Tanzanian nurses’ exposure and experience of violence

A questionnaire study

Authors: John Lönnroos Andreas Torstensson

Tutor: Caisa Öster

Examinator: Pranee Lundberg

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ABSTRACT

Introduction: Physical and verbal violence within the health care sector, especially towards nurses, is a problem that have been reported from many countries worldwide.

Aim: The aim of this study was to examine workplace-related violence, and its outcomes, experienced by Tanzanian nurses in a tertiary hospital facility.

Method: This was a descriptive, retrospective, cross-sectional study. The study was carried out in patient wards in a tertiary hospital facility. 54 nurses’ working at a hospital in Tanzania with regular contacts with patients were asked to return a questionnaire, comprising 17 questions with fixed-alternative answers.

Results: Of the 32 participants (59% response rate), 16 nurses reported having experienced physical or verbal violence. The most common type of violence was “verbal threat/aggression” (n = 11) and the most common source of aggression was from “patient relative/visitor” (n = 9).

Conclusion: The main findings of this study confirmed that workplace-related violence towards nurses’ did occur in the hospital where the study took place. The results are supported by existing research and literature that workplace-related violence is a worldwide problem. Education and awareness regarding violence prevention as a part of nursing education could help preventing workplace-related violence.

Keywords: Nurse, violence, questionnaire, health care, Tanzania.
ABSTRAKT

Introduktion: Våld i fysisk eller psykisk form är inom hälso- och sjukvårdssektorn, speciellt riktat mot sjuksköterskor, ett problem som rapporterats från flertalet länder över hela världen.

Mål: Målet med denna studie var att utforska arbetsplatsrelaterat våld och upplevda utfall av dessa hos sjuksköterskor på ett referenssjukhus i Tanzania.

Metod: Detta var en deskriptiv, retrospektiv, tvärsnittsstudie. Den utfördes på vårdavdelningar på ett referenssjukhus. 54 sjuksköterskor med regelbunden patientkontakt som arbetade på KCMC tillfrågades om att fylla i en enkät innehållandes 17 frågor med valbara alternativ.

Resultat: Utav de 32 deltagarna (59% svarsfrekvens) hade 16 sjuksköterskor rapporterat att ha upplevt psykiskt eller fysiskt våld. Majoriteten av sjuksköterskorna rapporterade typen av våld som verbalt (n = 11) och den vanligaste källan av våld var patientens närstående (n = 9).

Slutsats: De huvudsakliga fynden från denna studie var att våld riktat mot sjuksköterskor på arbetsplatsen förkom på sjukhuset där studien utfördes. Resultaten i denna studie stämmer överens med redan existerande forskning och stöder teorin om att detta fenomen är globalt. För att förhindra arbetsplatsrelaterat våld bör utbildning rörande våldsprevention ingå i sjuksköterskors utbildning.

Nyckelord: Sjuksköterska, våld, enkät, sjukvård, Tanzania.
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1. INTRODUCTION

1.1 Background with subject related literature

Verbal and physical violence within the health care system is a factor that can be problematic for nurses. This will not only have implications for nurses’ physical and mental state, it might also lead to degraded patient care (Arnetz, Arnetz & Pettersson, 1996). In a study by Arnetz et al. (1996), 30% of 2690 participating nurses stated that they had experienced violence at work. Furthermore, the result showed that there is a correlation between the risk of being exposed to violence and which field nurses work in. There is a higher prevalence of nurses exposed to violence in both psychiatric (76.5%) and geriatric (40.1%) care compared to other fields. Other studies (Gacki-Smith et al., 2009; Chen, Ku & Yang, 2012) indicate an alarmingly high frequency of violence towards nurses working in emergency departments in U.S.A. and Taiwan. Approximately 25% of the nurses stated that they had been exposed to physical violence more than 20 times in the past three years. Almost 20% reported exposure to verbal abuse more than 200 times during the same time period (Gacki-Smith et al., 2009). A study conducted in Nigeria by Ogundipe et al. (2012) showed that 65% of the staff at the emergency department involved in the study had been exposed to violence, and out of those, almost 16% had been threatened with a weapon. The negative effects from nurses experiencing violence have been shown to be extensive. Among other things, fear and depression are typical outcomes, which often lead to nurses taking on sick leave. Violence can affect an individual’s dignity, self-esteem and ability to care for a patient (Whelan, 2008).

The result from a study by Hegney, Eley, Plank, Buikstra & Parker (2006) indicated a general increase in violence within health care; the largest increase was within geriatric care. A Swedish study of threats and violence towards municipal staff, working mainly with the care of elderly or developmentally impaired patients, showed that 51% of the staff had been exposed to threat or violence in the previous 12 months (Menckel & Viitasara, 2002).

Clements, DeRanieri, Clark, Manno & Wolcik Kuhn (2005) stated that physical violence occurs in US health-care facilities four times more often than in all other industrial workplaces combined. With regard to the violence within health care, verbal threats are more common than physical attacks. This could be one factor causing a low public awareness of this ongoing issue. Any form of violence can easily lead to trauma and grief for the exposed staff (Clements et al., 2005).
1.2 Definition
The act of violence can be defined in many ways, however, for this study the authors have chosen to define violence the same way as Nolan, Soares, Dallender, Thomsen & Arnetz (2001).

