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Original Research Article

Study on Workplace Violence Against Nurses: Prevalence, Causes, and Preventive Measures

Sangamesh Kinni[1*], Jagadish Mali[2], More Snehal[2], Shaikh Tamanna[2]

[1]Assistant Professor, K T Patil College of BSc Nursing, Osmanabad
[2]Tutors, K T Patil College of BSc Nursing, Osmanabad

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Abstract: ***Background:*** Violence against nurses in the workplace (WPV) is a rising public health problem, and this is particularly pronounced in rural areas with scarce healthcare resources and law enforcement. Background Osmanabad, as a district in the Maharashtra state of India, has specific vulnerabilities arising due to a lack of staff in the hospitals, sociocultural prejudices, and the high number of treatment seekers. Events of violence against such relatively small, young populations, predominantly female Staff, can also be taken to mean that they face an increasing risk of verbal abuse, physical aggression, and psychological harm. ***Objectives:*** This study was conducted to estimate the extent and nature of WPV against nurses practicing in Osmanabad; to identify structural and interpersonal contributors of workplace violence against nurses; to examine reporting practices and institutional responses; and to suggest culturally sensitive intervention strategies targeting this type of violence in such a rural setting. ***Methods:*** Design: Descriptive cross-sectional mixed-method studies with a combination of quantitative and qualitative data collection were used. Seventy registered nurses were purposively sampled and surveyed through structured questionnaires, and 12 were involved in semi-structured interviews. Quantitative data was analysed in SPSS version 23.0, and qualitative analysis of the interviews was performed with the software NVivo. The study received ethical approvals, and informed consent was acquired before data collection commenced. ***Results:*** Verbal abuse was experienced by 68.6% of the nurses, and physical assault by 12.9%. Alarmingly, 72.8% of experiences of violence were not reported, many were silenced by the fear of revenge, and the view that violence is an acceptable practice. The ED was the location for almost half of the WPV cases. Nurses reported large psychological effects with emotional exhaustion (47.1%) and anxiety (41.4%). There was low institutional readiness, with 15.7% of institutions having a reporting system. ***Conclusions:*** WPV in Osmanabad is widespread and augmented by the neglect of the system as well as by cultural ignorance. The results highlight the necessity for multi-level interventions to enhance institutional accountability, legislation reform, and community awareness. It is important to keep nurses safe: think about your health, but also the principle of equal care in rural India.

Keywords: Workplace violence, nursing, rural healthcare, Osmanabad, verbal abuse, psychological impact, institutional preparedness.

1. INTRODUCTION

1.1 Background

Workplace violence (WPV) against nurses is prevalent worldwide and adversely affects health care delivery, nurses' professional integrity, and patient care. As the primary health care giver, nurses are also more susceptible to verbal abuse, physical violence, and psychological threats, which are typically exerted by patients, attendants, and sometimes even fellow staff. In India, the matter is more aggravated due to systemic issues like understaffing, inadequate infrastructure, and limited legal protection for healthcare workers [1].

Osmanabad is a rural district located in the state of Maharashtra, and it has specific challenges in rural healthcare. Resource constraints, high patient volumes,

***Corresponding Author:** Sangamesh Kinni

and cultural misunderstandings surrounding the role of nursing serve to create a work environment where WPV is entrenched and under-reported [2]. Although the country should address violence against healthcare providers at a national level, rural districts such as Osmanabad are not well represented in research and policy dialogues [3].

1.2 Rationale

There is still a paucity of evidence-based information concerning the border rural population of a country such as Osmanabad, although WPV has been adequately explored in urban-tertiary car4-P4 settings [4]. To develop culturally appropriate and context-relevant Interventions, it is necessary to understand the extent and reasons for the occurrence of WPV in these settings. This gap will be prospectively examined by comparing WPV against nurses in Osmanabad using a mixed-methods approach (quantitative with synthesis of qualitative data) that incorporates both quantitative data and qualitative narratives [5].

1.3 Problem Statement

Nurses working in Osmanabad experience a high prevalence of WPV; many cases go unreported and unattended. 1: With inadequacy of institutional support, absence of effective laws, and social undervaluation of nursing jobs, a cycle of silence and vulnerability also, is also highlighted [6]. Without focused research, these problems may continue to perpetuate health inequities and threaten the safety of providers and patients [7].

1.4 Objectives

- To estimate the prevalence of WPV among nurses in Osmanabad.
- To determine structural, relational, and cultural antecedents to WPV.
- To offer culturally competent and community-based prevention recommendations.

