



**WORKPLACE VIOLENCE TOWARDS NURSES IN THULAMELA
MUNICIPALITY HOSPITALS, VHEMBE DISTRICT**

BY

MADZHADZHI LIVHUWANI PRECIOUS

Student no.: 11514194

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SUPERVISOR: PROF. H.A AKINSOLA

CO-SUPERVISOR: MRS J.T. MABUNDA

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DECLARATION

I, Livhuwani Precious Madzhadzhi declare that the thesis hereby submitted to the University of Venda, for Masters Degree in Public Health has not previously been submitted by me for a degree at this University or at any other university. It is my work in design and execution and all material contained herein has been duly acknowledged.

LPM Madzhadzhi

Signature of student

30.04.2015

Date

Student number: 11514194

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- Mr Moyo Moses, the biostatistician, for your skills in analysing my data.
- My husband, Thendo, you make it impossible for me to forget you. Thank you for supporting and encouraging me throughout my studies.
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ABSTRACT

Violence is present in all work environments but nurses are at an increased risk. They have very close contact with patients and their relatives, and thus are at a great risk of being abused in the hospital environment. Nurses are exposed to violence 16 times more often than in other employment. The aim of the study was to describe workplace violence towards nurses in Thulamela hospitals. The study adopted a cross-sectional design using questionnaires to collect data. The researcher selected 100 participants from each hospital, giving a convenient sample of 300. The data was analysed descriptively using the SPSS Version 20.

The study results show that the majority 225(85%) of the respondents had experienced workplace violence. The most common types of violence which was experienced were threats (95%), pushing (92%), ethnic harassment (82%), pinching (68%) and biting (67%). Regarding the causes of workplace violence, the majority of the respondents indicated that age, gender, mental disorder, alcohol and waiting time as the risk factors. Recommendations include developing and implementing employee health and wellness programmes and continuous workshops on workplace violence.

Key Words: Nurse, workplace and Violence

CHAPTER 1 INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Work-related violence is a common problem worldwide and nurses are at increased risk. According to the World Health Organisation (2002), violence includes physical assault, homicide, verbal abuse, bullying or mobbing, sexual and racial harassment and psychological stress. The National Institute for Occupational Safety and Health defines workplace violence as “violent act (including physical assault and threats of assaults) directed towards a person at work or on duty (Kwok, Cheung, Fung, Kwok, Tong, Yen and Leung, 2006).

Violence is present in all work environments but nurses are on the frontline of the health care system. They have closest contact with patient and their relatives, and thus are at great risk of being abused in the hospital environment. International studies have reported that the prevalence of workplace violence against nurses in the hospital setting varied from 10% up to 87 % (Kwok et al., 2006).

In healthcare environments, occupational violence has been especially prevalent. Studies have repeatedly shown that workers in this occupational group are subject to higher rates of verbal and physical assault than almost any other occupational group, with workers being subject to abuse from patients, family members, peers and employers (O’Brien-Pallas, Wang, Hayes and LaPorte, 2008). It is an established fact that even among healthcare workers the rates of workplace violence in nursing are particularly high. The 2000 British Crime Survey shows the likelihood of nurses being assaulted is second only to security and protective services occupations. Studies conducted internationally clearly indicate that this is not an isolated phenomenon but is, in fact, a cause for global concern. What is startling is that when one considers that underreporting of workplace violence in nursing is an all too common phenomenon the prevalence of violence against nurses is likely even higher than is being reported (O’Brien et al. 2008).

Research into the consequences of workplace violence over the past two decades has brought about a heightened awareness of how widespread and damaging these assaults are. Yet evidence suggests that the prevalence of workplace violence remains unacceptably high. For example, a recent Statistics Canada report found that in 2004 approximately 17 % of all self-

reported incidents of violent victimisation took place in the workplace (Pallas et al. 2000). In the United States, homicide is the second leading cause of death at the workplace and a staggering 2 million non-fatal workplace assaults are estimated to take place every year. Findings such as these are echoed by studies across the globe that report high incident rates of workplace violence, with some studies even reporting an increase in workplace violence in recent years (O'Brien et al, 2008).

Despite the variable range of reported violence, there is a consensus that the most commonly encountered violence is verbal abuse. The highest incidence of workplace violence occurs in psychiatric wards, accident and emergency departments, and high dependency units. The reported percentage of nurses being abused in psychiatric wards and accident and emergency departments is an astonishing 98% and 100%, respectively, due largely to the characteristics of patients. Healthcare workers' experience of workplace violence must certainly have a negative correlation with job satisfaction and performance. Such a decrease in performance will directly impact on patient care and consequently the effectiveness of the health care system (Kwok et al, 2006).

Work-related violence was not apparently identified as an important public health problem in the United States until 1991. In the United States, homicide was the fourth leading cause of occupational fatality in 2005, and approximately 1.7 million non-fatal acts of work-related violence occurred annually in the United States between 1993 and 1999. However, work-related violence occurrence is not contained within national borders. Specific industries or group of workers appear to be at increased risk for violence. Hospital and healthcare workers, particularly nurses, are at high risk for non-fatal violence. Between 1993 and 1999 in the United States, nurses experienced work-related violence at the higher rate (22 per 1000) among all types of healthcare workers (Nachreiner, Gerberich, Ryan and Mc.Govelen, 2007).

According to the Bureau of Justice Statistics, workplace assaults injure 1.7 million workers each year (U.S. Department of Justice, 2001). In terms of injury rates from workplace violence, healthcare and social service industries are second only to the field of law enforcement (OSHA, 2006). Nearly 500,000 nurses become victims of violence in their workplace each year, according to the U.S. Department of Justice. Nurses are three times more likely to be the victims of violence than any other professional group (Keely, 2002).

In South Africa, the Medical Research Council conducted a study on workplace violence in the healthcare industry and reported that most respondents had experienced it in different forms. Verbal abuse was reported by 92.3% of respondents, while 36.4% of interviewees had occasionally been threatened with physical assault (Malangu, 2012). Within health facilities, emergency departments and psychiatric settings constitute areas with more incidence of violence. Levels of violence are very high in South Africa already. However, the workplace was always regarded as being free from violence in comparison to the streets, but not anymore. The violence in society has spilled over into the workplace and to an extent into the homes (increase in domestic violence) of South Africa and the best way to address violence in South Africa is to confront it head on, starting with the workplace (Malangu, 2012).

Just as an array of actions and behaviours can constitute workplace violence, equally complex and layered are the consequences of this violence on the quality of one's work life and health. Although physical injury is one potential result of violence, it has been reported that acts of workplace violence causing serious injury or physical harm occur far less frequently than assaults which result in little or no physical harm. While the immediate effects of this type of violence may be less obvious, some of the more prominently reported consequences of this violence include: anger, fear or anxiety, post-traumatic stress disorder symptoms (PTSD), guilt, self-blame, and shame. Additionally, others have reported that the psychological or emotional fallout of workplace violence impact work-related outcomes, resulting in poor work attitudes, decreased affective commitment, increased turnover intentions, increased job neglect and decreased job performance and productivity (O'Brien et al. 2008).

Researchers investigating the impact of this violence on nurses show that it can interfere with normal working and leisure activities for months or years after the incident. In a recent review of the non-somatic effects of patient aggression against nurses, it was reported that assaults can undermine the nurse-patient relationship by causing behavioural change such as a decreased eagerness to spend time with patients, decreased willingness to answer patients' calls, avoidance of patients, adopting a passive role in treatment, or even causing callousness towards patients (O'Brien et al. 2008). Likewise, verbal abuse in the workplace has been linked to decreased morale, productivity and nursing care delivery, as well as increased workload and errors. The anxiety and stress about personal safety following workplace

violence can also indirectly complicate or exacerbate other work stressors. For nurses working in more remote areas the fear of personal safety may persist even when off-duty.

Apart from the effects on psychological health, personal well-being, employee morale and nursing care delivery as described above, a direct link has also been reported between aggressive incidents at work and sick leave, drug and alcohol use, burn out, staff turnover and desire to leave the profession in nurses. This is substantiated by studies such as those by Cox (2006) which reported 16% of nursing turnover was directly related to factors associated with verbal abuse. Other authors have reported similar findings, showing significant positive correlations between verbal abuse and variables such as “looking for a new job” and thoughts of “quitting within the next 6 months”. A significant negative correlation has also been reported between job satisfaction levels and the number of different types of violence experienced by nurses over their most recent five shifts (O’Brien et al. 2008).

Workplace violence negatively affects the dignity, happiness and well-being of the victim. Aggressive behaviour is used as a struggle tactic in interpersonal conflict. Bullying seems to contain at least four phases: aggressive behaviour, bullying, stigmatisation and severe trauma. In most corporate environments, the victim is often treated as the problem. When stepping into the case, upper management, union representatives, or personnel administration tend to accept the prejudices produced by the offenders, thus blaming the victim for his/her misfortune (Crowley, 2000). Third parties or managers may see the situation no more than fair treatment of a difficult and neurotic person. This is the denial and shame by which abuse thrives. Like one manager said in a focus group discussion - offering the explanation to a difficult phenomenon like workplace violence: "It is people bringing their problems to the workplace". Although very few managers hold sentiments like these, the reality is that knowledge about workplace violence and its effects on the individual is not unknown and more awareness is necessary. This is to the detriment of the victim who seeks, more than anything else, validation of the experience (Crowley, 2000).

1.2 PROBLEM STATEMENT

The South African Medical Research Council conducted a study on workplace violence in the health care industry and reported that most respondents had experienced it in different forms. Verbal abuse was reported by 92.3% of respondents, while 36.4% of interviewees had occasionally been threatened with physical assault (Malanqo, 2012). Within health facilities,

emergency departments and psychiatric settings constitute areas with more incidence of violence. Levels of violence are very high in South Africa already. However, the workplace was always regarded as being free from the violence as compared to the streets, but not anymore. The violence in society has spilled over into the workplace and to an extent into homes (increase in domestic violence) of South Africa and the best way to address violence in this country is to start with the workplace (Malangu, 2012).

The aim of this study is to describe workplace violence towards the nurses in Thulamela. According to the statistics from the labour relation office from Department of Health in Vhembe district, there are many cases of workplace violence towards nurses but they are under-reported. Only few cases of assault among the nurses are reported within the year 2011-2013. One case of assault at Donald Frazer hospital and three of fighting between the nurses were reported. Although the workplace violence is reported, there is no analysis conducted in order to look at trends, and the extent of the problem so that informed decisions can be taken to address the problem; hence the need for this study.

Previously, the range and extent of workplace violence affecting nurses in Thulamela municipality hospitals was not well established. This study will therefore serve as a baseline to clarify as to what are the types of workplace violence mostly experienced by nurses, the causes and the management of workplace violence towards the nurses in Thulamela municipality. The analysis of workplace violence against nurses will therefore not only indicate the demographics but should also ideally be crucial in designing the preventative interventions relevant to the vulnerability of nurses.

1.3 RATIONALE OF THE STUDY

Information about workplace violence against nurses in Thulamela hospitals, Vhembe district is not available because there is no known study around the issue. The nurses constitute a vulnerable group because they have direct contact with patients on a daily basis at the workplace. There is danger, if nothing is done to address the issue of violence among the nurses.

1.4 SIGNIFICANCE OF THE STUDY

The study seeks to describe workplace violence towards nurses in Thulamela hospitals, Vhembe district. Findings from this study might assist the Department of Health, hospital

management and other stakeholders to seek appropriate strategies in dealing with the problem.

1.5 AIM AND OBJECTIVES OF THE STUDY

1.5.1 Aim of the study

The aim of this study is to describe workplace violence towards the nurses in Thulamela hospitals, Vhembe district.

1.5.2 The objectives of the study

- To analyse the types of workplace violence towards nurses in Thulamela hospitals.
- To determine the causes of workplace violence towards nurses in Thulamela hospitals.
- To evaluate the management of workplace violence towards nurses in Thulamela hospitals.

1.6 DEFINITIONS AND OPERATIONALISATION OF CONCEPTS INTO VARIABLES

Nurse is defined as a person who takes cares of the sick or infirm (Concise Oxford English Dictionary. 11th Edition, 1995).

In this study, a **nurse** is anyone who is trained to care for the sick working in three hospitals in the study having direct contact with patients.

Workplace is defined as a place where people work (Concise Oxford English Dictionary. 11th Edition, 1995)

In this study, **workplace** is three hospitals in the study area where nurses are doing their work.

Malangu (2012) defines **workplace violence** as “incidents where employee(s) are physically abused, harassed, threatened or assaulted which can be overt, covert, direct, indirect in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.

In this study, **workplace violence** is an incident where the nurses are physically abused, harassed, threatened or assaulted by the patients, relatives and colleagues within the three hospitals in the study.

2.1 INTRODUCTION

Violence is defined as challenging behaviours including spitting, biting, verbal threats (including swearing), kicking, pinching, hitting, passive resistance and self-destructive behaviour (Viitasara, 2004).

In this study, **violence** is an act of aggression directed against nurses by the patients, relatives and colleagues within the three hospitals in the study.

2.2.1 Workplace violence in the health care setting

Although workplace violence occurs in every area of health care, certain settings of practice are well known for their increased risk. This risk is highest in emergency departments, psychiatric units, admission departments and acute care units (Thomas, 2003).

One of the most frequent health care settings in which violence occurs is the Psychiatric ward. In psychiatric wards, nurses compose the most vulnerable group and may face serious health problems. The magnitude of workplace violence in psychiatric wards varies greatly in different settings (Chen, Gvohwa, Mekang, Chiu and Der Wang, 2008). Nurses working in some psychiatric inpatient settings are exposed to violence on a daily basis due to the nature of the populations served, the public protection functions of inpatient settings, the culture and demands of the institutional environment, the reduced number of registered nurses to lesser-trained mental health workers and the limitations of the treatment services provided.

Macintosh (2006) examined risk factors for violent events reported to managers in psychiatric units in New Zealand. Results of the survey indicated the following: Inpatient care poses a higher risk to staff for all violent events than does community care, geriatric psychiatry has a higher risk of assault, attack, and sexual harassment than other forms of care, and child and adolescent psychiatric units, alcohol and substance abuse units, and other specialty units were no more violent than other units.

