, the prevalence of workplace violence against Chinese nurses was 68.31%.

Descriptive results for the JSE-HP, which measured empathy, ranged from 71 to 140 with an average of 112.35 and SD of 15.36. Because higher scores indicate greater empathy, these participants self-evaluated as having strong empathetic skills. Further, the PES-NWI reflected an overall positive assessment of the work environment with a total average of 83.41, range of 35 to 112, and SD of 13.35.

The following variables most strongly correlated with nursing workplace violence: only children, less than 5 years of experience, working on a rotation, and working in the emergency and pediatric departments. In addition, subscales of the JSE-HP and PES-NWI had varying relationships with physical and nonphysical violence (ie, threats and verbal abuse). Physical violence had significant, inverse correlations with nurse participation in hospital matters, collegial nurse-physician relations, perspective taking, and standing in the patient's shoes. In other words, nurses engaged in affairs of the facility, collegial with physician colleagues, and demonstrating high empathy were less likely to experience physical violence. Nonphysical violence occurred with lower scores of foundations for quality care, staffing and resource adequacy, compassionate care, and standing in the patient's shoes. Thus, nonphysical

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