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Research Article

Aggressions Suffered and Determining Factors of Physical and Non-Physical Violence Towards Personnel Nursing by Patients and Companions

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Abstract

Background: The relationship between healthcare personnel and patient companions can give rise to cases of aggression in relation to an accumulation of misunderstandings, resentments or fears, which should be detected and deactivated before they could cause aggression. since if these are allowed to pass, episodes of verbal violence may occur concurrently get to the physical.

Objective: to analyze the determining factors of physical and non-physical violence towards health personnel. health for patients and companions.

Methods: An observational, descriptive, cross-sectional study was carried out using retrospective analysis of reports of assaults suffered by health professionals nursing. The scope of the study included nursing staff working in the pediatric critical areas of a hospital in the Buenos Aires metropolitan area. The study included a sample of 63 analysis units, made up of each of the nursing professionals, selected through non-probabilistic intentional sampling.

Results: In the sample, the female sex predominated with 76.2%, average age of 45.3 years and with a predominance of 66.7% of the staff with a Bachelor's degree in Nursing. When the history of violence by patients and/or companions, the staff was investigated 90.5% of nursing staff responded that they were victims, highlighting that in the services of outpatient and Emergency all respondents have been victims of violence by patients and/or companions. The most frequent type of violence was insults with 73.7%. The result of applying the model based on Cronbach's alpha in our sample was 0.863. The sample had an average score on the non-physical violence indicator of 23.95 points (catalogued as present violence); and in physical violence 5.42 points (catalogued as absent violence).

Conclusions: We have been able to draw a number of conclusions from the results. from this study, where a considerable number of nursing staff experience abuse verbal, threats and physical abuse. Therefore, our study contributes to the general understanding of violence in the field of nursing in the Argentine context, however, is needed more knowledge about the consequences of workplace violence and its implications through the development of multicenter studies or studies with larger populations.

Keywords: workplace violence; exposure to violence; outpatient care; Nursing

Introduction

Millions of people around the world are affected by workplace violence, which is has become the main source of inequality, discrimination, estimates and disputes within the workplace, affecting the dignity of the worker and the success and effectiveness of any organization [1]. In recent years, workplace violence has experienced exponential growth, where nearly 25% of violent incidents have occurred in the health sector and 50% of its

professionals have experienced some type of incident in their work career [2]. Workplace violence has become a phenomenon that emerges worldwide, generating incidents in any work-related activity, mainly in health care because they are carried out in direct contact with the user [3]. It is common that when mentioning violence, it is believed that it only covers those incidents or physical aggressions, without taking into account those that really predominate, such as psychological aggression, such as threats or verbal insults. It is usually very common that most health workers have normalized this type of non-physical aggression which they receive in the form of insults and harassment and therefore are not reported [4]. Although any health worker can be the target of a violent act, both physical and verbal in any of its areas where workers who are usually involved in their activity develop their activity those most exposed to aggression from the patient, family member and/or companion are those who are they work in critical areas such as urgent and emergency services [4].

The relationship between healthcare personnel and patients' companions can give rise to cases of aggressiveness in relation to an accumulation of misunderstandings, resentments or fears, which they should be detected and deactivated before they could cause an attack, since if these If they are allowed to pass, episodes of verbal violence may occur concurrently and may even become physical [5]. Health personnel not only assist those who have been violated in any form, but that the care provider has become a requester of assistance by becoming the object of aggressions by those who should care, becoming a topic of research where establishes that health establishments are part of the most exposed work environments to any type of aggression. Although any service-providing work environment can become a site conducive to the flow of violence, the health sector is the one that represents the greatest danger to its workers [6]. Violent demonstrations against health personnel were only considered as facts isolated cases that occurred in mental health sectors until the 1990s. Then, with the passage of time, years both public health service organizations and population culture. I experience great changes, becoming more demanding and demanding [3]. Currently, international organizations recognize violence as a barrier to development of nations and a threat to health, due to the multiple demands they undergo each of the professionals, such as stress, social pressures, reforms of the systems of health [7,8]. The attacks against health workers have not only been continuously increasing, but they have also naturalized, it became a custom for both patients and family members and/or companions, question any health personnel, through physical harassment and/or emotional that affects the quality of their professional performance and their work motivation. [5.9].

Violence has become a great shadow that crosses any border without making a difference except for none, invading the sectors that should protect us and give us security such as workplaces, mainly the sectors where workers work, public health, resulting in both physical and psychological injuries that affect the dignity and self-esteem of the working person [10]. Despite the multiple manifestations of violence that the health worker receives only a few So many of those physical and non-physical aggressions that are so serious are reported require medical attention [10].

