ASSESSMENT OF WORKPLACE VIOLENCE AND ITS PERCEIVED EFFECTS AMONG NURSES IN FEDERAL TEACHING HOSPITAL, IDO EKITI, EKITI STATE, NIGERIA

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ABSTRACT

Workplace violence is a pervasive concern in healthcare, especially among nurses who are frontline caregivers. This study assessed the workplace violence among nurses and perceived effects at Federal Teaching Hospital, Ido-Ekiti, Ekiti State. The design of this study is a descriptive cross-sectional. Two hundred and thirty-one nurses were recruited using stratified random sampling technique. Respondents completed a structured, self-administered questionnaire. Data were analyzed using SPSS version 25.0. Descriptive and inferential statistics were used, presented in frequencies, percentages. Chi-square tests examined associations between variables at 0.05 level of significance. The socio- demographic characteristics revealed that majority of the respondents were aged 20–30 years (45.5%), female (74%), married (50.6%), held a Bachelor of Nursing Science degree (79.9%), ranked as Senior Nursing Officers (65.4%), and had 1–4 years of nursing experience (35.5%), with most working in the male medical ward (20.3%). This study shows that majority of the participants has experience workplace violence due to the fact that majority of the participants one form of workplace violence in the past 12 months (60.6%), the common type experience is Verbal abuse (52.9%) and the perpetrators are Patient's relative/visitors (34.7%). This study shows that the frequency of workplace violence is low (40.26%). This study observed that severity of workplace violence was low (34.2%). This study observed that the perceived effects of workplace violence among nurses are increased stress and anxiety (93.5%), burnout (93.9%), satisfaction difficulty (64.5%), reduced productivity, fear of going to work (70.6%), negative impact on personal relationship (80.9%) and the contributing factors to workplace violence among nurses include staff shortages (93.9%), overcrowded waiting areas (74.9%), lack of security (92.7%), inadequate training on violence prevention (85.2%), high patient turnover (80.5%), patients under the influence of alcohol (73.2%), lack of clear policies on workplace violence (84%), poor communication between staff and management (79.6%) and societal factors (e.g increasing aggression)(87.4%). A significant association was found between nurses' department and workplace violence experience in the past 12 months ($\chi^2 = 39.162$, $P < 0.001$). Secondly, there is a significant relationship between the department of the nurses and their experience of workplace violence in the past twelve months, with P-value (0.000< 0.05). This study concludes that in Nigerian tertiary hospitals, the physical and psychological consequences of workplace violence are profound, with implications for nurse retention and patient care quality. It is recommended that urgent interventions, including policy support and dissemination, enforcement, staff training, and security enhancement, effective communication are essential to ensure a safer and more supportive working environment that minimizes workplace violence among nurses.

Keywords: Assessment; Workplace Violence; Nurses; Perceived Effects; Hospital.

INTRODUCTION

Nurses are at the highest risk of WPV due to their direct contact with patients and visitors compared to other professional roles in healthcare (Li YL et al., 2020). One out of every five nurses experience a physically violent event each year (Fang et al., 2018). The World Health Organization WHO 2020), estimates there are 27.9 million nurses across the globe. This equates to more than five and a half million nurses experiencing a physically violent event while providing patient care each year. While the number of events is staggering, it may not fully encompass the magnitude of the problem due to underreporting. Underreporting is defined as a failure of the victimized employee to report events to employers, police, or other officials (Findorff et al., 2020). OSHA estimates that two-thirds of all workplace-related injuries and

illnesses go unreported, while West (2022) found that underreporting is a pervasive challenge for nurses and poses a significant safety issue for patients and staff. More specifically, workplace violence against nurses.

According to The Joint Commission (TJC) reporting events is critical to address WPV. On its part, the American Nurses Association (ANA) advocates that any verbal, nonverbal, written, or physical violence should be reported (ANA, 2021). When an organization can track violent events, the ability to address WPV is improved (ANA, 2021). Moreover, different forms of WPV are not reported equally or proportionately. Physically violent events are more likely to be reported, especially if there was an injury or lost time from work (Song et al., 2020). However, Kozak et al., (2018) found that each year, 94% of nurses experience verbal aggression.

Workplace violence against nurses is a critical issue with severe consequences for both individuals and the healthcare systems. The World Health Organization (WHO) highlights that "between 8 and 38% of nurses suffer from healthcare violence at some point in their career" (WHO, 2022). This violence can manifest in various forms, including physical assault, verbal abuse, and psychological harassment, perpetrated by patients, their relatives, or even other staff members.

Several factors contribute to this trend. Understaffing, a common issue in many healthcare settings, can lead to increased stress and burnout among nurses, making them more susceptible to aggressive behavior. Inadequate security measures within hospitals can further exacerbate the problem, leaving nurses vulnerable to attacks. Moreover, a lack of proper training in de-escalation techniques and conflict resolution can hinder nurses' ability to manage challenging situations, potentially escalating conflicts. The consequences of workplace violence against nurses are far-reaching. Physical injuries, post-traumatic stress disorder, and increased rates of job dissatisfaction are common among victims. This violence also impacts patient care quality, leading to decreased patient satisfaction and increased healthcare costs. Furthermore, it contributes to high staff turnover rates, creating a significant burden on healthcare systems

To address this issue effectively, a multi-pronged approach is necessary. Improving staffing levels to reduce nurse workload and burnout is crucial. Implementing robust security measures, such as surveillance systems and trained security personnel can enhance safety within healthcare facilities. Providing comprehensive training programs on de-escalation techniques, communication skills, and cultural competency can empower nurses to better manage challenging interactions. Finally, fostering a culture of respect and zero tolerance for violence within healthcare organizations is essential to creating a safe and supportive working environment for all nurses.