1.5 Significance of the Study

Our study adds to the emerging literature on WPV in India, with a focus on a rural district, which frequently falls below the radar of national health discourses. It is congruent with the larger aims of equity in health care, empowerment of nursing, and policy reform. The results could be useful for nursing educators, hospital administrators, and policymakers to establish safe and inclusive health care.

2. REVIEW OF LITERATURE

2.1 Global Description of the Phenomenon of Violence in Nursing.

Workplace violence (WPV) directed at nurses is a common and significant problem in health care systems around the world. Prevalence rates between 31% and 87% have been reported by studies in China, Sweden, and the United States, with verbal abuse being the most commonly reported form of aggression. Nurses in stress-prone departments such as emergency and psychiatric care are at particularly high risk [8]. WPV has been associated with higher levels of burnout, rates of absenteeism, and suboptimal levels of patient care [9].

2.2 WPV in the Indian Context

WPV is largely underreported in India, because of the cultural, economic, and power relations, besides the lack of a robust system for laws and legislations [11]. Srivastava and Kumar reported that verbal abuse was witnessed by more than 50% of nurses in tertiary care hospitals, with 12% having personally been a subject of physical attack [10]. The normalisation of violence and absence of a supportive environment is the reason; silence begets silence [11].

2.3 Rural Healthcare and WPV

Conditions are further exacerbated in rural district hospitals such as Osmanabad due to sparse infrastructure, high patient-to-nurse ratio, and social-cultural misconceptions around what a nurse does [12]. Research from similar rural areas in South Asia shows that gender, caste, and occupational identity overlap to increase nurses' risk of violence [13]. The lack of formal processes for complaint resolution further disempowers rural nurses [14].

2.4 Psychological and Professional Impact

Moreover, WPV has important psychological repercussions, ranging from anxiety and depression to posttraumatic stress disorder symptoms [15,16]. In terms of profession, it results in a drop in job satisfaction, higher job turnover, and a suboptimal quality of patient care 1 8. Rural nurses lack MH support, exacerbating WPV repercussions in the long term.

2.5 Psychosocial preventive interventions and cultural competence

Culturally sensitive interventions such as community mobilization and communication training have been found to be effective in decreasing the prevalence of WPV [17]. Nurse confidence and de-escalation skills are improved by scenario-based training and resilience programmes. But these kinds of schemes are hardly ever put into practice in rural India because of resource limitations.

3. RESEARCH METHODOLOGY

3.1 Research Design

Methodology This is a descriptive cross-sectional mixed-methods study based on quantitative and qualitative methods to study the prevalence, causes, and preventive strategies of WPV faced by the nurses in Osmanabad. The mixed-methods approach facilitates data triangulation to increase the validity and richness of results.

3.2 Study Area

The study was carried out in the Osmanabad district of the Marathwada region of Maharashtra, India. The district has a mainly rural population, poor

healthcare facilities, and high dependence on government health facilities. The study population consisted of nurses practicing in government and private hospitals with at least 100 beds.

3.3 Study Population

Registered nurses working in rural community settings in Osmanabad constituted the target population. 70 nurses were recruited to take part, to create some variability in terms of their age, gender, experience, and type of institute.

3.4 Sampling Technique

We used a purposive sampling process in order to include nurses working with patient care as their primary responsibility, and who had been in a position to work in the high-risk departments (emergency, maternity, ICUs). Participants had to have worked for at least six months in their present practice in order to be included in this study.

3.5 Data Collection Tools

Two primary tools were used:

Structured Questionnaire: Created to obtain quantitative data regarding the forms of WPV, frequency of experiencing abuse, tendency to report, and their perceptions of the institutional support. The questionnaire consisted of closed and Likert-type statements.

Semi-Structured Interview Guide – Administered to a sub-sample of participants (n = 12) to capture qualitative stories addressing personal experiences, emotional toll, and coping strategies following WPV.

3.6 Data Collection Procedure

The study was carried out for six weeks following due administrative sanctions from the concerned hospital administrations. Participants were informed about the objectives of the study and gave their consent. Self-completion questionnaires and face-to-face interviews in private areas to maintain confidentiality and emotional well-being.

3.7 Ethical Considerations

Approval from an established institutional ethics committee was obtained. Participants were informed that participation was voluntary, their anonymity would be protected, and that they could withdraw from the study at any time. The interviews were conducted empathetically and discreetly, and sensitive disclosures in interviews were managed with care.