The emergency nurse may encounter many forms of violence. These include verbal abuse, physical threats, assault and emotional abuse (Lyneham, 2004). Anyone who is working in the emergency department is working on the frontline of a war zone. The emergency department (ED) is the closest to the front line of a war zone. Emergency nurses are

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This section will focus on data based literature. The data based literature will review literature on the types of workplace violence, risk factors of workplace violence and management of workplace violence.

2.2 DATA BASED LITERATURE

2.2.1 Workplace violence in the health care setting

Although workplace violence occurs in every area of health care, certain settings of practice are well known for their increased risk. This risk is highest in emergency departments, psychiatric units, admission departments and acute care units (Thomas, 2003).

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The emergency nurse may encounter many forms of violence. These include verbal abuse, physical threats, assault and emotional abuse (Lyneham, 2008). Anyone who is working in the emergency department is working on the frontline of a war zone. The emergency department (ED) is the entrance door to all other hospital wards. Emergency nurses are

practising on the frontline of patient care (Catlette, 2005). In addition, many well-known problems such as hospital over-crowding, long waiting times, considering nurses as uncaring, shortage of emergency nurses and misconceptions regarding staff behaviour can result in emergency department violent incidents (Smith, Juarez, Boyett, Homeyer, Robinson and Maclean, 2009).

2.3 TYPES OF WORKPLACE VIOLENCE AGAINST NURSES

Workplace violence can be divided into two main types: physical abuse and psychological abuse (Di Martino, 2002). Subtypes and definitions include:

2.3.1 Physical abuse

Physical abuse is as an assault or attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives (National Institute for Occupational Safety and Health, 2006). Physical assaults involve the use of force and include punching, kicking, slapping, biting, spitting, and thrown objects that hit another person (National Database of Nursing Quality Indicators [NDNQI], 2005).

Physical abuse is an assault which is intended for the purpose of inflicting severe or aggravated bodily injury, usually accompanied by a weapon or by means likely to produce death or great bodily harm (United State Department of Justice, as cited in Brumbaugh, 2008). It also involves physical harassment which create an unpleasant or hostile situation, especially by uninvited and unwelcome physical conduct (Merriam-Webster, 2006) and homicide or killing of one person by another (Copeland, 2007).

2.3.2 Psychological (emotional) abuse

Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats (Di Martino, 2002).

Verbal abuse is a threat expression of intent to cause harm, including verbal threats, threatening body language, and written threats (NIOSH, 2006). Verbal abuse can be blatant or subtle and consist of communication through words, tone, or manner that disparages, intimidates, patronizes, threatens, accuses, or disrespects another person (Ulrich, Lavandero, Hart, Woods, Leggett and Tabor, 2006). Verbal abuse includes threats of violence without

actual physical contact, threatening or harassing behaviours, emotional abuse and emotional aggression (Taylor and Rew, 2009).

Bullying/mobbing defined as repeated and over time, offensive behaviour through vindictive, cruel or malicious attempts to humiliate or undermine an individual or groups of employees. Mobbing is an occupational situation in which someone is the object of negative, intentional, persistent and repetitive actions, characterized by the asymmetry of the relationship, the relative difference of power between victim and harasser and the absence of visible symptoms, except for the psychological deterioration of the victim (Di Martino, 2002).

Workplace bullying is a form of aggression at work (Neumann and Baron, 2005) that goes beyond incivility. Bullying is a more deliberate and repetitive form of inter-personal behaviour that adversely affects the health or the financial well-being of the targeted person. Work- place bullying consists of recurrent and persistent negative actions toward one or more individual(s), which involve a perceived power imbalance and create a hostile work environment. It is a form of interpersonal mistreatment that escalates the intensity of verbal assault, directs attention and energy away from the job, and may subsequently render the targeted nurse at risk of unsafe clinical performance (Salin, 2003). Intimidating workplace behaviour can include threats to professional status, threats to personal standing, isolation, overwork, and destabilization (Rayner and Hoel, 1997).

If persistent, bullying has detrimental or negative effects on the victim (Cusak, 2000). Bullying, or “mobbing” as it is called in many Continental European countries, is defined by Namie (2003) as a status-blind interpersonal hostility that is deliberate, repeated and sufficiently severe as to harm the targeted person’s health or economic status.

Harassment is any conduct based on age, disability, Human Immune Virus status, domestic circumstances, sex, sexual orientation, gender reassignment, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority, property, birth or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work (Di Martino, 2002).

Sexual harassment is any unwanted, unreciprocated and unwelcome behaviour of a sexual nature that is offensive to the person involved, and causes that person to feel threatened, humiliated or embarrassed (Di Martino, 2002).

As a form of aggression, sexual harassment has been an on-going problem. Rayner and Hoel (1997) reported that between 16% and 76% of nurses have experienced sexual harassment. Crowley (2000) reported that 17% of nursing staff have been sexually assaulted. The problem has been exacerbated by the fact that relatively little empirical research has been conducted into incidents of sexual harassment in health care organizations because nursing staff have been reluctant to have this topic addressed due to the sensitivity, taboo and stigma attached to it (Rayner and Hoel, 1997).

Racial harassment is any threatening conduct that is based on race, colour, language, national origin, religion, association with a minority, birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work (Di Martino, 2002).

Shields and Price (1999) assert that black African nurses are the most likely to be racially harassed by work colleagues, with more than 48% of them having suffered such behaviour in their careers. South Asian nurses are the most likely to experience such abuse on a frequent basis (8.4%) whilst Southeast Asians have the lowest incidence of frequent or infrequent racial harassment from staff. Given the hands-on nature of nursing, and the high proportion of total work-time typically spent interacting with patients, it is a worrying feature of the British NHS that over two-thirds of Black nurses, and more than half of Asian nurses, report having been the subject of racial harassment by patients or their families in their working lives. Interestingly, black Africans are far more likely to experience harassment from patients on a frequent basis (14.5%) than black Caribbean nurses, as are South East Asians when compared to South Asians.

2.4 CAUSES OF WORKPLACE VIOLENCE AGAINST NURSES

There are numbers of factor associated with workplace violence. Common risk factors for workplace violence include the following: Perpetrator risk factors, worker risk factors, setting and environmental risk factors.

2.4.1 Perpetrator risk factors

There are many risk factors associated with the perpetrators of workplace violence. These include the ones discussed below:

Mental health disorders (such as dementia, schizophrenia, anxiety, acute stress reaction, suicidal ideation, and alcohol and drug intoxication (American Medical Association, 2007) have often been identified in people who have committed workplace violence (Catlette, 2005). Patients with dementia were identified as a factor in 87% of physical assaults on nursing home assistants (Gates, Fitzwater, Telintelo, Succop and Sommer, 2003). Gerberich, Church, McGovern, Hansen, Nachreiner and Geisser (2004) found that patient dementia was linked to 11% of violent events while other psychiatric diseases were linked to another 25%. Gates et al. (2003) reported an increased rate of violence committed by patients with dementia.

Almvik, Rasmussen and Woods (2006) determined that the severity of physical violence perpetrated by male patients was significantly greater than violence perpetrated by female patients ($p < .01$). This may be because men are more likely to enact physical violence and women are more likely to enact verbal violence. In addition, men are physically capable of causing more bodily injury when hitting, striking, or pushing healthcare workers compared with women who commit physical violence.

Gerberich et al. (2004) reported that the gender and age of a perpetrator are factors associated with violence against healthcare workers. They found that the majority of verbally violent perpetrators were men (73%, $n = 1,594$) age 35–65 (54%, $n = 1,186$). Physical violence was most often enacted by men (59%, $n = 386$) and people 66 years or older (64%, $n = 423$). Children 17 years old and younger represented the smallest group of perpetrators of physical violence (5.3%, $n = 35$) and verbal violence (5.7%, $n = 122$). James, Madeley and Dove (2006) reported similar findings for gender when studying safety event reports from a hospital in the United Kingdom. Males nurses (66%, $n = 97$) and patients between 16 and 35 years (55%, $n = 82$) were most likely to be perpetrators of violence.

Another leading perpetrator risk factor for verbal or physical violence is the influence of drugs or alcohol (Gerberich et al. 2004) In one study, 35% of healthcare workers believed that the violent perpetrator was using drugs or alcohol before the violent event (DuHart, 2001). In a second study, participants believed that perpetrators were under the influence of drugs or alcohol in 50% of all verbally violent events and 96% of all physically violent events (Crilly, Chaboyer and Creedy, 2004).

Patients' and visitors' inability to deal with a crisis situation is another perpetrator risk factor for workplace violence (Catlette, 2005). For example, the stress experienced during an emergency department (ED) visit may create a crisis during which patients or visitors are no longer able to deal with a situation as they normally would. This stress may increase verbal or physical violence. Crises can occur when there are disagreements with the medical plan, denials of a service or request, conflicts with healthcare workers, excessive waiting times for assessments and interventions, inability to focus beyond oneself, perceptions that a healthcare worker is rude or uncaring, grief over the death of a child, and inability to change a healthcare outcome (Keely, 2002).

2.4.2 Worker risk factors

Certain characteristics have been found to increase the risk of workers being targets of workplace violence in the healthcare setting, including the worker's gender, age, years of experience, hours worked, marital status, and previous workplace violence training (Ayranci, Yenelmez, Balci and Kaptanoglu, 2006).

Ayranci et al (2006) ascertained that women experienced a higher percentage of verbal and physical violence compared to men, although the difference was not significant. However, most researchers reported that men experienced workplace violence significantly more often than women (Anderson and Parish, 2003). In contrast, Tolhurst, Baker, Murray, Bell, Sutton and Dean (2003) determined that there was no significant difference in the overall frequency of verbally and physically violent events between groups of male and female physicians, however, the percentage of men who experienced at least one violent event during the preceding 12 months was greater than the percentage of women. Privitera, Weisman, Cerulli, Tu and Groman (2005) noted that the gender of clinical and nonclinical mental health workers did not significantly affect the number of verbally or physically violent events they endured. However, a greater percentage of female physicians had a fear of future violence compared with male physicians (Tolhurst et al. 2003).

Healthcare workers younger than 40 years old were most frequently the victims of violent events (Ayranci et al. 2006). Researchers also observed that older workers experience significantly less violence than younger workers (Camerino, Estryng-Behar, Conway, Van Der Heijden and Hasselhorn, 2008). In addition, Gates et al. (2003) researched how a nursing home assistant's age affected the incidence of violence. As the age of caregivers increased,

the frequency of violence committed against them decreased. Gates et al. (2003) posited that this relationship may be a result of older nursing home assistants being more adaptable, patient, and empathetic and moving more slowly during interactions with the elderly.

Other healthcare worker characteristics associated with an increased risk of workplace violence include the number of hours worked per week and marital status. Part-time employees experienced reduced risk of physical assault compared with full-time employees (OR = 0.35, $p < .001$; Thomas 2003), even though part-time employees experienced a significant ($p < .01$) increase in violent events from 2001 to 2004 (Hegney et al. 2006). Lin and Liu's study (2005) reported that un-married workers were significantly ($p < .01$) more likely to experience workplace violence compared with married workers, which may be the result of married workers being accustomed to working with others toward a mutual understanding or agreement.

Evidence about whether violence-prevention training reduces the risk of workplace violence is contradictory. One group of researchers found that participants who had not attended violence-prevention training were at greater risk for workplace violence than workers who did attend training (Ergün and Karadakovan, 2005). However, Nachreiner, Gerberich, McGovern, Church, Hansen, Geisser (2005) reported that violence training increased the likelihood of being a victim of physical violence. Specific training components that contributed to an increase in the risk for experiencing violence included managing assaultive or violent patients (OR = 1.551; $p = .03$), reporting work-related physical assault (OR = 1.639, $p > 0.05$), practicing self-defence (OR = 1.393, $p > 0.05$), and recognizing risk factors for violence (OR = 1.314, $p > .05$). Lee et al. (1999) stated that the relative risks for physical violence against a nurse increased when the nurse had received assault-prevention training with a previous employer (RR = 2.57), had completed training with his or her current employer (RR = 4.64), and his or her employer accepted assault as being part of the job (RR = 8.14).

2.4.3 Environmental risk factors

According to Steinman (2003), the causes of workplace violence among the nurses vary from hospital to hospital depending on location, size, and type of care. Common environmental risk factors for hospital violence include the ones discussed below:

According to Steinman (2003), most large facilities are close to densely populated and high crime areas. When a facility is in or near a high crime area, the risk of violence would be much higher. The Johannesburg General Hospital is located near a densely populated, impoverished and high crime area (drugs, gangs, prostitution) of Hillbrow and Yeoville and also close to central Johannesburg. Milpark Hospital, known as South Africa's top private trauma hospital also presents with a high incidence of workplace violence, so does Parkland Clinic. Both hospitals are close to Hillbrow and Yeoville and their casualty sections serving these areas would also have high levels of violence. Criminals are also taken to these hospitals when public hospitals cannot attend to the injured person in custody.

The location of the facility is one of the most important contributing factors as well as the presence of a casualty or trauma unit. In large facilities, certain areas are viewed to be dangerous and healthcare workers are well aware that crime syndicates operate there. A physician told a field worker that it is dangerous to walk in the passages at night because of inadequate lighting and criminals that hide out in the facilities. According to one of the matrons of the larger hospitals, one of the biggest problems is the many entrances to the facility. It is difficult if not impossible to control and to safeguard all these entrances. Too many entrances would pose a safety threat to healthcare staff (Steinman, 2003).

Increased waiting times and frustration, tension and stress can fuel aggression. In the current climate of healthcare crisis in Australia both emergency nurses and patients/families are more likely to be stressed and tense due to long waiting times, bed closure, limited staff resources and the intensifying acuity of presenting illness. With bed closures the waiting times for non-urgent patients is likely to increase in some hospitals. Waiting time in particular has been signalled as escalating violence-related events. The way in which individual nurses and patients/families respond to aggression and tension can potentiate a time bomb of escalating violence. Unfortunately, tense situations are often on full display to waiting patients adding to frustration and the need for sound communication skills during intense periods (Lyneham, 2008).