There are many consequences generated by the aggressive behavior of users and family members and/or companions to health professionals, consequences ranging from physical to headaches, abdominal pain, trauma, abrasions to psychological symptoms, post-traumatic stress disorder, job insecurity that can lead to burnout syndrome [3]. The negative consequences of violence against health personnel impact the type of health care and the quality of care to be provided, which may induce the professional to abandonment of career development [3]. It also impacts their organizations and the economy of each country, due to the increase in absenteeism, poor quality in the provision of services, decreased performance of each affected worker and the costs arising from legal claims [3]. The objective of this study was to analyze the determining factors of physical and non-physical violence towards health personnel by patients and companions.

Methodological Design

An observational, descriptive, cross-sectional study was carried out through the analysis retrospective review of reports of assaults suffered by nursing professionals.

The scope of the study included nursing staff working in critical areas pediatric wards of a hospital in Greater Buenos Aires. The study population included all nursing professionals who provide services in these areas. The study included a sample of 63 analysis units, each consisting of nursing professionals, selected through non-probabilistic sampling of the type intentional.

For data processing, two instruments were used, in the form of a questionnaire self-administered:

1. Sociodemographic and work data sheet: Sex, Age, Level of education, Year of employment, graduation and Service in which he/she works.
2. Perception of workplace violence events that investigated the background of violence by patients and/or companions, complaints of these actions violence, the situations that trigger violence, and the consequences these had situations of violence.
3. Validated survey to assess violence: validated and adapted survey to assess aggressive behavior towards health personnel. The Aggressive Behavior Scale Towards Health Professionals (*Healthcare-Worker's Aggressive Behavior Scale*),[11]. Translated into Spanish and adapted by Muñoz et al.,12A pilot test was carried out with the purpose of contextualizing the instrument to our environment.

The study had the corresponding approvals from the institution where the study was conducted. In addition, the ethical aspects of the research were taken into account, each of the participants. They were informed about the purpose, characteristics of the study and that the results would only be used for research purposes, the units of analysis were added to the previous study signing of informed consent.

Quantitative variables were described with the mean and standard deviation (SD), given the asymmetric distribution of the same. For the qualitative variables, their frequency was expressed absolute and its percentage. To assess the relationship between variables, linear correlations were used, and for the differences between groups the one-factor ANOVA test was used. A indicator as significant when it had a $p \leq 0.05$.

Results

In Table 1, it was observed that the sample under study was predominantly female with a 76.2%, average age of 45.3 years and with a predominance of 66.7% of staff with a degree of Nursing graduates.

Table 1: Sociodemographic characteristics of the sample.

Variable	N	%
Sex		
Female	48	76.2%
Male	15	23.8%
Age		
Media (SD)	45.3 (9.4)	
Range	28-60	
Level of training		
Nursing Assistant	6	9.5%
Nurse	12	19.0%
Bachelor of Nursing	42	66.7%
Mastery	3	4.8%
Job seniority		
Media (SD)	8.85 (4.97)	
Range	1-18	
Service where you work		
Outpatient Clinic	3	4.8%
Internment	36	57.1%
Emergency	24	38.1%

When asked about the history of violence by patients and/or companions, the nursing staff responded in 90.5% that they were victims, highlighting that in the services in the Outpatient and Emergency Department, all respondents have been victims of violence by of patients and/or companions. The most frequent type of violence was insults with a 73.7%. The rest of the indicators can be seen in Table 2.

Table 2: Perception of workplace violence events.

Indicator	N	%
Victim of violence by patients and/or companions		
Yeah	57	90.5%
No	6	9.5%
Victims by department		
Outpatient Clinic	3	100.0%
Internment	30	83.3%
Emergency	24	100.0%
Type of aggression		
Abuse	42	73.7%
Threats	36	63.2%
Coercions	12	21.1%
Discrimination	3	5.3%
Reported assaults		
Yeah	12	19.0%
No	51	81.0%
Situations that trigger violence		
Waiting time	36	57.1%
Lack of Information	27	42.9%
Priority to other patients	24	38.1%
Resistance to procedures	15	23.8%
Consequences		
Without consequences	45	71.4%
Requires psychological support	12	19.0%
Injuries	6	9.5%
Sick leave	6	9.5%

* Percentage of the total service.

* Percentage of those who were victims of violence.

The instrument applied was composed of 12 items, to analyze its reliability it was applied an internal consistency model, where the variance of each item was 25.982; and the total variance was 124,522. The result of applying the model based on Cronbach's alpha in our sample was 0.863. The mean values, standard deviation, variance, skewness and kurtosis of each item can be seen in Table 3.

Table 3: Descriptive statistics of the items.