By implementing these strategies, healthcare institutions can significantly reduce workplace violence against nurses, creating a safer and more conducive environment for patient care. WPV is not acceptable and, regardless of the culprit's physical or psychological status, should be held responsible for such a heinous crime. WPV can have a vastly negative impact on nurses. Unfortunately, violence in the workplace has become so common that it is now considered an unpleasant part of the job and is ignored instead of being reported. Nurses should be educated appropriately on hospital policies against WPV and be encouraged to report any incidence (Acharya, et al., 2022). Different factors have been identified as factors that contribute to workplace violence against nurses: Patient factors, especially patients with untreated mental health conditions, such as psychosis or dementia, may exhibit aggressive behaviour. (Cho et al., 2023). Substance Abuse patients under the influence of drugs or alcohol are more likely to become violent; patients experiencing pain or chronic illness can lead to frustration and aggression toward caregivers (Cho et al., 2023)

Others are organizational factors, including inadequate staff, predisposing nurses to stress and burnout, this increases their vulnerability to patient aggression. Poor communication and coordination between departments leads to misunderstandings, frustration, and increased risk of conflict. Lack of clear policies and procedures regarding workplace violence prevention and response, etc, makes nurses feel unsupported and unsure of how to handle incidents. (Tesfaye et al.., 2022)

A study by Nwokedi et al. (2021) highlights how societal norms condone violence or aggression, leading to the acceptance and perpetuation of workplace violence against nurses. Limited public awareness. Inadequate legal and social support: Insufficient legal and social support systems for victims of workplace violence can discourage nurses from reporting incidents and seeking justice

The documented effects of workplace violence against nurses are numerous, including a devastating impact on their physical, mental, and emotional well-being (Acharya et al., 2022), low job satisfaction, productivity, and quality of care, and may leave the profession altogether (Hennepin Healthcare Survey, 2022). Others are physical injuries like cuts and fractures (Mahmoud, 2021); anxiety, depression, and other mental health problems (Farinaz, 2021). Nurses who are stressed or traumatized by workplace violence may be less able to provide quality care to their patients (Arespacochaga., et al, 2024)

Workplace violence, especially against healthcare workers, is a growing concern globally, and Nigeria is no exception. Nurses, being on the frontlines of patient care, are particularly vulnerable to various forms of violence, including physical, verbal, and psychological abuse. The prevalence of workplace violence in Nigerian hospitals has been exacerbated by factors such as inadequate staffing, lack of security measures, and a high-stress work environment (Ogunleye et al., 2022).

Research indicates that the incidence of workplace violence against nurses in Nigeria is not only alarming but also affects their mental well-being and job performance. Recent studies highlight that nurses often face aggression from patients, families, and colleagues, leading to burnout and decreased job satisfaction (Abiola et al., 2023). The ramifications extend beyond individual experiences; they can adversely affect healthcare delivery, leading to poorer patient outcomes and increased turnover rates among nursing staff (Ibrahim et al., 2022).

Orewa et al. (2025) conducted a qualitative meta-synthesis of nurses lived experiences with WPV in the United States of America and reported that nurses perceived violence as a "normalized" part of their job, yet it led to emotional exhaustion and a sense of abandonment by management. Many reported adopting maladaptive coping strategies, such as emotional detachment from patients, which they perceived as compromising care quality. The study highlighted the interplay between psychological strain and professional detachment as a perceived outcome of WPV. A narrative review by Kumar and Kumari (2024) synthesized global data, noting that over 20% of nurses perceived WPV as a key factor in their decision to leave the profession. In India, nurses reported feeling undervalued and unsafe, with psychological effects like depression and anxiety amplifying their intent to quit. This aligns with findings from Cai et al. (2021), where nurses perceived organizational inaction as exacerbating the effects of violence, leading to disillusionment with their roles.

Emerging studies call for urgent interventions in addressing workplace violence, including better institutional policies, enhanced security protocols, and training programs aimed at conflict de-escalation and stress management (Nwokocha et al., 2023). The need for comprehensive research to inform policymakers and healthcare administrators is evident, as measures to mitigate violence against nurses can profoundly improve the work environment and healthcare quality in Nigerian hospitals. Hence, this study aims to investigate workplace violence among nurses and its related consequences in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.

Theoretical Review

Robert K. Merton's Strain Theory was used to situate the study. It is a cornerstone of criminology and sociology, delves into the intricate relationship between societal structures, individual aspirations, and deviant behaviour. It provides a framework for understanding how the very fabric of society can inadvertently pressure individuals into engaging in criminal or deviant acts.

At its core, Strain Theory posits that societies establish specific goals and expectations for their members. These goals, often deeply ingrained in the cultural ethos, serve as powerful motivators. In many Western societies, the "American Dream" – the pursuit of material wealth, social status, and upward mobility – exemplifies such a dominant cultural goal. However, Merton astutely observed that not everyone possesses equal access to the legitimate means necessary to achieve these culturally sanctioned aspirations. Legitimate means typically refer to socially approved pathways for attaining success, such as education, hard work, and perseverance within the established social and economic systems (Merton, 1938). When individuals find themselves confronted with a disparity between their deeply ingrained desire to achieve societal goals and the limited or obstructed avenues available to them, a state of "strain" arises. This strain, Merton argued, can exert significant pressure on individuals, potentially driving them towards deviant or criminal behaviours.