Some health departments and hospitals have recognised the need to protect their staff but security equipment is not a panacea for violence. Security doors can reduce the risk of violence from the outside but do not prevent violence once the perpetrators are admitted to the inner sanctum of the department. Other security measures such as onsite security staff and duress alarms are only useful once a situation has occurred (Lyneham, 2008). The

effectiveness of these devices is dependent on the response time of the appropriate people. In many cases the personnel responsible are emergency nurses themselves. Clearly, consideration of the composition of a security team and their skill level and training is needed. Understaffing, excessive and unrealistic workloads and the physical layout of the hospital have all been identified as contributing to the ineffectiveness of current security measures. Security measures need to be tailored to individual settings in order to appropriately address needs. Violence response policies need also to be widely understood, used and evaluated regularly within an organisation to ensure maximum effectiveness.

If we recognise that television influences and mediates our cultural understandings of the world we live in, then little solace can be drawn from a recent airing of the popular TV drama 'ER'. This episode showed an emergency patient waiting for psychiatric assessment that subsequently wandered into a kitchen, took a knife, and proceeded to hide in a cubicle and silently stab two doctors who came in to make an assessment. Is this mere overkill for dramatic effect or a reality? It seems that the use of weapons in hospitals is increasing. It appears that anything that is not tied down has the potential to become a weapon. The availability of hospital equipment such as syringes, furniture and so on in turn becomes weapons to use against staff. For obvious reasons 'lock down' of essential equipment is inappropriate within a hospital environment (Lyneham, 2008).

The distinction between acceptable and unacceptable behaviour appears blurred for many nurses. Some nurses, for example, prefer to blame themselves for the violent behaviour. Victims of violence tended to blame themselves for not preventing the incident and others blamed the victim for allowing it to happen. Reasons for accepting violence related events commonly heard from nurses who experience violence from patients and relatives include: 'oh they were confused, upset,' 'We owe a duty of care, they must not be themselves', 'we have to take all sorts, it goes with the job', etc. It seems that when nurses perceive that the perpetrator of violence is of diminished capacity their actions should be tolerated. A 'zero tolerance' policy for workplace violence is now being advocated by practitioners and leaders of nursing worldwide. However, a more pressing issue remains to be addressed and that is the culture of 'whistleblowing' and its negative outcomes for those who 'blow the whistle'. How can nurses be encouraged to openly confront long-held values about their nursing practice and concomitant workplace culture (Lyneham, 2008)?

Another important, though perhaps more insidious, means by which level of violence is impacting the nursing environment is through the normalizing of violence in the workplace. Erickson and Evans (2000) have asserted that most nurses have come to accept violence and assault as part of their job, and they argue that as a result violent acts and aggression have become accepted as a normal part of the workplace. Others have further suggested that this normalization of workplace violence has fostered an environment in which institutional violence or bullying and intimidation tactics by other nurses and nurse managers have become commonplace. In fact, there may be an acceptance of a culture of violence in healthcare institutions which then increases the likelihood of underreporting of violent incidents and a consequent lack of awareness of the scope of the problem (Erickson and Evans, 2000).

The incidence of violence experienced by nurses is hard to measure and is grossly underestimated. Only the most serious incidents of aggression and violence in the workplace are reported (Rippon, 2000). Violent acts are not reported for a number of reasons. Nurses believe that there was insufficient time to complete reports on violence and that no real benefit were gained from reporting incidents. Again, we must ask what do nurses see as a 'violent incident' and how then do they grade such violence? For violence-related injuries sustained at work to be calculated they must be reported and recorded through Occupational Health and Safety Hazard/Incident reporting mechanisms at each organisation (Lyneham, 2008).

Public hospitals that are Work cover exempt are not included in injury-related claim statistics. If an individual is not physically injured and does not take time off work, potential non-physical violence-related injuries become concealed. As the aftermath of violence was explored with nurses, it was apparent that the events affected the individual in many ways. Such effects include: anger, frustration, not wanting to have anything further to do with the person, avoidance behaviour, and reluctance to go to work for the next shift, feelings of powerlessness, embarrassment and despair. Recognition and reporting of violence do play a part in addressing workplace violence but require support from colleagues, employers and appropriate systems of support to have any impact on positive outcomes for the nurse (Lyneham, 2008).

De-institutionalisation of care for people with mental health needs has had far reaching consequences nationally primarily the impact of a lack of community support structures and

its flow through to general hospital. One nurse in South Australia (SA) reported seeing 55 psychiatric patients in one week and while not all of the nurses in SA see so many people with mental health needs, nurses are concerned about the demand for care by psychiatric patients (Crowley, 2000). Many nurses are not experienced in psychiatric nursing which can lead to a lack of de-escalation knowledge, avoidance of psychiatric patients even when other staff might need assistance and a sense of personal insecurity. Nurses' feelings of insecurity, vulnerability and intimidation are linked to invasive behaviours of violence, aggression and hostility of people requiring psychiatric care in a general hospital setting where staff does not have the skills or resources to deal with them (Crowley, 2000).

Crowley (2000) suggests that this is compounded by nurses working in hospitals who experience a 'clash of cultures' between emergency care and mental health in an environment not conducive to 'privacy, quietness, safety and calmness' presumed necessary. Nurses believe that 'nothing will be done' if a report is made. In some cases, the nurse victim was accused of causing the situation. The nurse victim becomes further victimised and traumatised. Nurses suggest that reporting of an incident does not guarantee action, or if action does take place it may not be communicated to the nurse by management (Lyneham, 2008).

It seems that the pivotal role of the triage registered nurse in the practice of emergency nurses is also fraught with an increasing risk of exposure to violence. Triage nurses can be verbally abused face-to-face and over the telephone in full view of a waiting room full of patients and significant others, sometimes every hour while simultaneously trying to assess and prioritise waiting patients (Murray, 2008).

The common practice in South Africa involves an eight hour shift on triage, nurses have 8 hour day shifts and 10 hour night shifts, other states may have split shift options to reduce the intensity of the role demands. As the first nurse anxious, patient and their family may see, the triage registered nurse bears the brunt of frustrations related to the duration of 'waiting time' and the triage priority system of care. The triage registered nurse also liaises with nursing and medical staff within the ward and throughout the hospital and its associated networks. This means constant negotiations with tense, stress-filled staff each trying to get through the shift and to get patients seen as soon as possible. The communication skills and tolerance level of each registered nurse, often under duress, become paramount in the prevention and de-escalation of violence. These attributes set the scene for a patient's transition through the

ward. Consideration needs to be given to the skills and education required to fulfil a nursing triage role and to the structure of work practice at triage. Such consideration is necessary, as nurses also become frustrated and equally capable of hostile and negative actions towards the public and co-workers (Lyneham, 2008).

2.5 CONSEQUENCES OF WORKPLACE VIOLENCE

There are negative impacts associated with workplace violence. Common negative impacts for workplace violence include the following: consequences to the nurse, patient risk and cost to the organisation.

Nurses who have been assaulted experience both physical and emotional consequences including traumatic injuries and even death. The majority of physical injuries due to patient violence tend to be minor, although career-ending incidents involving permanent disability are not uncommon. The impact of an assault is often underestimated because physical injury is the most common measure used to assess impact. However, individuals have strong emotional and psychological reactions to assaults and threats of assault regardless of whether or not injury was sustained (Erickson and Evans, 2000). The effects workplace violence on the family of the victim could be far-reaching with additional financial burden to society, medical services and other family members (Rew and Ferns, 2005).

Exposure to bullying, and verbal and physical abuse from superiors and co-workers drain nurses of their enthusiasm for the profession and undermines job satisfaction and employee morale (Thomas, 2003). Insider-initiated aggression also appears to lower employees' commitment to their organization, although aggression by a member of the public does not (LeBlanc and Kelloway, 2002).

When incivility and bullying are sustained through disruptive behaviours in the workplace, nurses suffer and patient care is adversely affected. Twenty-five per cent of health care workers saw a strong link between disruptive behaviours and patient mortality, and as many as 53% and 75% of health care providers saw a strong link between disruptive behaviour and adverse clinical out-comes, such as patient safety, errors, adverse events, quality of care, and patient satisfaction (Rosenstein and Daniël, 2005).

According to Rew and Ferns (2005), the costs associated with workplace violence have major implications for the health of the workforce and the organization. It include the following:

increased staff turnover, recruitment, and retention. Increased staff absence from work, reduced efficiency and performance at work, reduced staff morale, reduced staff numbers, especially the loss of experienced staff, leading to increased pressure on remaining staff, higher incidence of patient complaints, higher risk of increased frustration by patients and staff, higher risk of violent incidents and falling reputation for the organisation.

Costs to organizations include low worker morale, absenteeism, sick leave, property damage, early retirement, high turnover, grievances and litigation, increased accidents, decreased performance and productivity, security costs, worker's compensation, reduced trust of management, and loss of public prestige. The persons subjected to bullying might be more eager to demonstrate their ability and commitment because of feelings of low self-esteem. Horizontal violence affects recruitment (Crowley, 2000).

Workplace violence also poses a threat to the career ambitions of healthcare workers. They are often disillusioned about the high levels of workplace violence and in the case of South African, healthcare workers leave for greener pastures. When the negative impact of workplace violence on the employee's performance, health, turnover, absenteeism and so on is considered, the cost of workplace violence is astronomically high (Rew and Ferns, 2005). The cost to replace a professional person in South Africa is estimated to be anything between R25000 - R45000 per person. The exit packages because of ill-health, early retirement, legal costs (the cost to the private sector with their 1578 conciliation hearings and compensation costs, just the past year could run into millions of South African rands.

2.6 MANAGEMENT OF WORKPLACE VIOLENCE AMONG THE NURSES

Einarsen, Hoel, Zapf and Cooper (2003) confirm that the impact of workplace violence on the victims can be devastating and thus leave the victim unable to cope with their lives. In addition, individuals cope differently with workplace trauma due to their individual personality differences. Furthermore, men and women also possess different coping mechanisms with which to process workplace trauma. The following are some of the coping mechanism for workplace violence:

Some healthcare workers protected themselves against the negative effect with self-report (Catlette, 2005). Catlette interviewed eight nurses about their experiences with workplace violence. They revealed that using self-report techniques such as humour, talking about the

experience, and taking advantage of leisure time were very much helpful in dealing with the exposure.



Support such as showing concern, listening to the victim's story from co-workers and managers has a positive effect. The support reduced their negative physical and psychological symptoms and negative attitudes towards their work (Gillespie, 2010). Support from supervisors may decrease the amount of stress and violence in the workplace. Bullied employees had lower social support from the supervisors (Nachreiner, Gerberich, Mc. Govern, Church, Hansen and Geisser, 2007).

Copeland (2007) asserts that in most corporate environments, the victim is often treated as the problem. When stepping into the case, upper management, union representatives, or personnel administration tend to accept the prejudices produced by the offenders, thus blaming the victim for his/her misfortune. Third parties or managers may see the situation no more than fair treatment of a difficult and neurotic person. This is the denial and shame by which abuse thrives. Like one manager said in a focus group discussion - offering the explanation to a difficult phenomenon like workplace violence - "it is people bringing their problems to the workplace".

2.7 WAYS TO PREVENT WORKPLACE VIOLENCE TOWARDS NURSES

Workplace violence can be prevented and the following are some of the ways in which this can be done.

Many accidents of violence at work are predictable and foreseeable, and therefore preventable. Most of the nurses are not aware of any existing guidelines in their department or hospitals. In order to improve staff knowledge of and performance in handling violent behaviour, training should not only be provided to volunteers, but should be compulsory for all staff members. Guidelines are only effective if staff are familiar with them. Nurses need to be well trained in coping with verbal abuse, and to report such accidents, instead of accepting them quietly. Staff should not regard violence as inevitable due to bad luck, incompetence or the result of individual personalities. Support from employers is vital to stop such trends from growing because a positive attitude towards workplace violence is the key to successful prevention (Kris, Yeung, Cheung, Chung and White, 2009).

Training is an essential element of an effective violence prevention program. Excellent Service Behaviour training improved nursing staff's communication skills, helped in understanding clients, needs and how to respond to them appropriately. Nursing staff could also learn how to handle aggression through safety training (Chalemrat et al. 2008).

In terms of violence, departments need to change their role from passive to active to show their support for colleagues. Instead of formal reporting from victimized staff, initiatives to evaluate the prevalence of violence should be regularly addressed. The key to successful prevention and control of violence is for the hospital managers to demonstrate their commitment to Zero tolerance of workplace violence towards their employees. Individual staff members should work in partnership with their departments so as to minimize the negative effects of violence (Kris et al. 2009)

In South Africa, according to Di Martino (2002), focus group participants said that training in skills, stress management, communication and conflict management, would be very useful. More communication, better orientation of new staff members, refresher courses, a culture of dignity and respect and regular meetings to ventilate and get to know staff members from other sections were called for. They believed that staff who had been physically attacked at the workplace should be treated with more care and understanding than they receive at present and that management should become more involved with staff members. It was stated that health care providers should act against outsiders including even doctors who violate the rights of staff members. They expressed the view that certain minority groups such as auxiliaries should have the opportunity to get together and discuss their problems with a senior staff member.

The organisation management should be responsible for developing workplace policies and procedures to prevent and manage bullying or any form of unacceptable behaviour. The workplace anti-bullying policies shall be consistent and aligned to the aforementioned legislative framework.

In the public service, there are a number of workplace policies that have been developed to prevent bullying and other forms of deviant behaviour. These policies address the prevention of sexual harassment, prevention of unfair labour practice, and prevention of unfair discrimination. All these policies are measures to ensure the prevention of abuse and bullying in the workplace, and therefore any contravention with any of the above policies shall be

viewed as a serious offence and may lead to disciplinary action being taken against the perpetrator (Steinman, 2003).



RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents and discusses, the study design, setting, population and sample size, measurement instrument, pre-test of the instrument, data collection, data management, data analysis and ethical considerations.

3.2 STUDY DESIGN

The study employed a quantitative approach using a cross-sectional design. It involved a once-off administration of the survey instrument to a sample of the study participants.