Item	Average of variance of the item	Asymmetry	Kurtosis		
Users question my decisions as a nurse	2.9	1.8	3,170	0.7	-0.7
Users hold me responsible for carry out incorrect actions	2.1	1.4	2,027	1,2	0.4
Users have even made inappropriate touches towards me (shoving, pointing)	1.9	1.1	1,229	1.5	1.5
Users accuse me unjustifiably of non-compliance, errors in the diagnosis and treatments	1.8	1.3	1,678	1.8	3.1
Users make jokes to me ironic	2.0	1,2	1,379	1,2	0.4
Users have come to exercise physical violence against me (pushing, shaking, spitting on me, etc.)	1.4	0.8	0.626	2.0	3.5
Users get angry with me due to lack of information	3.3	1.7	2,794	0.2	- 1.3
Users show their anger against me by destroying doors, glass or walls	2.1	1.4	1,896	1.5	1.6
Users get angry with me due to the delay in care	3.4	1.9	3,388	0.0	- 1.4
Users give me dirty looks or looks of contempt	3.5	1.8	3,107	0.0	- 1.3
Users record me with their cell phones while I do my work.	2.5	1.6	2,345	0.9	- 0.5
Users carry weapons or there are weapons at the place of care.	2.5	1.6	2,345	0.9	-0.5

The sample had an average score on the non-physical violence indicator of 23.95 points. (Catalogued as present violence); and in physical violence 5.42 points (catalogued as violence absent). The breakdown of the indicators in relation to sociodemographic variables, work and perception of violence can be seen in Table 4.

Table 4: Types of violence in relation to sociodemographic, work and social variables. perception of violence.

Variable/Indicator	Non-physical violence		Physical violence	
	Media (SD)	p value	Media (SD)	p value
Sex				
Female	23.6 (10.3)	0.637	5.5 (2.6)	0.440
Male	25.0 (7.6)		5.0 (1.3)	
Level of training				
Nursing Assistant	31.5 (1.6)	P = 0.044	8.5 (1.6)	P < 0.001
Nurse	22.5 (5.4)		4.7 (1.3)	
Bachelor's degree in Nursing	22.5 (10.8)		4.7 (1.7)	
Mastery	34.0 (0.0)		12.0 (0.0)	
Service where you work				
Outpatient Clinic	30.0 (0.0)	P = 0.091	7.0 (0.0)	P = 0.527
Internment	20.7 (6.3)		5.3 (1.7)	
Emergency	25.5 (11.3)		5.3 (2.8)	
Victim of violence				
Yeah	24.3 (9.7)	P = 0.365	5.6 (2.4)	P = 0.009
No	20.5 (9.3)		3.0 (0.0)	

Discussion

The prevalence of workplace violence varies widely due to the variety of physical and non-physical indicators and scales used to study it, highlights that 9 out of 10 respondents perceive having been a victim of violence, and that those who perceived it in turn they obtained average values classified in the order of non-physical violence. The results of this study were similar to other studies in nursing staff and others. health professionals [13–16].

No similar studies were found in the Argentine context in the consulted databases, only one Latin American report that includes Argentina as the country with the most respondents, but the analysis of this study does not allow for discrimination or comparison of the specific national context [17]. Significant differences were found only in terms of the respondents' level of education, but this value has few implications, given that in practice both professional nurses as graduates perform similar functions.

A study conducted in Mexico reports that 47.7% of participants experienced aggression, 12.8% verbal and 34.9% verbal/physical during the last year; women were the most assaulted (chi square = 12.12, p = 0.000), information that was confirmed by a model of logistic regression where being a woman and belonging to nursing, respectively, represented up to 2.5 and 3 times higher risk of suffering violence [18]. Verbal abuse was the most common unwanted behavior in the surveyed staff, similar to that reported by Joa and Morken [16]. Verbal abuse is also a sign of impending danger. Patients or other members of the staff may decide to use abusive language towards

nurses. Relatives of a patient Patients can also become aggressors by subjecting a nurse to verbal abuse [19]. Magin et al., for their part, observe that workplace violence in general is more likely among the staff providing customer service.20Verbal abuse seems to be part of work among emergency services workers (doctors, nurses, assistants).21 A study conducted among emergency room nurses revealed that violence verbal was more frequent in the triage area [22].

These results coincide with our study, where all respondents both from consultation both external and emergency personnel report a history of violence. It is possible that the personnel nursing staff are more exposed to unwanted behavior, since they have more hours of duty or consultation.