Key Elements of Strain Theory: Modes of Adaptation: Merton identified five ways individuals adapt to this strain: Conformity: Accepting both the cultural goals and the legitimate means to achieve them. This is the most common mode of adaptation. Innovation: Accepting the cultural goals but rejecting the legitimate means. This often leads to criminal activity. Ritualism: Rejecting the cultural goals but accepting the legitimate means. This can lead to a focus on following rules for their own sake, even if it doesn't lead to success. Retreatism: Rejecting both the cultural goals and the legitimate means. This can lead to withdrawal from society and substance abuse. Rebellion**:** Rejecting both the cultural goals and the legitimate means, but actively seeking to replace them with new ones. This can lead to social and political activism.

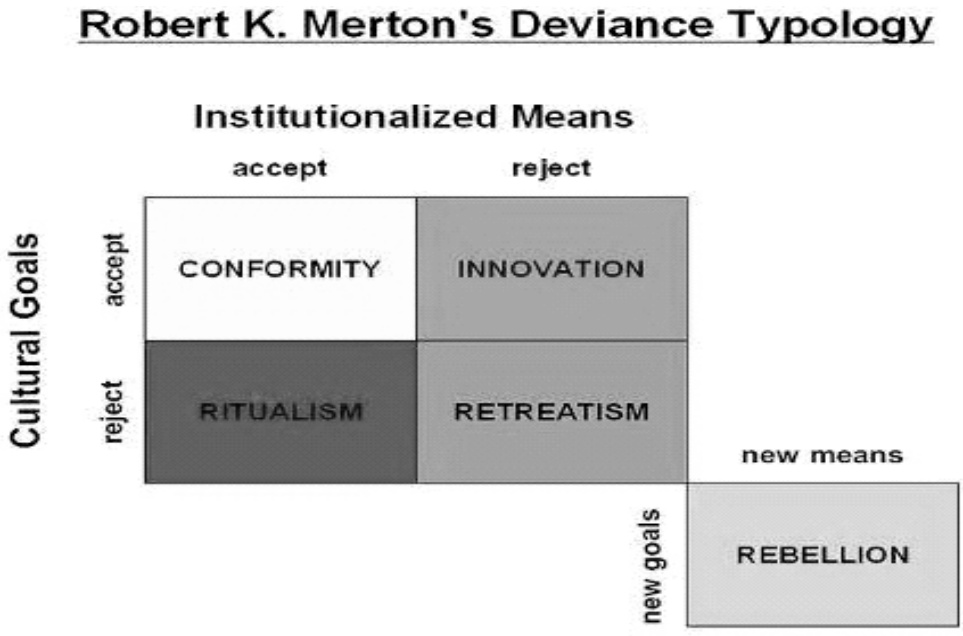

Figure 1 Robert Merton's deviance typology

The application of Strain Theory to workplace violence among nurses explains that stressful and unfavourable working conditions may create tension, frustration, and emotional pressure that increase the likelihood of violent incidents in healthcare settings. Factors such as staff shortages, excessive workload, overcrowding, inadequate security, poor management support, and high patient turnover may generate strain among patients, relatives, and healthcare workers, resulting in aggressive behaviours and workplace violence. The theory suggests that when individuals experience prolonged stress or inability to cope with challenging situations, they may respond through verbal, physical, or psychological aggression.

Objectives of the study

The overarching objective of this study is to assess workplace violence among nurses and its perceived effects in Federal Teaching Hospital, Ido-Ekiti (FETHI), Ekiti State, Nigeria.

The specific objectives are to:

1. Assess the experience; types & perpetrators of workplace violence among respondents in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
2. determine the level of Work Place Violence among Nurses in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
3. Determine the frequency of workplace violence
4. assess the factors contributing to the prevalence of Work Place Violence among Nurses in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
5. assess the perceived effects of workplace violence among Nurses in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.

Research Questions:

1. What is the level of workplace violences been experience? types & perpetrators of workplace violence among respondents in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
2. What is the frequency of workplace violence?
3. What are the forms of workplace violence experienced by nurses in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
4. What factors contribute to the occurrence of workplace violence among nurses in Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria.
5. What are the perceived effects of workplace violence among nurses in Federal Teaching Hospital, Ido-Ekiti , Ekiti State, Nigeria.

Hypothesis of the Study

Ho: There is no significant relationship between nurses' age and workplace violence against nurses

There is no significant relationship between the nurses' care department and the experience of workplace violence.

MATERIALS AND METHODS

Research Design: A descriptive cross-sectional research design was adopted to assess WPV among nurses and the perceived effects in Federal Teaching Hospital, Ido-Ekiti. Descriptive research aims to accurately and systematically describe a population, situation, or phenomenon (McCombes, 2022)

Research Setting: This study was conducted at Federal Teaching Hospital Ido-Ekiti, Ekiti State, Nigeria, which is affiliated to Federal University of Oye Ekiti. This hospital provides medical education, research, and clinical services. It is a general multi-specialty teaching hospital, with total number of 703 staff members in total with 432 nurses. It's a hospital with 600 bed space. The hospital has various medical departments: General medicine, Pediatrics, Pharmacy unit, Surgery, Emergency, Trauma, Geriatrics and Palliative care, Plastic and reconstructive surgery, Neurology, Renal and dialysis services,

Cardiology, ENT, and Ophthalmology. It offers outpatient clinics for various medical specialties and inpatient services for different conditions.