3.3 STUDY SETTING

The study was conducted in one regional and two district hospitals within the Thulamela municipality, Vhembe district. The three hospitals are Tshilidzini, Donald Frazer and Malamulele.

Tshilidzini hospital

Tshilidzini hospital is a district hospital located at Tshisaulu village which is within Thulamela municipality, Vhembe district. The hospital is situated alongside Punda Maria road. The hospital is near Limpopo College of nursing, Thohoyandou campus, Khwevha commercial school, Dimani secondary school and Worship house Christian centre. The hospital is linked to Tshisaulu clinic, Shayandima clinic, Lwamondo clinic, Dzwerani clinic. The hospital renders the following services: Social work, Dietician, Physiotherapy, Psychologist, Occupational therapy, X-ray, Speech and hearing, Optometrist, Forensic services and Nursing services. It is composed of 14 wards and 578 nurses. The hospital operates 24 hours every day.

Donald Frazer hospital

Donald Frazer is a district hospital situated about 28 kilometres east of Thohoyandou town and 40 kilometres west of Mutale municipality. The hospital serves approximately 850,125 population of Thulamela in Mutale. It is a 350 bedded hospital with seven wards and a clinic which operates within the hospital. This hospital offers outpatients and inpatient services.

Malamulele is a district hospital which is situated 28 kilometres west of Thohoyandou town. The hospital is next to Malamulele taxi rank and shopping complex. The hospital operates 24 hours every day. It is composed of 14 wards. The hospital offers outpatient and inpatient services.

3.4 STUDY POPULATION AND SAMPLING

3.4.1 Population and sampling

The study population was all nurses who are working in one regional and two district hospitals in Thulamela municipality. Due to limited time, the researcher selected 100 participants from each hospital as the sample size, giving a convenient sample size of 300. The 300 participants were selected randomly as follows:

Table 3.1 shows the population frame.

Table 3.1: The population frame

Facility strata	M	F	Total
Tshilidzini hospital	118	460	578
Malamulele hospital	38	345	383
Donald Fraser hospital	39	390	429
Total	195	1195	1390

(Source: HR office, Department of Health, Vhembe district (2013))

Tshilidzini hospital

Distribution of nurses in this hospital shows that there were 118 males and 460 females. By proportional allocation, the sample size according to gender was as follows:

$$\begin{aligned}
 \text{Males} &= \frac{118}{578} \times 100 \\
 &= 20 \text{ males}
 \end{aligned}$$

$$\begin{aligned}
 \text{Females} &= \frac{460}{578} \times 100 \\
 &= 80 \text{ females}
 \end{aligned}$$

In order to select the 20 males randomly, 118 ballots were made, of these 20 were marked “yes” and the remaining as “no”. The 118 ballots were placed in a box and mixed well. For

each of the men using the name register, a ballot was picked. When a yes ballot was picked for an individual's name, he was part of the sample.

In order to select the 80 females randomly, 460 ballots were made, of these 80 marked "yes" and the remaining as "no". The 460 ballots were placed in a box and mixed well. For each of the women using the name register, a ballot was picked. When a yes ballot was picked for an individual's name, she was part of the sample.

Donald Frazer hospital

The total population of nurses at Donald Frazer is 429, of these 39 are males and 390 are females. By proportionally representation, all males were included since the number is small (39). This implies that the number of females in the sub-sample was $100 - 39 = 61$.

Malamulele hospital

The total population of nurses for Malamulele hospital is 383, of these 38 are males and 345 are females. By proportional allocation, all the males were included since the number was small (38). The remaining 62 will be females. Based on the above, the sampling frame is shown in Table 3.2 below.

Table 3.2: Composition of sample

Facility strata	M	F	TOTAL
Tshilidzini hospital	20	80	100
Malamulele hospital	38	62	100
Donald Fraser hospital	39	61	100
Total	97	203	300

3.5 MEASUREMENT INSTRUMENT

A self-administered questionnaire (appendix 4) was used to collect data. The questionnaire contained closed-ended questions to describe workplace violence. The questionnaire was in English. The questionnaire was developed using the Workplace Violence in the Health Sector project and a comprehensive literature review. The questionnaire comprised four sections and 40 questions. Ten on demographic information of the participants, 21 questions on types of workplace violence, 05 on risk factors of workplace violence and 06 on management of workplace violence in hospitals.

3.6 PRE-TEST OF THE INSTRUMENT

A pre-test of the instrument was done by administering the questionnaire to 60 nurses. The purpose of pre-testing the questionnaire was to test its reliability, face and content validity, to identify and rectify the problem areas. Those who participated in the pre-test were not included in the main study.

3.7 DATA COLLECTION

The questionnaire for this study was distributed to the participants by the researcher who recorded the name of the ward to which the questionnaires were delivered. To ensure a high response rate, the researcher personally delivered and collected the questionnaires. The questionnaires were completed during lunch time.

3.8 DATA MANAGEMENT AND ANALYSIS

A biostatistician assisted with data analysis. All the data from the questionnaire were coded using a code book and entered into SPSS version 20 statistical programme. SPSS was used to analyse the data. Descriptive and inferential statistics were used to analyse the data. The data was presented in the form of frequency tables, pie –charts and bar graphs.

3.9 ETHICAL CONSIDERATION

3.9.1 Approval to conduct the study

The proposal was assessed and approved by the Higher Degrees Committee, School of Health Sciences and by the Ethics Committee of the University of Venda which granted ethical clearance to ensure safety and wellbeing of the participants.

3.9.2 Ethical clearance

Ethical clearance was obtained from the Research Ethics Committee, University of Venda.

3.9.3 Permission to conduct the study

Permission to conduct the study (appendix 1) was obtained from the Provincial Department of Health and the hospitals in the study.

3.9.4 Informed Consent

The research process, the aim of the study and also that participation is voluntary was explained to the participants. Those who agreed to participate after the explanation were given the consent form to complete (appendix 1).

3.9.5 Anonymity

In order to achieve anonymity, participants were not required to put their names on the questionnaires and they completed the questionnaires in the absence of the researcher.

3.9.6 Confidentiality

In order to achieve confidentiality, the data collected from the participants was kept confidential and was only shared with the supervisors. The documents related to the data were kept under lock and key by the researcher.

3.10 LIMITATIONS OF THE STUDY

The study was conducted among the nurses within one regional and two district hospitals in Thulamela municipality and the results cannot be generalised to other hospitals. The results are still vital for comparison violence among the nurses between various hospitals.

3.11 DISSEMINATION OF RESULTS

The results of the study will be submitted to the Department of Health and hospitals. A copy will be sent to the library at the University of Venda, presented at national and international journals and published in accredited journals.

CHAPTER 4

RESULTS OF THE STUDY

4.1 INTRODUCTION

In the previous chapter, the materials and methods used in this study were described. This chapter presents the results and interpretation of findings. Results are presented on frequency tables, bar charts and pie charts, and they were quantitatively analysed. Composite tables were used to present summary of results. Results are treated section by section.

4.2 DATA PRESENTATION AND ANALYSIS

4.2.1 Section A: Demographic results of respondents

Results on the distribution of gender, age range, marital status, educational level, position, employment level and ethnic group of respondents are shown on Table 4.1.

Table 4.1 shows that the majority of the respondents who took part in this research study were female (254, 84.7%). In terms of ethnic group, the majority of the respondents were Venda (224, 74.7%). One hundred and seventy seven (59%) of the respondents were in the age range 31-40. Most of the respondents, (160, 53.4%) were single. One hundred and eighty seven (62.3%) of the respondents were certificate holders. One hundred and thirty four (44.7%) of the respondents were professional nurses and 295 (98.3%) were employed on full-time basis.

Table 4.1: Distribution of gender, age range, marital status, educational level, position, employment level and ethnic group

Variable	No	%
Gender		
Female	254	84.7
Male	46	15.3
Ethnic group		
Sotho	14	4.7
Venda	224	74.7
Tsonga	62	20.6
Age range		
20 to 25	47	15.7
26 to 30	22	7.3
31 to 35	92	30.7
36 to 40	85	28.3
41 to 45	14	4.7
46 to 50	38	12.7
above 50	2	0.7
Marital status		
co-habiting	10	3.3
Married	130	43.3
Single	160	53.4
Education level		
Certificate	187	62.3
Diploma	88	29.4
Degree	25	8.3
Position		
Assistant nurse	113	37.6
Professional nurse	134	44.7
Staff nurse	53	17.7
Employment level		
Full time	295	98.3
Part time	5	1.7

Work experience in health sector, work in shift and type of ward results are shown on table 4.2.

Table 4.2: Work experience in health sector, work in shift and type of ward

Variable	No	%
Work experience in health sector		
Less than 6 years	98	32.7
6 to 10 years	82	27.3
11 to 15 years	50	16.7
16 to 20 years	37	12.3
21 to 25 years	22	7.3
above 25 years	11	3.7
Work in a shift		
No	13	4.3
Yes	287	95.7
Type of ward		
Casualty	113	37.7
Intensive care unit	16	5.3
Maternity	41	13.7
Medical	56	18.7
Out Patients Department	11	3.7
Paediatric	52	17.3
Surgical	11	3.7

Table 4.2 shows that 98 (32.7%) of the respondents had work experience below six years. The results also shows that the majority of the respondents 287(97.5%) worked in shift duties. The respondents were spread over several wards as shown on the table. Notably, 113 (37.7%) worked in the Casualty ward.

4.2.2 Section B: Types of workplace violence

The respondents were asked to indicate whether they were abused or not in the last 12 months. The results are shown in Fig 4.1 below.

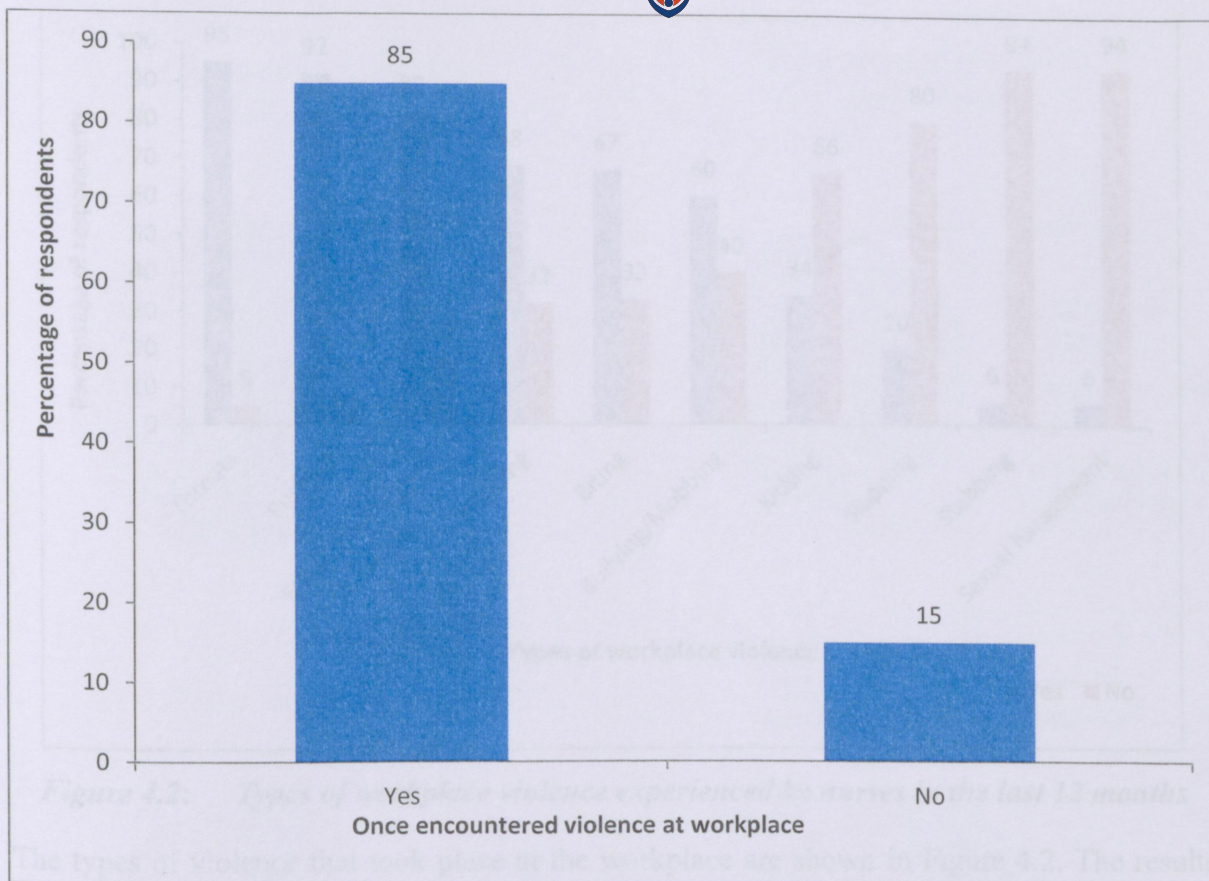


Figure 4.1: Distribution of respondents according to whether they experienced workplace violence

Figure 4.1 shows that 85% of the respondents (255) had experienced workplace violence. Of the 255 respondents who indicated that they experienced violence at work place, they further indicated the types of violence encountered. Fig 4.2 shows the type of violence.

Type of violence	Frequency	Percentage
Verbal	17	6.7%
Physical	16	6.3%
Sexual	25	9.8%
Other	17	6.7%
Total	75	29.5%

The results in Table 4.3 show that the prevalence of workplace violence in parks was highly distributed, with 17 (46%) of the respondents indicating that violence always occurred.

Distribution of responses on the gender of violence perpetrator, type of violence, type of violence perpetrator and the nature of violence are shown in Fig 4.3 below.