3.8 Data Analysis

Quantitative Data: Data were collected into Microsoft Excel and analysed by SPSS version. Analyses were summarized using descriptive statistics (frequencies, percentages, and means). Chi-square analysis was used to look for trends by demographic characteristics.

Qualitative analysis: Themes were developed related to key issues such as fear, stigma, and resilience through manual coding of transcribed interviews. The NVivo software was used to facilitate the organization of codes and to identify thematic clusters.

4. RESULTS AND ANALYSIS

4.1 Overview

Results. This section is to describe the results of both quantitative and qualitative data of 70 registered nurses in Osmanabad. Results are categorized by major subject area—demographics, prevalence and types of WPV, reporting practices, institutional response, departmental characteristics, and psychological effects. The clarity is reinforced through tables, and a brief explanation accompanies each table to capture the context of the findings.

4.2 Demographic Profile of Respondents

Table 1: Demographic Profile of Respondents

Variable	Category	Frequency (n=70)	Percentage (%)
Age	21–30 years	42	60.0
	31–40 years	18	25.7
	Above 40 years	10	14.3
Gender	Female	58	82.9
	Male	12	17.1
Experience	<5 years	33	47.1
	5–10 years	24	34.3
	>10 years	13	18.6

The workforce consisted mainly of young female nurses with less than 5 years of experience, reflecting high exposure to emotionally demanding clinical environments.

4.3 Prevalence of Workplace Violence (WPV)

Table 2: Prevalence of Workplace Violence (WPV)

Type of WPV Experienced	Number of Nurses	Percentage (%)
Verbal Abuse	48	68.6
Physical Assault	9	12.9
Threats/Intimidation	21	30.0
Sexual Harassment	4	5.7
No WPV Experienced	22	31.4

Verbal abuse is the most common type of WPV, burdening female and male nurses everywhere (more than two-thirds of all nurses), although threats and physical WPV – albeit less prevalent –make an important contribution to the psychological load.

4.4 Department-wise Distribution of WPV

Table 3: Department-wise Distribution of WPV

Department	WPV Incidents (n)	Percentage of Total WPV (%)
Emergency	22	45.8
Maternity	11	22.9
General Ward	9	18.8
ICU	6	12.5

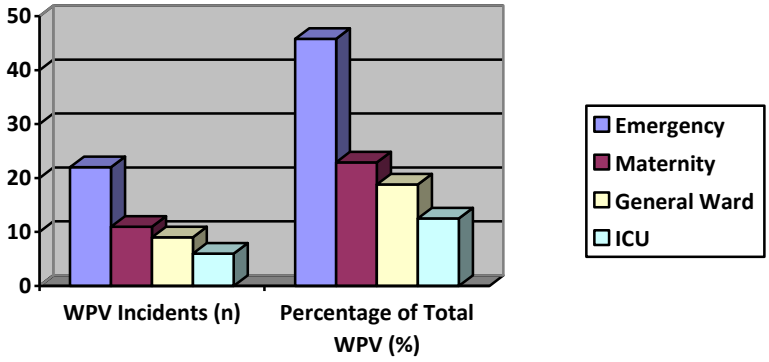

Figure 1: Department-wise Distribution of WPV

AED had the highest WPV prevalence, suggesting high patient-provider interactions during emergency care.

4.5 Psychological Impact on Nurses

Table 4: Psychological Impact on Nurses

Reported Symptoms	Frequency	Percentage (%)
Anxiety	29	41.4
Sleep Disturbance	21	30.0
Emotional Exhaustion	33	47.1
Desire to Quit Job	18	25.7

Emotional exhaustion and anxiety were predominant psychological sequels, and most nurses were considering leaving the profession.

4.6 Institutional Preparedness

Table 5: Institutional Preparedness

Facility Feature	Available (n)	Percentage (%)
CCTV Surveillance	19	27.1
Security Personnel on Duty	24	34.3

WPV Reporting Mechanism	11	15.7
Staff Training on De-escalation	6	8.6

The institutional prevention of WPV was low. Only 3 in 10 had working surveillance systems or trained staff, leaving nurses in a state of chronic risk.

5. DISCUSSION

5.1 Interpretation of Key Findings

The current study demonstrated that 68.6% Nurses had experienced verbal abuse in OMC, and 12.9% of nurses had been exposed to physical assault. These rates are consistent with other national studies conducted in analogous rural areas, where WPV may be normalized and underreported [18]. The frequency of verbal abuse reported is high and indicates a general acceptance of non-physical aggression, which is not captured as a concept in institutional policies.