Target Population: The target population of this study was the nurses at Federal Teaching Hospital, Ido-Ekiti, Ekiti State. The study population was nurses who participated in this study. The population of nurses in Federal Teaching Hospital was 432 Nurses

The inclusion criteria were: Nurses who were willing to participate in the study and were present in the hospital during the time of data collection.

While the exclusion criteria were nurses who were not willing to participate in the study and those who were not on duty during the data collection period.

Sample Size Determination Using Sloven's Formula:

n = N/(1+N*e2)

n = sample size

N = Population size = 432

e = margin of error = 0.05(5%) n = 432/(1+432*0.052)

n = 432/(1+432*0.0025)

n = 432/(1+1.08)

n = 432/2.08 n = 207.69

n = 208

With attrition: 208/(1-0.10) Sample size = 231

Instrument for data collection

The instrument used for this study is questionnaire which consists of the following sections;

Section A focus of demographic profile of the respondents

Section B (objective 1): Determine the level of WPV among respondents.

Section C (objective 2): Assess the factors contributing to the violence among respondents.

Section D (objective 3): Assess the perceived effects of WPV among respondents.

Validity of Instrument: To ensure that the research instrument measures what it was intended to measure, the face and content validity were determined by the research team's expert in health research. They reviewed the questionnaire for clarity of wording, relevance to study objectives, simplicity and appropriate language. They evaluated the questionnaires for necessary oversight and scrutiny. Experts identify unclear, repetitive, or irrelevant questions and suggest modifications. Furthermore, validity was ensured through the use of appropriate sampling techniques, adequate sample size, and standardized data collection procedures was ensured through training of research assistants for data collection.

Reliability of Instrument: A test-re-test analysis was adopted to ensure the reliability of the study. Twenty (25) questionnaires were administered to twenty (25) respondents among nurses in Osun State Teaching Hospital. (outside the sample population). The results while using chi-square analysis coefficient degree at 0.05 level of significance yielded the same result as the sample population.

Method of Data Collection: Data from the respondents were gathered using a self-administered questionnaire. The questionnaire was made available to all of the respondents for independent completion. The questionnaire was designed to provide vital answers not only for testing the hypotheses but also for other relevant questions emanating from problem analysis and literature review. The questionnaire was distributed among nurses in the study hospital wards and was collected after it was answered. The data collection was for 8 weeks during the months of May and June 2025.

Method of Data Analysis: Data was analyzed using both descriptive presented in frequencies, tables including percentages and inferential statistics using Chi-square test at 0.05 level of significance.

Sampling Technique: A stratified sampling method was used to select 231 respondents and ensure that various department or wards were represented.

Ethical Consideration: Approval for the study was obtained from the Human Research and Ethical Committee of Federal Teaching Hospital Ido-Ekiti. Protocol Number ERC/2025/04/07/236B. Every attempt was made to maintain the confidentiality of the respondents and the principle of non-maleficence was upheld. Information obtained from respondents was kept confidential, and anonymity was maintained throughout the period of study.

Beneficence: the researchers ensured the maximum benefit was sincerely communicated to benefit the subjects, the researchers also ensured that there was little or no risk in participating.

Respect for human dignity/ autonomy: The researchers fully disclosed and explained the nature of the study, respondents' right to refuse participation, researchers' responsibilities, and the possible risks and benefits accruable to the participants. The researchers ensured that respondents had the right to decide at any point to terminate their participation, to refuse to give information, or to ask for clarification about the purpose of the study or the specific study procedure.

Justice: The researchers ensured fair and non-discriminatory of subjects, and non-prejudicial treatment to those who refused to participate. The researchers ensured not intrusive more than was needed and that the participant's privacy was maintained throughout the study; all information collected was kept with utmost confidentiality.

Informed consent: Written informed consent was obtained before the commencement of the study. The researchers also ensured that the participants were capable of comprehending the information and had the power of free will.

RESULTS

Table 1 presents the demographic characteristics of the respondents. A greater proportion of the respondents were aged 20–30 years (45.5%), while 43.7% were within the 31–40 years age category, with a mean age of 32.4 years. The majority were female (74.0%) and married (50.6%). In terms of educational qualification, most respondents possessed a Bachelor of Nursing Science degree (79.7%). Regarding professional rank, the majority were Senior Nursing Officers (65.4%). Concerning years of nursing experience, 35.5% had 1–4 years of experience, while 34.6% had 5–8 years of experience. With respect to unit of practice, the highest proportion of respondents worked in the surgical ward (28.1%), followed by the male medical ward (20.3%) and emergency room (16.9%). The demographic characteristics of this study revealed that majority of the respondents are within 20-30years old (45.5%), Female (74%) and are married, (50.6%). Findings further revealed that majority of respondents have bachelor of nursing sciences as the highest educational qualification (79.8%) with the rank of senior nursing officer (65.4), having 1-4years experience as a nurse (35.5%) and work in the male medical ward.