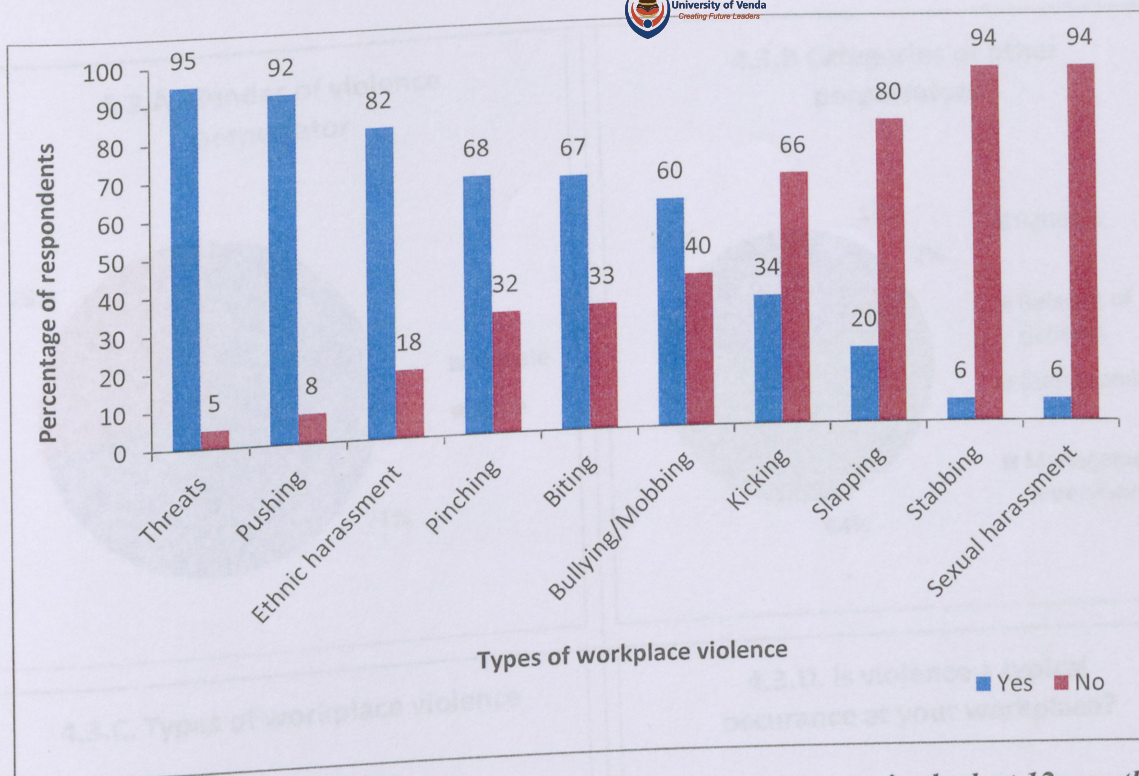


Figure 4.2: *Types of workplace violence experienced by nurses in the last 12 months*

The types of violence that took place at the workplace are shown in Figure 4.2. The results show that the common types of workplace violence were threats (95%) of respondents pushing (92%) and ethnic harassment (82%), pinching (68%), biting (67%), and bullying or mobbing.

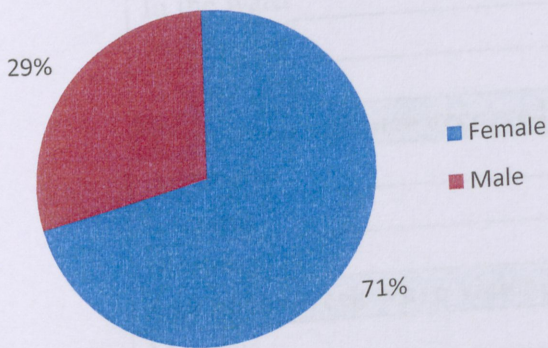
Table 4.3: *Distribution of respondents on the occurrence of workplace violence*

Rating (n =255)	No.	%
Rarely	27	11
Frequently	36	14
Sometimes	75	29
Always	117	46
Total	255	100

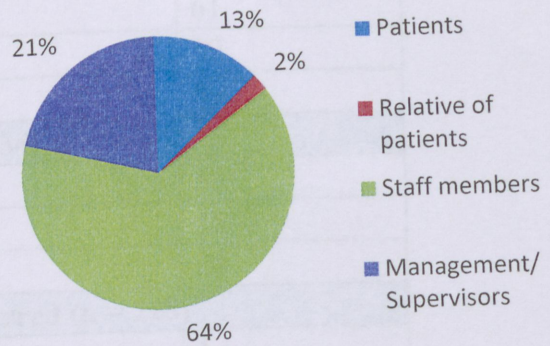
The results in Table 4.3 show that the prevalence of workplace violence on nurses was fairly distributed, with 117 (46%) of the respondents indicating that violence always occurred.

Distribution of responses on the gender of violence perpetrator, type of violence, type of violence perpetrator and the nature of violence are shown in Fig 4.3 below.

4.3.A. Gender of violence perpetrator



4.3.B Categories of other perpetrators



4.3.C. Types of workplace violence



4.3.D. Is violence a typical occurrence at your workplace?

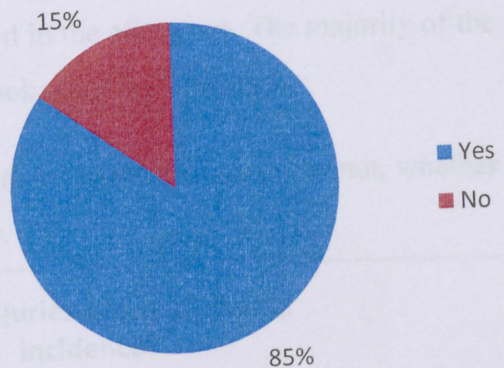


Figure 4.3: Shows the results of a number of variables under investigation

According to these results, 71% of the respondents indicated that violence on nurses was perpetrated by females. The results also show that there were various perpetrators of workplace violence on nurses. The majority of the respondents 64% indicated that staff members were the main perpetrators of violence on nurses. Furthermore, the results show that 94% of the respondents indicated that the violence on them was without weapons. The majority of the respondents (85%) affirmed that the violence they experienced was typical of their workplaces.

The results about the place where violence took place, times when violence occurred and days of the week when violence occurred are shown on Table 4.4.

Table 4.4: Place, time and day of the week violence occurred

Variable	No.	%
Place where violence took place (n =255)		
During health visits	30	12
In the ward	156	61
Parking lot	48	19
Way to work	21	8
Time when violence occurred (n = 234)		
Afternoon	138	59
Evening	36	15
Morning	60	26
Day of the week when violence occurred (n = 228)		
Monday	3	1
Tuesday	6	3
Wednesday	213	93
Thursday	6	3

Results show that most of the violent incidents (61%) took place in the wards. Out of 234 respondents, 138 (59%) indicated that violence occurred in the afternoon. The majority of the respondents, 93% indicated that most of the violence took place on Wednesday.

Distribution of respondents on whether the violent incidents were preventable or not, whether they were injured or not are shown in Figure 4.4 below.

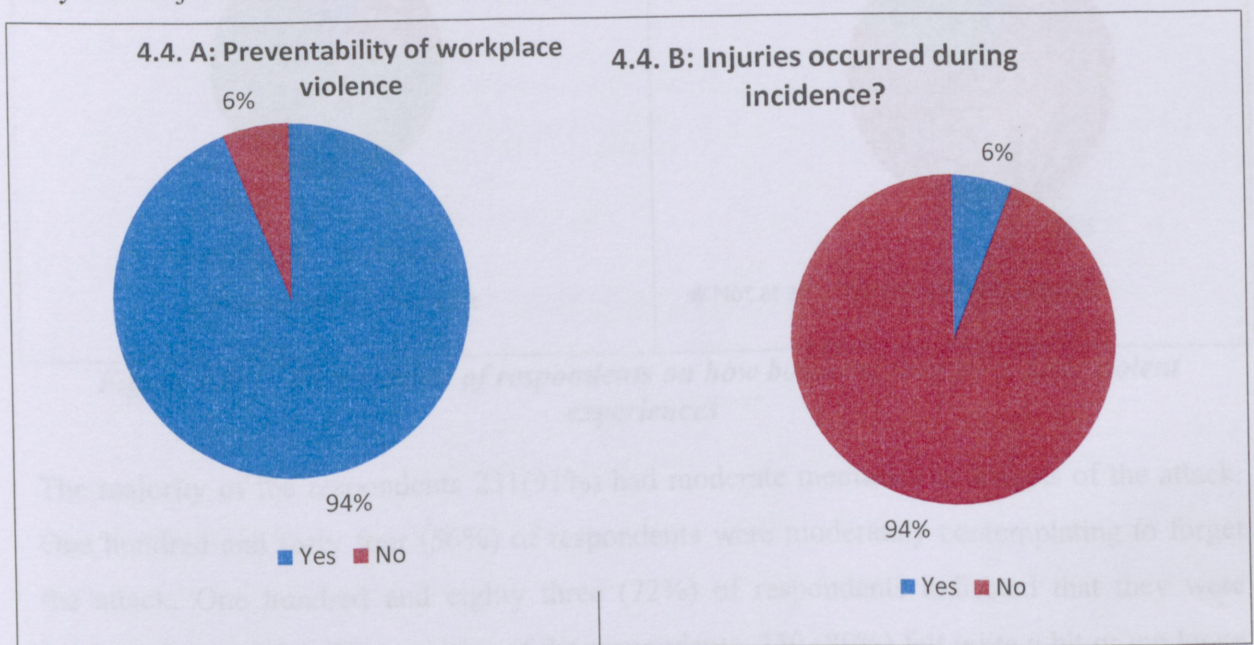


Figure 4.4: Preventability of violent incidents and injuries of respondents

The results show that the majority of the respondents (94%) thought that the violent incidents were preventable. Only 6% of the respondents indicated that they were injured during the

violent incidents while the majority (94%) of the respondents were involved in injury free violence situations.

Figure 4.5 shows the distribution of results of how bothered respondents were after experiencing violence.

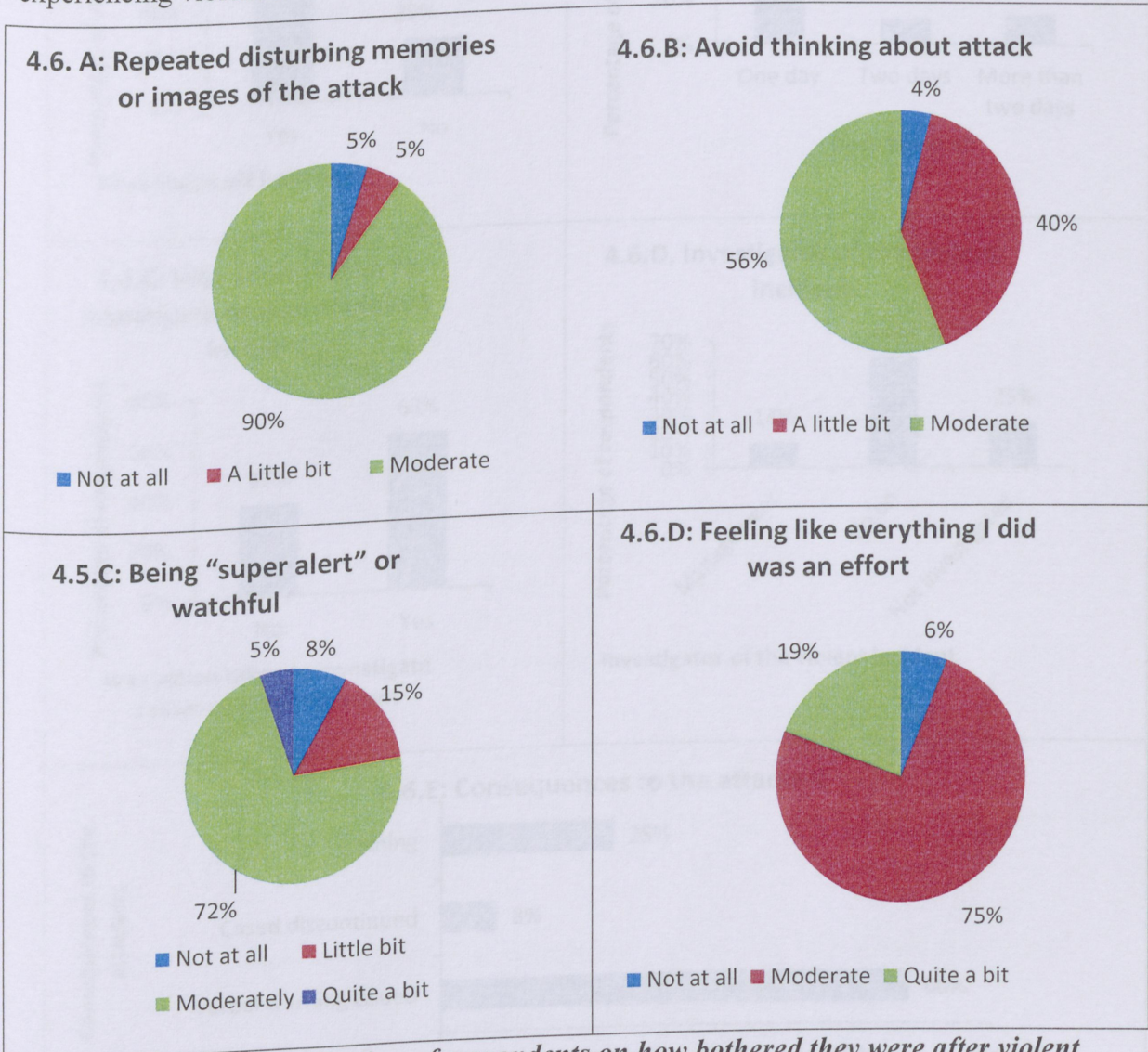


Figure 4.5: Distribution of respondents on how bothered they were after violent experiences

The majority of the respondents 231(91%) had moderate memories or images of the attack. One hundred and forty four (56%) of respondents were moderately contemplating to forget the attack. One hundred and eighty three (72%) of respondents indicated that they were moderately watchful. The majority of the respondents, 250 (80%) felt quite a bit or moderate that everything they did was due to the effort they put.