“[…] an act of violence includes physical force such as slapping, punching, kicking and biting; use of an object as a weapon; aggressive behaviour such as spitting, scratching and pinching; or a verbal threat involving no physical contact.”

(Nolan et al., 2001, s. 421)

1.3 Sources of violence
The most common source of violence and threat towards nurses is from patients (Pich, Hazelton & Kable, 2012). In a study by Chen et al. (2012), 61.4% of the nurses reported to have experienced violence from patients and 60.8% of the nurses reported experiencing violence from patients’ families. Furthermore there is also a high frequency of reported violence from colleagues, where 48.1% of nurses had experienced violence from medical colleagues and 29.5% had experienced violence from other nurses (Chen et al., 2012). Violence from colleagues occurs more commonly in stressful or unstable situations, for example operation rooms. Reasons for patients’ or patients’ family related violence is often related to the patient being under pressure, both physical and mental, leading to tension and stress within the families. As the nurses generally are the profession closest to the patient, violence could easily be directed towards the nurse. Particular reasons for violence to be directed towards the nurse include the patient being denied the requested treatment, feeling they are not receiving enough attention from the nurse, or have difficulties in communication (ibid.).

1.4 Patient care quality
A possible associated problem that could develop due to violence is degraded quality of care, experienced by the patient. This suboptimal care can be a result of the nurse avoiding contact with the patient as a direct result of fear, particularly of further acts of violence. It is noticed that health care staff can develop “patient-avoiding behavior” as a strategy to cope with stress after being assaulted or if they are scared of being exposed to violence. This can lead to a decrease in the time devoted to each patient, and reduced time for information gathering and social contact with patients. These are important parts of nursing and essential for the maintenance of health care quality (Arnetz, 2001; Arnetz & Arnetz, 2001).
1.5 Negative outcomes of violence towards nurses

The nurses’ inability to care for patients can consequently lead to curtailing the quality of public health care. Arnetz (2001) also pointed out that to prevent violence as a public health problem, the prevalence and risk factors needs to be assessed as well as the consequences it evokes. Ogundipe et al. (2012) presented negative outcomes of violence towards nurses in Nigeria. A total of 56% of those who had been the victim or had seen violence toward other nurses felt that they had suffered a loss of confidence in themselves. Other factors affecting the respondents after violence were a reduced level of job satisfaction and decline of their productivity, absenteeism, post-traumatic stress disorder and resignation (Ogundipe et al., 2012). As a consequence, there is a risk of staff burnout from physical and emotional exhaustion with reduced self-confidence, reduced job satisfaction and a loss of compassion towards their patients. Nearly half of the health care staff reported to be more cautious while working in close proximity to patients; 15% felt a reduced satisfaction while performing their work with direct patient contact and 13% felt fear (Arnetz & Arnetz, 2001). Economically, violence affects both the individual nurse and society negatively, with consequences such as sick-listed nurses, loss of working time and therapy for the affected personnel (Arnetz, 2001).

1.6 Risk factors

Everyone working as a health care staff can be exposed to workplace violence but there are factors that increase the risk. Magnavita and Heponiemi (2011) showed that nurses are at a notably high risk of physical violence from patients, and explains this phenomenon due to the nurses tasks which may often include unpleasant patient contact (for example injections or wound care), which then can provoke aggressive behavior. Hahn et al. (2012) showed that the characteristics of the health care staff have a significant role; younger aged staff experiences all forms of violence more commonly and medical doctors have the lowest risk of experiencing violence in the workplace. Also, working with patients aged over 65 years results in a higher risk of violence exposure (Hahn et al., 2012). There is a higher risk of patient-staff violence if the patients have diagnoses affecting their perception and volition including: cognitive impairment, delirium, dementia and intoxication. Further risk factors for violent behavior are when the patient experience emotional agitation like anxiety, stress, uncertainty and difficulty in comprehending a situation. Workplace environment is an additional contributing factor where emergency rooms, outpatient and intensive care units and intermediate care have a high risk of violence (Hahn et al., 2012; Chen et al. 2012). In the study of Ogundipes et al. (2012), the respondents rated the reasons for violence in the
emergency department on a scale from 1-5. The top reasons for violence revealed factors such as “overcrowded emergency rooms” (mean 3.91), “long waiting time and frustration of patients/relatives” (mean 3.88) and “understaffed emergency departments” (mean 3.57).

1.7 Violence prevention education
Martindell (2012) stated that the exposure of violence towards nurses working in emergency departments is excessive. Respondents from 65 different emergency departments reported a 78% prevalence of workplace violence within the previous 12 months. This is the reason that it is of high importance, according to Martindell (2012), to educate all staff working at an emergency department in violence prevention. Having education about violence prevention was not reducing the frequency of violence but violence was less likely to escalate from verbal threat to physical threat with the use of communication techniques. Therefore, education in violence prevention could help to raise the safety in the department for staff, patients and visitors, and help nurses feel more secure while working.