Table 1: Socio-demographic Characteristics of the Respondents (n=231)

VARIABLES	FREQUENCY	PERCENTAGE
Age		
20 – 30 years	105	45.5
31 – 40 years	101	43.7
31 – 50 years	23	10.0
51 – 60 years	2	0.9
Mean = 32.4years		
S.D = 6.4		
Gender		
Male	60	26.0
Female	171	74.0
Marital status		
Single	112	48.5
Married	117	50.6
Divorced	2	0.9
Highest educational qualification		
Diploma in nursing	37	16.1
Bachelor of nursing science	184	79.7
Master's degree	7	3.0
Doctorate in nursing	3	1.3
Rank		
Chief nursing officer	8	3.5
Assistant chief nursing officer	14	6.1
Principal nursing officer	22	9.5
Senior nursing officer	151	65.4
Nursing officer	36	15.6
Years of experience as a nurse		
1 – 4 years	82	35.5
5 – 8 years	80	34.6
9 – 14 years	46	19.9
15 years and above	23	10.0
Department/unit		
Emergency room	39	16.9
Intensive care unit	30	13.0
Surgical ward	65	28.1
Psychiatric unit	5	2.2
Renal unit	4	1.7
Theatre	3	1.3
Male medical ward	47	20.3
Female medical ward	38	16.5

Figure 2 above shows the rank of the respondents. The majority (65.4%) of the respondents are senior nursing officers by rank, while the least common (3.5%) rank is the chief nursing officer rank

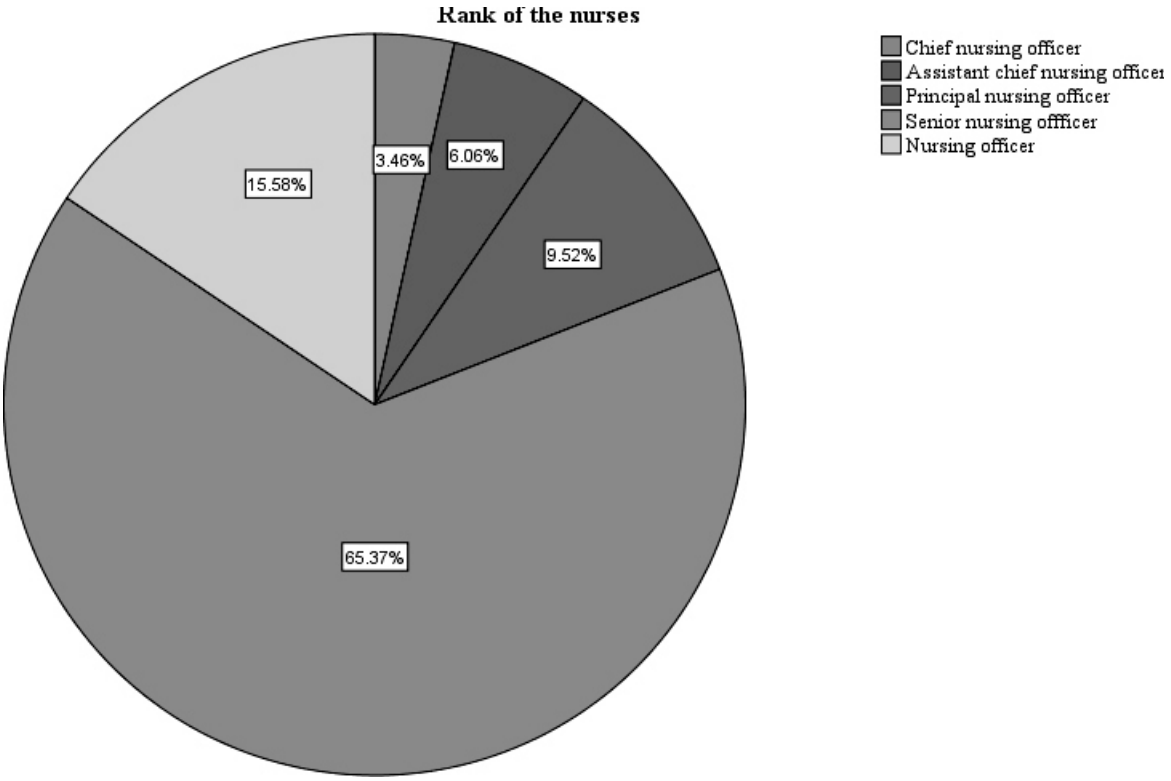

Figure 2. Rank of study respondents

Table 2 Majority (60.6%) of the respondents have experienced workplace violence within the 12 months preceding the study. The most common workplace violence experienced was verbal abuse (52.9%), followed by discrimination (18.3%), bullying/mobbing (13.6%), sexual harassment (9.3%). The most frequent perpetrators of workplace violence reported by the nurses were patients' relatives/visitors (34.7%), followed by patients (29.9%), staff member (23.1%) and finally, supervisor/manager (12.3%) The most common (52.9%) workplace violence experienced was verbal abuse, then discrimination (18.3%), bullying/mobbing (13.6%), sexual harassment (9.3%). The most frequent perpetrators of workplace violence reported by the nurses were patients' relatives/visitors (34.7%), then patients (29.9%), staff member (23.1%) and finally, supervisor/manager (12.3%).