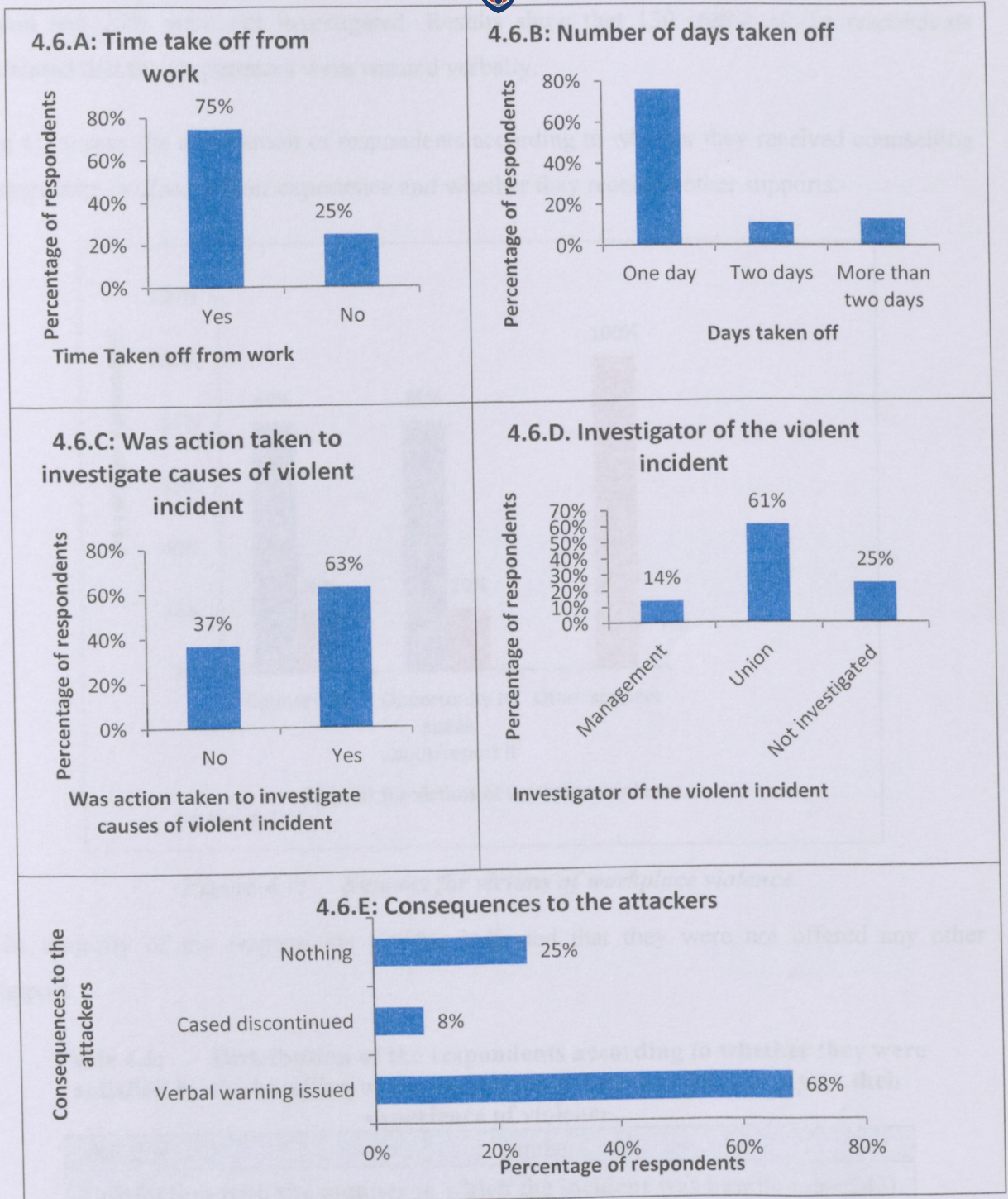


Figure 4.6: Issues related to occurrence of violence in the study setting

Fig 4.6 shows that 190 (63.3%) of the respondents confirmed that they took time off from work to deal with the aftermath of the violence they experienced. The results indicate that 145 (48%) of the respondents took one day off from work. The majority of respondents, 69% indicated that action was taken to investigate the incidents. The distribution of respondents on who investigated the incident show that 30 (61%) of incidents were investigated by the labour

union and 25% were not investigated. Results show that 130 (68%) of the respondents indicated that the perpetrators were warned verbally.

Fig 4.7 shows the distribution of respondents according to whether they received counselling opportunity to discuss their experience and whether they received other supports.

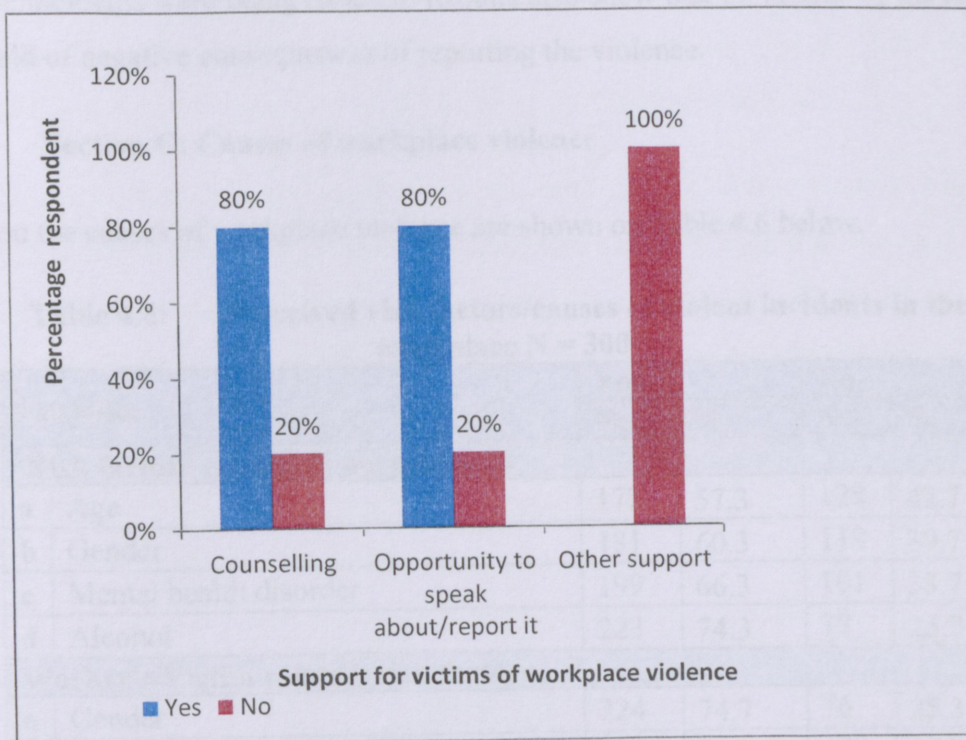


Figure 4.7: Support for victims of workplace violence

The majority of the respondents (100%) indicated that they were not offered any other support.

Table 4.5: Distribution of the respondents according to whether they were satisfied by the handling of the incident and why they did not report their experience of violence.

Variable	Number	%
Satisfaction with the manner in which the incident was handled (n =243)		
Satisfied	12	5
Not sure	99	41
Dissatisfied	120	49
Very dissatisfied	12	5
Reasons for not reporting or telling others about violence (n =138)		
Afraid of negative consequences	60	43
Felt ashamed	24	17
Felt guilty	42	30
It was not important	12	9

Table 4.5 shows the distribution of respondents on whether they were satisfied with the manner in which the incident was handled and also on the reasons for not reporting or telling others.

Results indicate that only (12, 4%) of the respondents were satisfied with the manner in which the incidents were being handled. Results also show that 60 (43%) of the respondents were afraid of negative consequences of reporting the violence.

4.2.3 Section C: Causes of workplace violence

Results on the causes of workplace violence are shown on Table 4.6 below.

Table 4.6: Perceived risk factors/causes of violent incidents in the workplace N = 300

Variable		Yes		No.	
		No.	%	No.	%
Risk factors related to perpetrators					
a	Age	172	57.3	128	42.7
b	Gender	181	60.3	119	39.7
c	Mental health disorder	199	66.3	101	33.7
d	Alcohol	223	74.3	77	25.7
Worker's/Victim related risk factors					
a	Gender	224	74.7	76	25.3
b	Age	178	59.3	122	40.7
c	Marital Status	226	75.3	74	24.7
d	Working hours	233	77.7	67	22.3
Staffing situation specific risk factors					
a	Working full-time with clients	245	81.7	55	18.3
b	Working when understaffed	264	88.0	36	12.0
c	Transporting patients	225	75.0	75	25.0
d	Long waits for services	195	65.0	105	35.0
Work/environmental situation specific risk factors					
a	Working periods	174	58.0	126	42.0
b	Overcrowded	220	73.3	80	26.7
c	Working alone	247	82.3	53	17.7
d	Poor environmental design	235	78.3	65	21.7
e	Inadequate security	197	65.7	103	34.3
f	Lack of staff training	229	76.3	71	23.7
g	Unrestricted movement of the public	177	59.0	123	41.0
h	Poorly lit corridors, rooms/parking lot	226	75.3	74	24.7

Age gender, mental health disorder and alcohol were the perpetrator risk factors which were investigated. For age, 172 (57.3%) respondents regarded this as a risk factor. One hundred

and eighty one (60.3%) of respondents also affirmed that gender was a cause of violence. For mental health disorder, 199 (66.3%) of the respondents affirmed that this was a risk factor for perpetrators. For alcohol, 223 (74.3%) acknowledged that it was a cause for violence.

For the four factors which were being investigated, the respondents indicated that all factors were workers risk factors. For gender, 74.7% of the respondents indicated that it was a victim's risk factors. Age was indicated to be a risk factor by 59.3% of the respondents. Marital status was also reported as a risk factor by 75.3% of respondents.

Table 4.6 shows that the majority of the respondents confirmed that working full-time with clients, being understaffed, transporting patients and patients' long wait for service were all causes of violence. Two hundred and forty five (81.7%) of the respondents regarded working full-time with clients as cause for work related violence. The results also show that all the investigated factors were found to be environmental causes of violence.

Respondents perceived safety of the work setting: Figure 4.8 shows results on respondents' perceptions about safety at workplace.

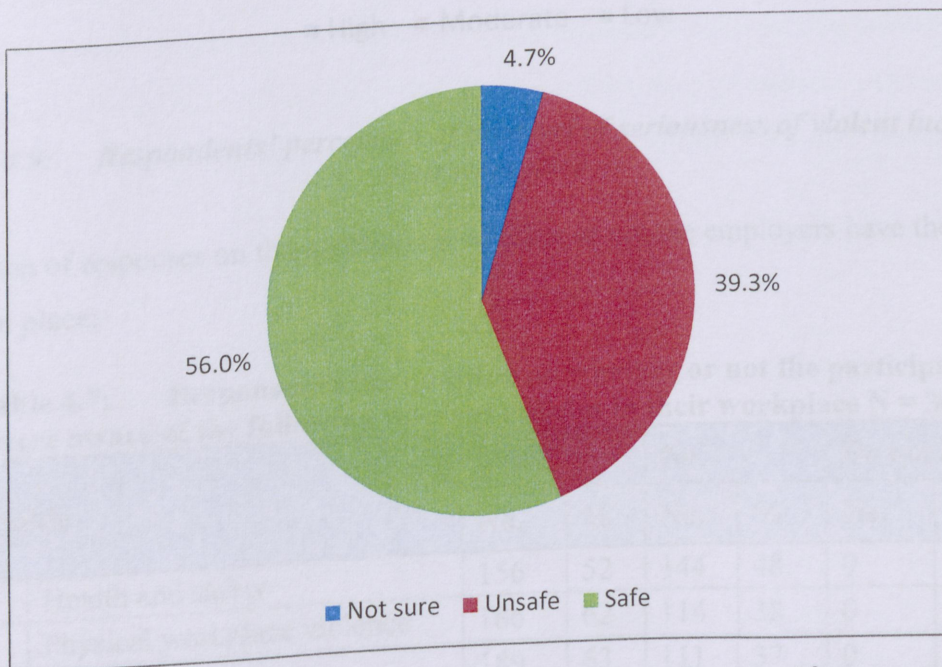


Figure 4.8: *Distribution of respondents' perception on safety at work*

Results show that 56% of the respondents indicated that they were safe at their workplace.

4.2.4 Section D: Management of workplace violence

Results for respondents' perception on workplace violence in their institutions are shown in Figure 4.8 below. The results on rating show that 35% of respondents rated their perceptions on workplace violence as moderate.

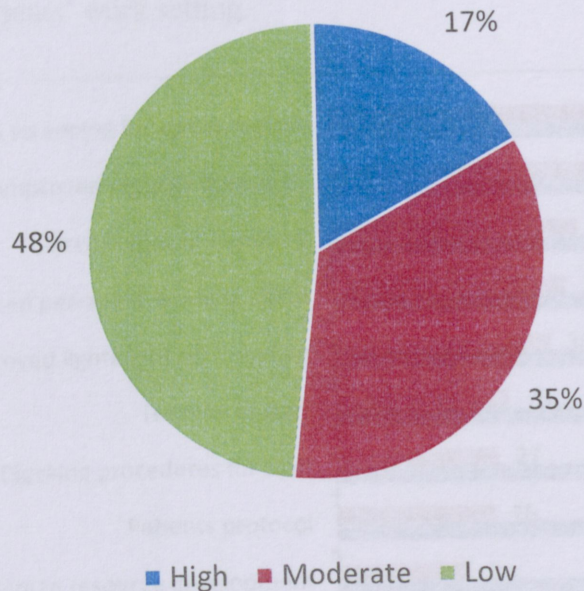


Figure 4.9: Respondents' perception of the level of seriousness of violent incidents in their workplace

Distribution of responses on the question on whether or not the employers have the following policies in place:

Table 4.7: Responses to the question on whether or not the participants were aware of the following relevant policies in their workplace N = 300

Variable		Yes		No		Do not know	
		No.	%	No.	%	No.	%
a.	Health and safety	156	52	144	48	0	0
b.	Physical workplace violence	186	62	114	38	0	0
c.	Verbal abuse	189	63	111	37	0	0
d.	Sexual harassment	177	59	15	5	108	36
e.	Racial Harassment	225	75	15	5	60	20
f.	Bullying	186	62	51	17	63	21
g.	Threat	231	77	42	14	27	9

The list of the common policies which the employer are expected to put in place to address workplace problems is shown in Table 4.7. A question was asked as to whether the

respondents were aware of the availability of these policies in their workplace. Their responses indicates that a range of 52% and 77% of the respondents were aware of various policies. However, between 21% and 36% of the respondents did not know whether their hospitals had any policy on sexual harassment, racial harassment and bullying.