In relation to the circumstances that lead to acts of violence in our study, reports the most frequent waiting time and lack of information; other studies suggest that the most common circumstances were delay in care (44.2%), lack of resources (33.6%), reports from medical staff (28.2%) and communication of deaths (8.6%). The first two reflect the deficiencies of the care system. Delays in care are a serious problem, especially in emergency areas, and reflect problems within the organization and the availability of the necessary and appropriately qualified personnel. The lack of resources is also a clear indicator of the weakness of the health system. Therefore, we do make it a priority to develop measures to improve the provision of timely and efficient care quality, not only to reduce the alarming level of attacks on health workers, but also to care for the sick [17].

Generally, the response of the victim is spontaneous and aimed at resuming dialogue with the victim aggressor, however, studies report that in some cases the assistance of a colleague is required or a security officer. Organizational characteristics (microsystems and mesosystems) influence the way professionals respond to aggressive behavior, of which it is to expect that institutional protocols systematically determine the person's attitude attacked to reduce undesirable consequences [23].

Authors such as Walker and Avant refer to consequences as events or incidents that follow the occurrence of workplace violence and systematize it into psychological consequences,

emotional, physical, organizational or professional [24]. Although in our study the majority of acts of violence had no consequences, report psychological and physical consequences. In this sense, it is suggested that the consequences Emotional and psychological distress are largely experienced by nurses, with the most common being psychological violence is the most common type of abuse reported by nurses in nursing homes health [25].

These include, but are not limited to, stress, lack of sleep, and anger. The emotional and emotional consequences psychological ones are more frequent than physical ones and represent the highest percentage of consequences experienced. These consequences end up affecting the quality of the work carried out, since a stressed nurse will not meet expected standards.26Violence also evokes feelings of humiliation, which can lead to increased absenteeism.27 Attacks on health workers in Latin American countries are a problem common that has mental and work-related consequences and causes workers health workers feel unsafe in their workplaces. The problem is exacerbated not only because puts thousands of people at risk of invasion, but also because it violates basic rights to the safety at work, and its consequences alter the quality of the services provided and they thus affect the public health of the entire population [17].

A systematic review concluded that regardless of the form it takes, violence in the workplace can have emotional, professional, physical and psychological consequences of far-reaching. The studies reviewed show to what extent workplace violence continues being a problem for members of the nursing staff. It is proposed that to address this problem will require a collaborative effort involving various parties stakeholders, such as administrators, nurses, leaders, educators and other professionals both community and national levels. If the prevalence of workplace violence is not addressed, work in health centres. There will be important ethical, legal and morale for the sector and will ultimately undermine the quality of care provided.28 Violence against nurses can be reduced by addressing the factors that contribute to it.

This violence occurs. For example, researchers suggest that when there is enough with adequate staff and training programs, abuse and violence can be greatly reduced. measure by adding facilities such as beds and other medical equipment, encouraging work in team and assigning work fairly [29]. Similarly, other studies recommend controlling public access and limiting opening hours. visit, which would stabilize the situation in hospitals and thus ensure the safety of the nurses. The implementation of certain policies and laws would also minimize violence in the workplace.

For example, some of the studies reviewed here showed that hiding information to a patient's family can trigger violence [14,30–33]. Among the limitations of this study, it can be described that the profile of the aggressors or the frequency of aggression according to whether they were patients and/or companions. In the literature refers to the influence of drugs and mental illness as the most common causes frequent verbal abuse, threats and physical abuse [16].

Conclusion

We have been able to draw a number of conclusions from the results of this study, where a significant number of nursing staff experience verbal abuse, threats and physical abuse. Our study therefore contributes to the general understanding of violence in the field of nursing in the Argentine context, however, more knowledge is needed on the consequences of workplace violence and its implications through the development of multicenter studies or studies with larger populations. In any case, the institutions of health care providers should have a zero-tolerance policy regarding violence towards staff health and take steps to prevent behaviors.

In our opinion, the systematic use of this scale within the prevention of occupational risks it can be useful for the early detection of negative behaviour from an organizational point of view, identifying risk services. The increase in acts of violence against nursing staff reflects a trend towards accumulate and cause more serious psychological consequences and exposure to health professionals. health, especially those considered vulnerable.

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Conflict of Interest

The authors declare that there is no conflict of interest.

Authorship Contribution

1. Conceptualization: Isabel Galeano and Javier González Argote
2. Data curation: Javier González Argote
3. Formal analysis: Javier González Argote
4. Acquisition of funds: Isabel Galeano and Javier González Argote
5. Research: Isabel Galeano and Javier González Argote
6. Methodology: Isabel Galeano and Javier González Argote
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10. 1Supervision: Javier González Argote
11. Validation: Isabel Galeano and Javier González Argote
12. Visualization: Isabel Galeano and Javier González Argote
13. Writing – original draft: Isabel Galeano and Javier González Argote
14. Writing – review and editing: Isabel Galeano and Javier González Argote.

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