This study shows that majority of the participants has experience one form of workplace violence or the other in the past 12 months (60.6%), the common type experience is Verbal abuse (52.9%) and the perpetrators are Patient's relative/visitors (34.7%)

Table 2 Experience; Types & Perpetrators of Workplace Violence (N= 231)

Variable	Frequency (n)	Percentage (%)
Experience of workplace violence in the past 12 months		
Yes	140	60.6
No	91	39.4
Total	231	100%
**Types of violence experienced		
Physical	15	5.8
Verbal abuse	136	52.9
Sexual harassment	24	9.3
Bully/Mobbing	35	13.6
Discrimination	47	18.3
Total	257	100%
**Perpetrators of violence		
Patients	92	29.9
Patients relative /visitors	107	34.7
Staff members	71	23.1
Supervisors /Managers	38	12.3
Total	*308*	*100%*

** Multiple responses were a llowed for types and perpetrators of workplace violence; therefore, totals exceed the number of respondents.

Figure 3 above shows the frequency of workplace violence. The majority (47.6%) of the respondents rarely experience workplace violence, 37.7% of the respondents sometimes experience workplace violence, 12.12% of the respondents never experience workplace violence, and 2.60% often experience workplace violence. The frequency of workplace violence is low (40.26%)

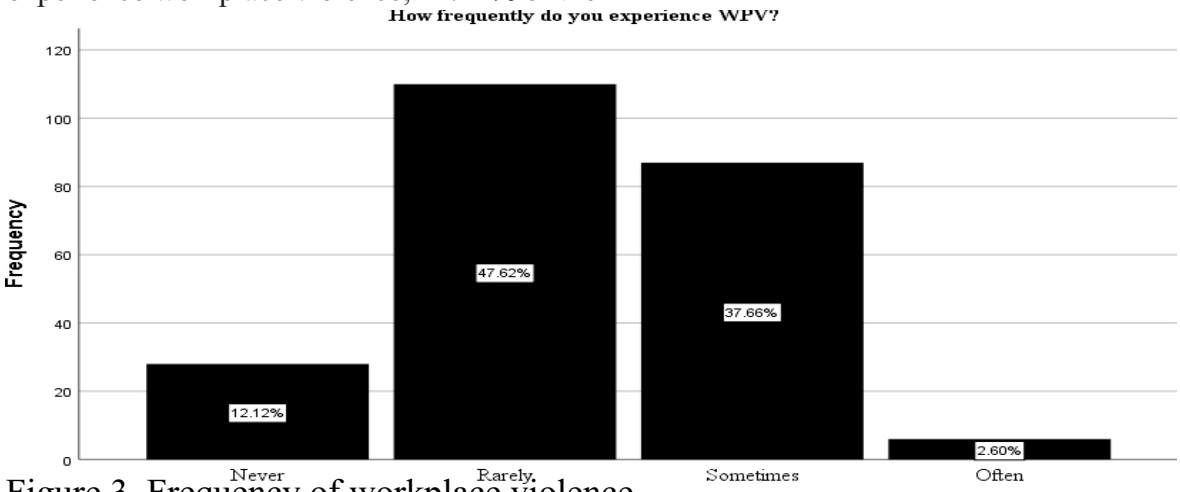

Figure 3. Frequency of workplace violence

Table 3. below displays the perceived effects of workplace violence among nurses. The majority of the respondents strongly agree that workplace violence results in effects like increased stress and anxiety (52.8%), burnout (54.1%), and decreased job satisfaction (48.1%). Most respondents agree that workplace violence can result in effects like difficulty sleeping (47.2%), reduced productivity (45.5%), fear of going to work (54.1%), negative impact on personal relationship (59.3%) and thoughts of leaving the nursing profession (48.5%). This study observed that the perceived effects of workplace violence among nurses are Increased stress and anxiety (93.5%), burnout (93.9%), satisfaction difficulty (64.5%), reduced productivity, fear of going to work (70.6%), negative impact on personal relationship (80.9%) but sleeping reduced (39.4%), decreased job (48.9%) and thoughts of leaving the nursing profession (22.1%) were not the perceived effects of workplace violence.

Table 3 Perceived Effect of workplace Violence among study respondents

Variables	SA (%)	A n (%)	U (%)	D (%)	SD (%)
Increased stress and anxiety	122 (52.8)	94 (40.7)	6 (2.6)	3 (1.3)	3 (1.3)
Burnout	125 (54.1)	92 (39.8)	0 (0.0)	5 (2.2)	9 (3.9)
Decreased job satisfaction	4 (1.7)	109 (47.2)	8 (3.5)	0 (0.0)	111 (48.1)
Difficulty sleeping	40 (17.3)	109 (47.2)	8 (3.5)	39 (16.9)	39 (16.9)
Reduced productivity	86 (37.2)	5 (2.2)	105 (45.5)	17 (7.4)	15 (6.5)
Fear of going to work	38 (16.5)	125 (54.1)	8 (3.5)	30 (13.0)	33 (14.3)
Negative impact on per sonal relationships	50 (21.6)	137 (59.3)	112 (48.5)	20 (8.7)	16 (6.9)
Thoughts of leaving the nursing profession	39 (16.9)	12 (5.2)	112 (48.5)	30 (13.0)	38 (16.5)

*Key: SA = Strongly Agree; A = Agree; U = Undecided; D = Disagree; SD = Strongly Disagree.