Figure 4.10 shows the control measures developed or implemented to address workplace violence in the respondents' work setting.

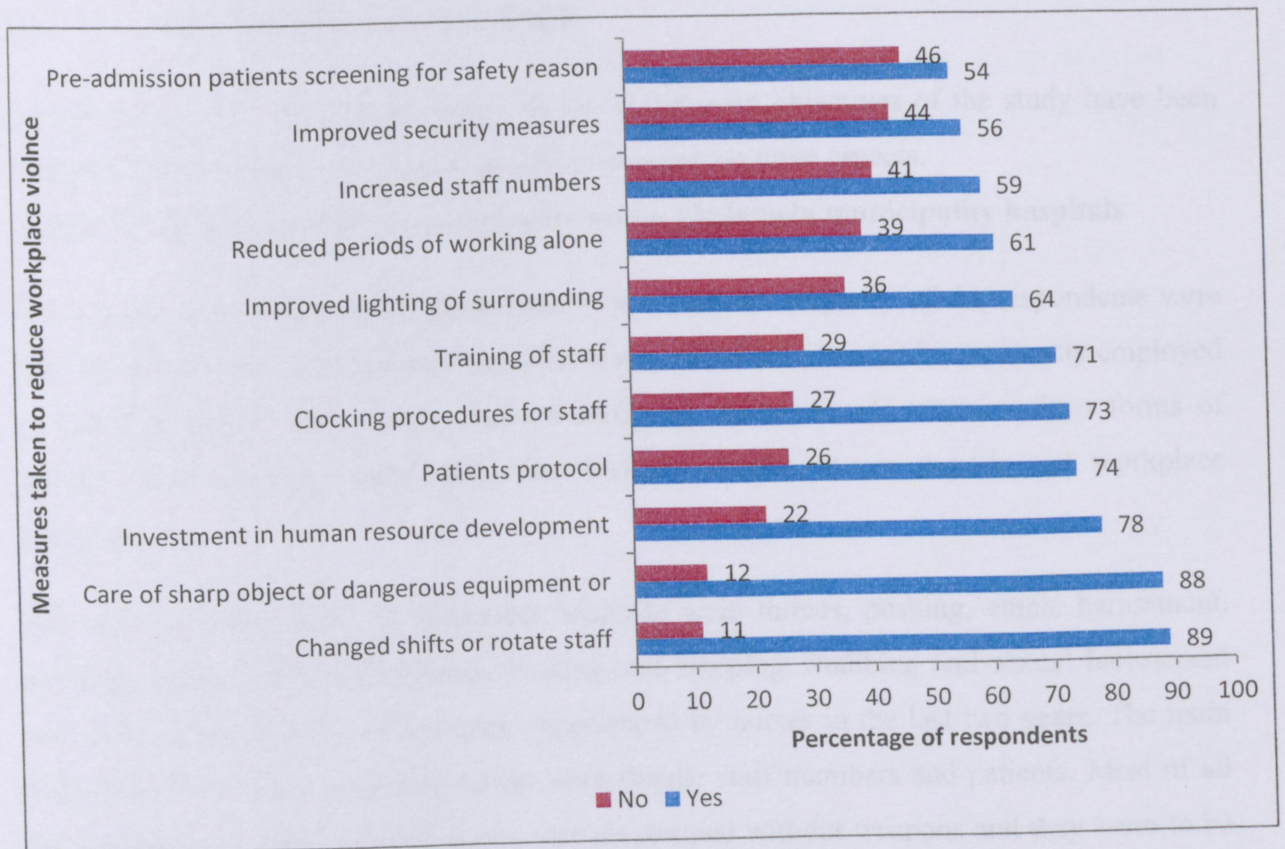


Figure 4.10: Mechanisms taken to reduce workplace violence of nurse

A list of possible control measures which the hospitals are expected to develop and implement to address workplace violence were presented to the participants. A question was asked whether or not the respondents were aware about the development or implementation of these control measures in their workplace. The responses to the questions are shown on fig 4.9. However, it is worth noting that over 60% of the respondents were aware that eight control measures have been developed and implemented in their workplace.

CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This Chapter discusses the results and interpretation of the findings in accordance with the objectives of the study. It also discusses the recommendations and conclusion.

5.2 DISCUSSION OF FINDINGS

In this section, the researcher wanted to see if the main objectives of the study have been addressed. The findings will be discussed by focusing on three aspects.

Types of workplace violence towards nurses in Thulamela municipality hospitals

The results of the study under these aspect show that the majority of the respondents were female nurses whose employment experience was above six years and were mostly employed on full-time basis. These nurses were working in various wards where various forms of gender violence were perpetrated. The majority of the nurses experienced workplace violence.

The most common types of workplace violence were threats, pushing, ethnic harassment, pinching, biting, bullying/mobbing, kicking and slapping. Stabbing and sexual harassment were less common forms of violence experienced by nurses in the last two years. The main perpetrators of violence against nurses were female staff members and patients. Most of all the workplace violence against nurses was perpetrated without weapons and they seem to be typical of work place violence. Violence took place mainly in wards, predominantly in the afternoon or evenings especially on Wednesday. Although the majority of the violent incidents were injury free, there were some in which nurses got injured.

The findings by this study confirm that workplace violence against nurses is prevalent. This finding is consistent with the findings made by Kwok et al. (2006) who say that international studies have reported an increase of workplace violence against nurses of between 10% and 87%. According to O'Brein et al. (2008), there has been a high prevalence of violence in the health care environment towards nurses. Such types of workplace violence included threats and physical assault. The violence against nurses is also reported to be the highest compared to any other occupational. This high prevalence of workplace violence towards nurses is

likely caused by the fact that nurses are also always in direct contact with different types of patients, relatives and colleagues (Kwok et al. 2006). According to Malangu (2012), verbal threats were the most common type of threat towards nurses at workplaces. Lin et al. also supports the findings of this study by indicating that for all types of violence, verbal abuse was the most frequent type of violent experience.

The study is consistent with the results by Quine, 1999 who reported that patients were the main perpetrators of violent incidents. The study also found that the ward was the most dangerous place for nurses with 82% of violent incidents. Another study by Gates et al. (2006) investigated workplace violence at an emergency unit in the U.S.A confirmed that patients were the main perpetrators of violence.

Causes of workplace violence against nurses in Thulamela municipality hospital

There were a number of factors associated with workplace violence established by this research. Workplace violence against nurses was due to the following perpetrator risk factors: alcohol, mental health disorder, gender based violence and age of perpetrator.

These findings are also supported by previous researchers in this area in other countries or medical set-up. For example, the American Medical Association (2007) identifies mental health disorder such as dementia, schizophrenia and suicidal ideation. Patients with dementia were identified as a factor in 87% of physical assaults on nursing home assistants (Gates et al, 2003). Another study conducted by Gates et al. (2003) reported an increased rate of violence committed by patients with dementia. Gerberich et al. (2004) also observes that that the gender and age of a perpetrator were influential factors in causing workplace violence against healthcare workers. The report from these researchers show that gender (male) was rated 73% and age (35 to 65) rated 54% as causes of workplace violence. This finding contradicts this study in that female (71%) were the common perpetrators compared to male (29%). This finding could be attributed to the fact most of the patients who visited the hospital were likely to be female. Therefore, nurses were in constant contact with female patients and their relatives who were also likely female. It is not surprising that females were mostly the perpetrators of violence in this study because most of the incidents were of verbal abuse.

Influence of alcohol towards workplace violence against nurses was also a contributory factor in this study, 74.3% of respondents believed it to be a cause. This was consistent with the results of the study by Gerberich et al. (2004) who found that 35% of nurses believed that

violence towards them was due to alcohol intake by perpetrators. Crilly, et al. (2004) also confirmed that alcohol was a factor that influenced perpetrators to be violent towards nurses at workplaces. These authors ascribe 50% of verbally and 96% of all physically violent events to the influence of alcohol. The study by Quine (1999) also confirms the findings of this study. Quine reports that the majority of patients who abuse nurses were under the influence of alcohol and 45.2% were psychiatric patients.

Of the four workers risk factors investigated, it was found that three factors were the main causes of workplace violence on nurses. Working hours was the major cause, marital status was the second, gender was the third and age was the least. Nurses work during day and night and are likely to meet different types of patients. Nurses indicated that their working hours was a contributory factor to gender violence. It would seem that nurses who worked during evening experienced more violence than those during the day. In this study, marital status was also found to be an influential factor in gender violence against nurses. This result is supported by Lin et al. (2005) who found that unmarried nurses were significantly ($p \leq 0.01$) more likely to experience workplace violence than married nurse. In this study, single nurses were the majority (53.4%). Furthermore, in this study, 75.3% of the respondents affirmed that marital status was a possible cause for workplace violence. The study results contradict the study by Gates et.al. (2003) which shows that male nurses were more at risk for violence compared to female nurses. Gates et al. (2003) also supported the study findings when reporting that younger nurses were more vulnerable to workplace violence compared to older nurses.

There were also work related causes of violence in which understaffing was thought to be the major cause, transportation of patients was the second and long waits for services was the least factor. Most of the hospitals are understaffed, a situation which causes nurses to do a lot of work and fails to attend to patients within the prescribed time. This causes patients to react violently towards nurses. The forms of violence such as threats and physical pushing become prevalent. Nurses are also involved in the transportation of patients from one hospital to another, even from one ward to another. Patients have an opportunity to act violently towards nurses by insulting or pinching. The transfers done against the wishes of the patients are always accompanied by violence. In some cases one nurse could be in charge of more than eight patients (the prescribed number) during transportation. This means those patients who receive service later than they expect were likely to be violent in one way or the other. Long

wait for service by patients caused anxiety among them and then translated to violence (Keely 2002). This situation arises from a number of causes such as understaffing, nurse exhaustion, intolerance by patients, unexpected emergency calls and also shortage of treatment, oversight by management and reassigning of nurses to other areas where they lack familiarity with the procedures (Lyneham, 2008). And thus waiting time in particular has been shown as escalating work place violent related events.

The study also found that some environmental factors contributed to violence against nurses at workplace. Violence was perpetrated in situations where nurses were working alone. The perpetrators find it easy to attack one nurse at workplace. The environment in which the nurses work are poorly designed and make it easy for them to be attacked as indicated by the majority of respondents in this study. Nurses also worked in overcrowded places that made it easy for them to be targeted by violence perpetrators. Many nurses experienced violence as a result of working in overcrowded places. The majority of the nurses experienced violence perpetrated in poorly lit corridors or parking lots. These results are consistent with findings by Steinman (2003) who observes that the environment in which nurses are working is dangerous to work in at night due to inadequate lighting for it makes it easier for the criminals to hide in the facility. Most of the hospitals have many entrances making it difficult to control and safeguard. This implies that violence perpetrators could easily enter or leave without being detected.

Another factor which caused workplace violence was lack of training of nurses. Besides environmental factors mentioned above, the nurses who experienced violence attribute this to their poor training in dealing with workplace violence or the way they conducted themselves among the patients and co-workers. Ergün (2005) found that participants who had not attended violence prevention training were at greater risk for workplace violence compared to those who attended training. This could be the case in this study that the majority of the respondents hardly attended training on violence handling.

Management of workplace violence against nurses in Thulamela municipality hospitals

The results of the study under these aspect show that the respondents rated their perception on workplace violence as high. The results also showed that the majority of respondents were aware of the various policies on workplace violence. The respondents in this study were aware of the various control measures which have been developed and implemented in their

workplace. The study results were supported by May and Crubbs (2002) who found that nurses were concerned about their safety 91% of the time but felt that their institution of employment only took protective measures 41% of the time.

The study results contradict with those by Nabb (2000) who investigated workplace violence in private wards and found that 18% of the nurses were unaware of the existing policies. The other possible theory is that nurses have little knowledge about existing reporting procedures and policies on workplace violence (Ferns, 2006).

5.3 CONCLUSION

The conclusion of this study is in line with its specific objectives. This study demonstrates that the majority (85%) of nurses experience violence. The common type of violence experienced was verbal threat and pushing. Some of the violence was of criminal nature such as stabbing. Most of the violent incidences were taking place in the ward and the common perpetrators were female patients and relatives.

The study also revealed that the violent incidents experienced was associated with mental disorder, alcohol, gender and age of the perpetrators and also the gender, age of the nurse and lack of training by the victim. Action was taken by the union to investigate the incidents. The majority of nurses were afraid of negative consequences of reporting violence.

Finally, this study revealed that nurses perceived workplace violence in their institution as high. The hospitals management responded to workplace violence by improving the security measures, increased staff members and also by developing some policies on workplace violence. This means that workplace violence against nurses is a serious problem which may continue to escalate if nothing is done to address the issue.

5.4 RECOMMENDATIONS

The following recommendations are made based on the conclusion above:

5.4.1 Recommendation for society

From the findings of this study, it is recommended that when people are visiting the hospitals, they should understand that nurses are there to serve them and if there are some delays in

receiving the service, they should not abuse nurses. Members of society should support the nurses by not tolerating any form of abuse against them.

5.4.2 Recommendations for the Department of Health

The department should focus its attention on developing and implementing employee health and wellness programmes as a support mechanism for employees experiencing workplace violence. The employee health and wellness programme should be pro-active to include educational workshop and awareness on the impact of workplace violence.

5.4.3 Recommendation for the hospitals management

The hospitals management should make sure that the preventative measures in the hospitals are strengthened and that each nurse is included in all workplace violence related trainings, continuous workshops and awareness on the impact of workplace violence. Hospitals management should make sure that each nurse becomes aware of all the existing policies on workplace violence.