Even when we now have laws at national levels like the Epidemic Diseases (Amendment) Act, 2020, it's quite inconsistent in the state to apply give robust application of the same, which still leaves the lives of nurses exposed to repeated events [7]. In this study, the 72.8% non-reporting rate highlights a spiralling culture of silence because of fear of reprisal and the absence of support mechanisms within the institution [19].

5.2 Comparison with Existing Literature

Data from Osmanabad are similar to those being reported from other Indian districts, where WPV is fueled by chronic staff shortages, lack of infrastructure, and gender microaggressions [5]. It emphasised that WPV is commonly accepted as an "unpleasant part of the job", causing emotional exhaustion and resignation. They have discovered that high-risk places where emergency and maternity screenings for adolescents are carried out are not adequately covered, as these workers would have more of such problematic experiences.

Findings of international studies not only confirm the vulnerability of nurses to WPV as a result of longer contact time with patients and the emotional labour [17]. But there is no institutionalized reporting as well as dealers in the Indian health care system, and India does not have standardized reporting and redress mechanisms.

5.3 Implications for Rural Healthcare Systems

WPV in Osmanabad presents the broader difficulties in curative rural care. Nurses are the primary care providers in low-resource settings, and they work with minimal security or administrative support. This psychological burden (in the form of emotional exhaustion (47.1%) and anxiety (41.4%)) not only damages the well-being of individual HCWs but also undermines care for patients and community trust.

Furthermore, the quit intention (25.7%) in nurses is an indicator of an imminent workforce crisis. WPV, if not checked, could contribute to widening the rural nursing gap and deepen health inequalities in districts across India, such as Osmanabad.

5.4 Cultural and Gender Dimensions

Misunderstanding of the cultural images regarding nursing job types, especially in patriarchal rural settings, is the cause of WPV. Since nurses are mostly women, fucking scrubbert, and can also be seen as subordinate or expendable, they become an appealing target of attack. Sexual harassment (5.7%) and other forms of gender-based violence, while less frequent, continue to be heavily stigmatized and underreported.

Culturally competent interventions, like community sensitization and inclusive training, are key to challenging these biases and promoting respect for patient-provider services.

5.5 Limitations of the Study

Purposive sampling can lead to selection bias, and the possibility of recall or social desirability bias was present in self-reported data. Longitudinal designs, larger samples over multiple districts, would be considered in future studies to enhance generalizability.

6. CONCLUSION

The victim of workplace violence (WPV) is considered the reciprocal damage that an organization and its employees inflict on and supposedly, sustain a lot of crisis, pressure, or tension in the workplace, like RX Doctors (1). The occurrence of violence against nurses in the workplace, being a prime issue in Rural Health Care, the nature and degree of neglect of violence against Nurses in Osmanabad, is elucidated by this study. WPV has become an endemic structural and cultural problem, as more than two-thirds of survivors reported verbal abuse and close to 13% suffered a physical attack. The information doesn't just substantiate victimization numbers; it, of course, demonstrates just how much underreporting takes place … about 73 percent of incidents did not get reported, which speaks volumes to a lack of trust in an institutionalized system and a system with no checks and balances.

WPV not only causes physical damage. "Nurses are emotionally exhausted, anxious, and wanting to leave the profession, which is a threat to the sustainability of nursing service in the district. Nurses, as steadfast agents of community care, need to be safeguarded, not only using legal structures but through empathic workplace cultures that value their positions.

The results emphasize that the health facilities at Osmanabad are woefully unprepared for the challenge of WPV. There has been insufficient attention to security, reporting, and support systems, as well as to deeply-rooted sociocultural attitudes and gender discrimination that fuel the crisis.

In order to protect the safety of nurses, hospitals and legislatures need to work closely to implement change at many levels: legal reform, organizational accountability, culturally sensitive community partnership, and resilience-building strategies. Tackling WPV is not just about occupational health; it is a moral obligation that accounts for the standard and fairness in healthcare provision in health facilities in underprivileged areas of India.

7. Conflicts Of Interest

The author has no conflicts of interest related to this study. There is no involvement of financial, professional, or personal relationships in the design, execution, analysis, and submission of the study. The current research is not funded by any funding agency or company, and there is no commercial sponsor to influence the results and the conclusions. Ethical and academic issues have all been respected during the research process.

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