Table 4. above presents the contributing factor to workplace violence among nurses. The majority of the respondents agree that staff shortages (47.6%), overcrowded waiting areas (40.35%), lack of security (62.3%), inadequate training on violence prevention (61.5%), high patient turnover (61.5%), influence of alcohol (61.5%), lack of clear policies on workplace violence (55.0%), poor communication between staff and management (59.3%), societal factors (63.2%) are the contributing factors to workplace violence among nurses. This study observe that the contributing factors to workplace violence among nurses include staff shortages (93.9%), overcrowded waiting areas (74.9%), lack of security (92.7%), inadequate training on violence prevention (85.2%), high patient turnover (80.5%), patients under the influence of alcohol (73.2%), lack of clear policies on workplace violence (84%), poor communication between staff and management (79.6%) and societal factors e.g increasing aggression (87.4%).

Table 4:Contributing Factor To Workplace Violence Among Nurses

Variables	SA n (%)	A n (%)	U n (%)	D n (%)	SD n (%)
Staff shortages	107 (46.3)	110 (47.6)	3 (1.3)	11 (4.8)	0 (0.0)
Overcrowded waiting areas	80 (34.6)	93 (40.3)	7 (3.0)	24 (10.4)	27 (11.7)
Lack of security	93 (40.3)	121 (52.4)	5 (2.2)	6 (2.6)	6 (2.6)
Inadequate training on violence prevention	53 (22.9)	144 (62.3)	2 (0.9)	15 (6.5)	17 (7.4)
High patient turnover	44 (19.0)	142 (61.5)	5 (2.2)	21 (9.1)	19 (8.2)
Patients under the influence of alcohol	58 (25.1)	111 (48.1)	5 (2.2)	30 (13.0)	27 (11.7)
Lack of clear policies on workplace violence	67 (29.0)	127 (55.0)	0 (0.0)	19 (8.2)	18 (7.8)
Poor communication between staff and management	47 (20.3)	137 (59.3)	8 (3.5)	6 (2.6)	33 (14.3)
Societal factors (e.g., incr easing aggression)	56 (24.2)	146 (63.2)	5 (2.2)	5 (2.2)	19 (8.2)

Table 6 below shows the awareness and perceived effectiveness of existing policies on workplace violence. The majority (54.1%) are not aware of existing policies in the hospital, and of the respondents aware of the policies, the majority (19.8%) perceive the policies as effective, 34 (32.1%) perceive them as not effective. 21 (41.5%) respondents do not know, 4 (3.8%) perceive them as not at all effective and only a few (2.8%) perceive the policies as very effective This study reveals that majority of the respondents are not aware of existing policies (51.4%) and do not know if it is effective (41.5%)

Table 6 Awareness and Perceived Effectiveness of Existing Workpla ce Violence Policies among Nurses (n = 231)

Variables	Frequency (n)	Percentage (%)
Awareness of Existing Workplace Violence Policy		
Yes	106	45.9
No	125	54.1
Total	231	100.0
Perception of Effectiveness of Existing Policies		
(n = 106)		
Very effective	3	2.8
Effective	21	19.8
Don't know	44	41.5
Not effective	34	32.1
Not at all effective	4	3.8
Total	106	100.0

Table 7. Awareness And Effectiveness of Existing Policies

VARIABLES	N	PERCENTAGE
Are you aware of any existing policy?		
Yes No	106	45.9
	125	54.1
Perception of effectiveness of existing	3	2.8
policies (n=106)	21	19.8
Very effective Don't know Not	44	41.5
effective	34	32.1
Not at all effective	4	3.8

Hypothesis 1

There will be no significant association between nurses' age and workplace violence against nurses. Table 7 below showed that there is no significant relationship between the nurses' age and workplace violence against nurses with (P= 0.596 > 0.05), therefore the null hypothesis is retained.

Table 8. Relationship Between Nurses' Age and Workplace Violence (N=231)

Age of the nurses	Experience of workplace violence		Total	Chi-square value	P-value	Remark
	Yes	No				
20-30	66	39	105			
31-40	59	42	101			
41-50	13	10	23	X2= 1.886a		
51-60	2	0	2		0.596	Ho retained
Total	91	140	231			

Hypothesis 2

There is no significant association between the department of the nurses and their experience of workplace violence in the past twelve months. Table 8 Chi-square test showing the relationship between the department of the nurses and their experience of workplace violence in the past twelve months (n=231).

Table 8 showed that there is a significant relationship between the department of the nurses and their experience of workplace violence in the past twelve months, with p-value (0.000< 0.05), the null hypothesis is rejected.

Table 9 Chi -Square Showing Relationship Between Department of The Nurses And Their Experience of Workplace Violence in The Past Twelve Months (N=231)

Department of the nurses	Experience of workplace violence in the past twelve months		Total	Df	Chi-square value	P-value	Remark
	Yes	No					
Emergency room	11	28	39				
Intensive care unit	12	18	30				
Surgical ward	47	18	65				
Psychiatric unit	5	0	5			0.000	Ho
Renal unit	4	0	4				rejected;
Theatre	3	0	3				H1
Male medical ward	36	11	47	8	X^2=39.162a		accepted.
Female medical ward	22	16	38				
Total	91	140	231				

DISCUSSION

This study assesses workplace violence among nurses and perceived effects in federal teaching Hospital, Ado Ekiti, Ekiti State. The demographic characteristics of this study indicate that majority of the respondents are within the ages of 20 - 30years, female and are married. Study further revealed that majority of the respondent's highest educational qualification is Bachelor of Nursing Science, with the rank of senior nursing officer, with 1-4years of experience as a nurse, working in male medical ward.