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APPENDIX 1: CONSENT FORM

I, Madzhadzhi Livhuwani Precious, a post graduate student at the University of Venda, Department of Public Health am conducting a research titled 'Workplace violence towards nurses in Thulamela Municipality Hospitals, Vhembe district'.

I would like you to participate in this study. Information obtained from you will be treated as confidential. Your participation in this study is voluntary and your decision to take part in this study will have no negative impact on your life or health. You can withdraw from participation in the study at any point if you wish to do so.

Researcher's signature Madzhadzhi Livhuwani Precious Date 05/11/2014

Participant

I _____ have read through the content of this form and hereby voluntarily consent to participate in the study.

Participant's signature _____ date _____

For more information contact Madzhadzhi L. P (Researcher) – 0727477715

APPENDIX 2: PARTICIPANT INFORMATION SHEET

TITLE OF THE STUDY: WORKPLACE VIOLENCE TOWARDS NURSES IN THULAMELA MUNICIPALITY HOSPITALS, VHEMBE DISTRICT

Introduction

Dear participants

My name is Livhuwani Precious Madzhadzhi and I am doing research for the purpose of obtaining a Masters in Public Health at the University of Venda. I am inviting you to participate in this research. This information sheet will help you to decide if you want to participate and before you agree to take part, you should have full understanding of what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the researcher.

The nature and purpose of the study

The purpose of the study is to describe workplace violence against nurses in Thulamela hospitals, Vhembe district.

Procedure to be followed

The study involves completing a questionnaire that is provided. The researcher will summarize the findings.

Risk and discomfort involved

There is no risk in participating in the study.

Possible benefits of this study

The results of this study might assist the Department of Health, management of hospitals and other stakeholders to seek appropriate strategies in dealing with workplace violence against nurses.

What are your rights as participants?

Taking part in this study is voluntary and there will be no payment for participating. Should you choose not to participate, there will be no negative results for you.

Confidentiality

All information that you give will be kept confidential. The questionnaire is anonymous and you should not write your name on it. Research reports and articles in journals will not include any information that will identify you.

Contact person

Ms. Madzhadzhi Livhuwani- 0727477715

QUESTIONNAIRE

Please complete the questionnaire by either ticking boxes with an “x” or writing in the spaces provided. If you do not know how to answer one question, just go on to the next one.

SECTION A: Demographic information of the participant

1. What is your age in years? _____

2. Gender

a)	Male	
b)	Female	

3. What is your marital status?

Mark with an (x) in an appropriate circle

- i) Single
- ii) Married
- iii) Window/Widower
- iv) Separated/divorced
- v) Co-Habiting/partner

4. Education

Mark with an (x) in an appropriate circle

- i) Certificate
- ii) Diploma
- iii) Bachelor’s degree
- iv) Masters degree

5. Position *(mark an appropriate answer with an x)*

a)	Professional nurse	
b)	Staff nurse	
c)	Assistant nurse	

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6. What is your employment level? (Mark an appropriate answer with an x)

a)	Full time	
b)	Part time	

7. What is your ethnic group? (Mark an appropriate answer with an x)

a)	Venda	
b)	Tsonga	
c)	Sotho	
d)	Other (Specify)	

8. How many years have you worked in the health sector? Please specify

9. Do you work shift?

Yes	No
1	2

10. Type of ward

	VARIABLES (Section)	Tick
(a)	Surgical	
(b)	Medical	
(c)	Paediatric	
(d)	Maternity	
(e)	Psychiatric	
(f)	TB ward	
(g)	Private	
(h)	ICU	
(i)	Casualty	
(j)	OPD	

SECTION B: TYPES OF WORKPLACE VIOLENCE

11. In the last 12 months, have you been attacked in your workplace?

(Mark with an (x) in an appropriate box) if the answer is YES answer

Yes	No
1	2

2-21. if is NO please go to section B.

12. The following are the types of workplace violence, which one have you experienced?

Please tick all relevant boxes (You may tick more than one)

	VARIABLES	YES	NO
(a)	Kicking		
(b)	Slapping		
(c)	Stabbing		
(d)	Pushing		
(e)	Biting		
(f)	Pinching		
(g)	Bullying/Mobbing		
(h)	Sexual harassment		
(i)	Racial harassment		
(j)	Threat		
(k)	Other (Specify)		

13. How often have you experienced workplace violence in the last 12 months?

Mark with an (x) in an appropriate circle

- i) Frequently
- ii) Always
- iii) Frequently
- iv) Sometimes
- v) Rarely
- vi) Once

14. Please think of the last time that you were attacked in your workplace. How would you describe this incident?

(Mark an appropriate answer with an x)

a)	Violence with a weapon	
b)	without a weapon	

15. Do you consider this to be a typical incident of violence in your workplace? (Mark an appropriate answer with an x)

Yes	No	Do not know
1	2	3

16. Who attacked you?

Mark with an (x) in an appropriate circle ...

- i) Patient
- ii) Relatives of patient
- iii) Staff member
- iv) Management/Supervisor
- v) External colleague/worker
- vi) Other, specify

17. What was the gender of the perpetrator?

(Mark with an (x) in an appropriate box)

1	2
Male	Female

18. Where did the incident take place?

- i) In the ward
- ii) Way to work
- iii) Parking lots
- iv) During health visits

19. What time did it happen?

- i) In the morning
- ii) In the evening
- iii) In the afternoon
- iv) Do not remember

20. Which day of the week did it happen?

- i) Monday
- ii) Tuesday
- iii) Wednesday
- iv) Thursday
- v) Friday
- vi) Saturday
- vii) Sunday
- viii) Do not remember

21. How did you respond to the violent act that you faced? You may tick more than one box

Variables	Physical assault	Verbal abuse	Bullying	Sexual harassment
(a) I did nothing				
(b) I warned the perpetrator and told him/her to stop the violent behaviour				
(c) I talked about it with my family/friends				
(d) I talked about it with my colleagues				
(e) I wanted to be transferred to another place				
(f) Reported it to the management				
(g) Tried to pretend it never happen				
(h) Tried to defend myself				
(i) Sought counselling				
(j) Sought help from the association				
(k) Sought help from the union				
(l) Pursued prosecution				
(m) Completed incident form				
(n) Completed compensation claim				
(o) Other (specify)				

22. Do you think the incident could have been prevented?

Yes	No	Do not know
1	2	3

23. Where you injured as a result of the violent incident?

Yes	No	Donot know
1	2	3

24. How bothered you have been by these experiences since you were attacked. Please tick one option per question.

VARIABLES	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
(a) Repeated, disturbing memories, thoughts or images of the attack?					
(b) Avoiding thinking about or talking about the attack or avoiding having feelings related to it?					
(c) Being "super-alert" or watchful and on guard?					
(d) Feeling like everything you did was an effort?					

25. Did you have to take off days from work after being attacked?

Yes	No	Do not know
1	2	3

26. If yes, for how long?

Mark with an (x) in an appropriate circle

- vii) One day
- viii) 2-3 days
- ix) One week
- x) 2-3 weeks
- xi) 1 month
- xii) 2-6 months
- xiii) 7-12 months

27. Was any action taken to investigate the causes of the incident?

Yes	No	Do not know
1	2	3

If No or do not know, please go to section B

28. If yes by whom?

Mark with an (x) in an appropriate circle

- i) Management
- ii) Union
- iii) Association
- iv) Community
- v) Police
- vi) Group

Other, please specify _____

29. What were the consequences for the attacker?

Mark with an (x) in an appropriate circle

- i) None
- ii) Verbal warning issued
- iii) Reported to police
- iv) Care
- v) Discontinued
- vi) Aggressors prosecuted

Other _____

30. Did your employer or supervisor offer to provide you with:

	VARIABLES	YES	NO
(a)	Counselling		
(b)	Opportunity to speak about/report it		
(c)	Other support		

31. How satisfied are you with the manner in which the incident was handled?

(Please rate: 1 = very dissatisfied, 5= very satisfied)

Mark with an (x) in an appropriate circle

- i) Very dissatisfied
- ii) Dissatisfied
- iii) Average
- iv) Satisfied
- v) Very satisfied.....

32. If you did not report or tell about the incident to others, why not?

Please tick every relevant box

Mark with an (x) in an appropriate circle

- i) It was not important
- ii) Felt ashamed
- iii) Felt Guilty
- iv) Afraid of negative consequences
- v) Useless
- vi) Aggressors prosecuted
- vii) Did not know who to report to, specify

SECTION C: CAUSES OF WORKPLACE VIOLENCE

33. Please identify the causes of the workplace violence that you experienced from the list below (can be more than one choice)

	Risk factors	YES	NO	DON'T KNOW
1.	Perpetrator risk factors			
(a)	Age			
(b)	Gender			
(c)	Mental health disorder			
(d)	Alcohol abuse			
2.	Worker's (victim) risk factors			
(a)	Gender			
(b)	Age			
(c)	Marital status			
(d)	Working hours			
(e)	Other (please specify)			
3.	Work related causes of violence			
(a)	Working full time with clients			
(b)	Working when understaffed			
(c)	Transporting patients			
(d)	Long waits for service			
4.	Environmental causes of violence			
(a)	Working periods			
(b)	Overcrowded			
(c)	Working alone			
(d)	Poor environmental design			
(e)	Inadequate security			
(f)	Lack of staff training and policies and managing crises with potentially volatile patients			
(g)	Unrestricted movement of the public			
(h)	Poorly lit corridors, rooms, parking lots and other areas			
(i)	Other (specify)			

34. How do you perceive safety within your institution?

unsafe	Not sure	safe
1	2	3

SECTION D: MANAGEMENT OF WORKPLACE VIOLENCE

35. How do you perceive the incident of workplace violence in your institution?

a)	Extremely high	
b)	High	
c)	Average	
d)	Low	
e)	Extremely low	

36. Has your employer developed specific policies on?

	VARIABLES	YES	NO	DO NOT KNOW
(a)	Health and safety			
(b)	Physical workplace violence			
(c)	Verbal abuse			
(d)	Sexual harassment			
(e)	Racial harassment			
(f)	Bullying/ Mobbing			
(g)	Threat			

37. What measures to deal with workplace violence exist in your workplace?

Please tick every relevant box

No.	VARIABLE	
1.	Improved security measures (e.g. guards, alarms, portable telephones)	
2.	Improved lighting of surroundings (e.g. lighting, noise, heat, access to food, cleanliness, privacy) Restrict public access	
3.	Care of sharp object or dangerous equipment	
4.	Changed shifts or rotas (i.e. working times)	
5.	Investment in human resource development (training for career advancement, retreats, rewards for achievement, promotion of healthy environment)	
6.	Training (e.g. workplace violence, coping strategies, communication skills, conflict resolution, self- defence)	
7.	Reduced periods of working alone	
8.	Clock-in procedures for staff (especially for home care)	
9.	Increased staff numbers	
11.	Pre-admission patient screening for safety reason (to record and be aware of previous aggressive behaviour)	
12.	None of these	

Other: _____

38. To what extent do you think these measures would be helpful in your work setting?

	VARIABLES	LOTS	NOT AT ALL	LITTLE
(a)	Improved surroundings			
(b)	Restrict public access			
(c)	Patient screening			
(d)	Increased staff number			
(e)	Check-in procedure for staff			
(f)	Reduced periods of working alone			
(g)	Training			

39. Which of the following changes, if any, have occurred in the workplace/health care setting in the last 2 years?

Mark with an (x) in an appropriate circle

- i) None
- ii) Restructuring/reorganization
- iii) Staff cuts
- iv) Increase staff numbers
- v) Restriction of resources
- vi) Additional resources

40. In your opinion, what impact have the above changes had on your daily work?

Please tick any relevant box

Mark with an (x) in an appropriate circle

- i) None
- ii) Work situation for staff worsened
- iii) Work situation for staff improved
- iv) Situation for patient/client improved
- v) Do not know

Other _____

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**APPENDIX 4: UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE
CLEARANCE CERTIFICATE**

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

**NAME OF RESEARCHER/INVESTIGATOR:
Ms LP Madzhadzhi**

**Student No:
11514194**

**PROJECT TITLE: Workplace violence towards nurses
in Thulamela Municipality Hospitals, Vhembe
District.**

PROJECT NO: SHS/14/PH/09/2807

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof A Olukoga	University of Venda	Supervisor
Ms JT Mabunda	University of Venda	Co-Supervisor
Ms LP Madzhadzhi	University of Venda	Investigator - Student

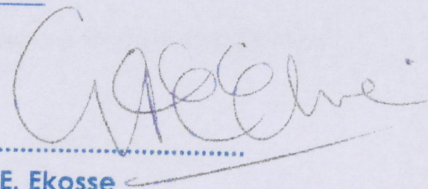
**ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE**

Date Considered: July 2014

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

Name of the Chairperson of the Committee: Prof. G.E. Ekosse




University of Venda

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APPENDIX 5: DEPARTMENT OF HEALTH PERMISSION LETTER



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REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Madzhadzi LP

University of Venda
Private Bag X5050
Thohoyandou
0950

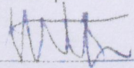
Greetings,

Workplace violence towards nurses in Thulamela Municipality Hospitals, Vhembe District

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.



Head of Department

15/10/2014

Date

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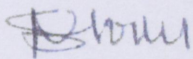
APPENDIX 6: EDITING AND PROOFREADING REPORT

Editing and Proofreading Report

This letter serves to confirm that I, Dr I. Ndlovu of the English Department, University of Venda, have proofread and edited a Masters dissertation titled “Workplace Violence Towards Nurses in Thulamela Municipality Hospitals, Vhembe District” by Madzhadzhi Livhuwani Precious (Student no.: 11514194), to be submitted in partial fulfilment of the requirements for the degree of Masters in Public Health at the University of Venda.

I carefully read through the dissertation, focusing on proofreading and minor editorial issues. The recommended changes are clearly highlighted. It is now up to the candidate to effect these recommendations.

Yours Sincerely



Dr Isaac Ndlovu, PhD
Lecturer: English Department
University of Venda
Private Bag X5050
Thohoyandou 0950
South Africa
Tel.: +27 15 962 8305
Fax: +27 15 962 4749
E-mail: isaac.ndlovu@univen.ac.za