Finding reveals that majority of the respondents has experienced workplace violence in the past 12 months, the common type experience is Verbal abuse and the perpetrators are Patient's relative/visitors. This study is consistent with Nada et al. (2022) and Mahmoud (2021), who found verbal violence to be the most common type among nurses globally. This finding is in harmony with Kozak et al., (2018) who noted that the most frequent perpetrators were patients' relatives and patients themselves. This study also corroborates with the results from Adugna et al. (2023), who identified relatives as primary aggressors.

This study documents that the severity level of workplace violence experienced among respondents is low. This finding was support by the submission of Cai et al., (2021) who observe that non-physical violence among respondents. The findings align with Hsu et al. (2022) who showed low-level violence among respondents.

This study observed that the perceived effects of workplace violence among nurses are increased stress and anxiety, burnout, satisfaction difficulty, reduced productivity, fear of going to work, negative impact on personal relationship This study mirror global trends reported by Bae (2022) and Yang et al. (2025), who link WPV to nurse attrition, burnout, and impaired performance. This study is similar to Orewa et al. (2025) including Kumar and Kumari (2024) who noted that workplace violence was perceived to negatively affect nurses' personal relationships and sleep with PTSD-like symptoms. This study aligns with Hsu et al. (2022) who shows that chronic, low-level violence can be detrimental over time, eroding resilience and job satisfaction.

This study reveals that majority of the respondents are not aware of existing policies and do not know if it is effective. The study found no statistically significant association between age and WPV experience which contrasts with Yang et al. (2025), who reported that younger nurses were more vulnerable.

However, there is a significant association between the departments and WPV experience, with surgical wards and male medical wards reporting higher incidents. This study aligns with Sayatan et al. (2022), who observed that nurses in high-pressure departments, especially surgical and emergency units, are at greater risk

The findings of the study showed that several factors contributed to workplace violence among nurses, including staff shortages, overcrowded waiting areas, lack of security personnel, inadequate training on violence prevention, high patient turnover, patients under the influence of alcohol, absence of clear workplace violence policies, poor communication between staff and management, and broader societal factors such as increasing aggression. These findings suggest that workplace violence is influenced by both organizational and societal determinants. The findings are consistent with the reports of Tesfaye et al. (2022) and Ogunleye et al. (2022), who emphasized that organizational structures and institutional inefficiencies can exacerbate or inadvertently enable workplace violence. Furthermore, the present study aligns with the findings of Nwokedi et al. (2021), who observed that societal aggression and a culture of disrespect toward nurses contribute significantly to workplace violence. This underscores the multifaceted nature of workplace violence and highlights the need for systemic and comprehensive interventions rather than isolated, incident-based responses.

A key finding of the study is the perceived effects of workplace violence among nurses which are increased stress and anxiety, burnout, satisfaction difficulty, productivity fear of going to work; negative impact on personal relationship. These findings mirror global trends reported by Bae (2022) and Yang et al. (2025), who link WPV to nurse attrition, burnout, and impaired performance. This research findings are similar to Orewa et al. (2025) and Kumar and Kumari (2024) who noted that workplace violence was perceived to negatively affect nurses' personal relationships and sleep with PTSD-like symptoms. These findings aligns with those of Hsu et al. (2022) who shows that chronic, low-level violence can be detrimental over time, eroding resilience and job satisfaction. Majority of the respondents are not aware of existing policies and do not know if it is effective.

The study found no statistically significant association between age and WPV experience. This result contrasts with Yang et al. (2025), who reported that younger nurses were more vulnerable.

The study reveals that there is a significant association between the departments and WPV experience, with surgical wards and male medical wards reporting higher incidents. This finding aligns with Sayatan et al. (2022), who observed that nurses in high-pressure departments, especially surgical and emergency units, are at greater risk of work place violence.

Implications to nursing practice and education

Nurses must be equipped with practical skills in conflict de-escalation, assertive communication, and self-defense. This finding show that violence is often underreported and inadequately addressed, calling for a culture shift where WPV is recognized as a critical safety issue. In preparing future nurses, their educational curricula should incorporate training on handling aggression, emotional resilience, and legal rights.

Future research should explore interventions that reduce WPV, evaluate policy effectiveness, as well as explore lived experiences of violence and coping mechanisms among nurses.

CONCLUSION

This study reveals a disturbing yet familiar reality: workplace violence against nurses is prevalent, underreported, and psychologically damaging. Despite existing policies, lack of awareness and ineffective enforcement remain major barriers to progress. The findings underscore the need for institutional reform, robust policy implementation, and a cultural shift that places the safety and well-being of nurses at the centre of healthcare delivery and team management

RECOMMENDATIONS

Based on the findings of the study we propose that the hospital administration should institute surveillance systems and deploy trained security personnel to high-risk departments; develop and enforce a zero-tolerance policy toward workplace violence with clear reporting and disciplinary procedures. Provide emotional support services, such as counselling and debriefing sessions, for affected staff. Implement workshops on conflict resolution, resilience, and assertiveness training for nurses.

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