1.8 Tanzania
The country selected for research is Tanzania, which is a republic in Eastern Africa with a population of nearly 47 million (CIA, 2012a). According to Gapminder (2010) Tanzania has a low “Government health spending per person and year” (21 $), compared to United Kingdom (2,938 $), and Sweden (3,820 $). The indicator, Hospital bed density per 1,000 inhabitants, serves as a general measure of inpatient service availability, and includes both public and private hospital beds. Tanzania has 1.1 beds/1,000 inhabitants compared to United Kingdom (3.38) and Norway (3.52) (CIA, 2012b).

1.9 Problem statement
With knowledge from the previous studies, violence is a well-studied and extensive problem in many nations worldwide (Arnetz, 2001; Nolan et al., 2001; Whelan, 2008; Gacki-Smith et al., 2009; Magnativa & Heponiemi, 2011; Hahn et al., 2012; Chen et al., 2012; Ogundipe et al., 2012). However, the authors did not find any similar studies done in Tanzania.

Worldwide, the majority of those exposed to violence do not document the incident and in the study by Chens et al. (2012) only 8.1% of those who experienced violence documented it. The reasons for not documenting the incident was: not having any benefits from reporting (43.6%), not wanting to avoid the responsibility that comes with the job (42.2%) and not having enough time to write a report of the situation (34.7%). Thus, this study was carried out
to increase the knowledge about the incidence of work-related violence towards nurses in Tanzania. The expectation of the study result was that it would contribute to a deeper understanding of differences in violence - particularly its frequency and type - between different workplaces. More knowledge about the most exposed group will possibly contribute to knowledge of how to best establish prevention methods for violence within health care, for example more education about how to manage violent situations. This examined subject has relevance in the field of care since violence can have negative implications in the relationship between nurse and patient.

1.10 Aim
The aim of this study was to examine workplace-related violence, and its outcomes, experienced by Tanzanian nurses in a tertiary hospital facility.

1.11 Research questions
- Have the nurses’ experienced exposure to violence in their work place?
- How frequently have the nurses been exposed to violence?
- What are the types of violence that nurses have been exposed to?
- Where do the exposed nurses work within the hospital?
- Who is the source of violence?
- How are the nurses’ works with patients affected in the exposed group?
- How has the exposed nurses' health been during the last month?
- Have the nurses' received education on managing violence?

2. METHODS
2.1 Design
This study used a descriptive, retrospective, cross-sectional method. A descriptive study design has a primary goal in assessing the frequency and distribution at one specific point in time, without making inferences or causal relationships. The cross-sectional design, with all data collected at the same time, is an appropriate way of describing the occurrence of a
phenomenon at a fixed point (Polit & Beck, 2010). By using this design, data could be collected retrospectively with respect to the occurrence of violence. Since it is both an economically sound and time efficient study design, focus could stay on acquiring as much substantial data as possible (ibid.).

2.2 Setting
The study was carried out in the emergency ward (E.R.), intensive care unit (I.C.U.), medical ward and surgical ward at the hospital Kilimanjaro Christian Medical Centre (KCMC) in northern Tanzania. KCMC is a private tertiary hospital that provides over 450 beds for patients and is a referral hospital for over 11 million people (KCMC, 2012).

2.3 Sample
The eligible criteria of the study sample were the accessible population of nurses working at KCMC with regular contacts with patients. A total of 54 nurses were asked to participate in the study. Excluded participants were nurses who did not understand English and newly graduated nurses with less than one year of experience, due to the risk of deviation, owing to short experiences as a practicing nurse. To minimize the sampling errors that might occur and to get increased statistical power the authors chose to get as many questionnaires completed as possible (Polit & Beck, 2010). The non-responders chose not to participate in the study for reasons not known to the authors. There were five participants that stated that they had less than one year of experience, therefore their questionnaires were excluded which gave a total of 32 participants.

2.4 The questionnaire
For this study, an existing questionnaire was used with the approval from the original authors (Arnetz & Arnetz, 2000). See Appendix three for the original document. The use of a validated questionnaire was recommended by Olsson and Sörensson (2011), and therefore the authors did not see any reason to test the questionnaire furthermore before using it in this study. However, some of the original questions were removed in order to focus on the aim of this study (questions 4, 5 and 9). Also all questions about an earlier intervention program described in Arnetz & Arnetz (2000) were excluded (questions 20-34). The final questionnaire comprised 17 questions with fixed-alternative answers to ensure that the answers were comparable and to make the analyses less complex (see Appendix two). However, the respondents also had a chance to answer four questions in their own words if the fixed-alternatives not were found to be sufficient. These questions involved reactions.
(question 13), how the respondents were affected by violent incidents (question 16), the source of violence (question 9) and type of violence (question 10).

Fixed answers are time efficient, an important advantage for the participants who work within the care-giving sector. One downside of fixed-alternative questions is that potentially significant information could be left out due to the superficial nature of quantitative studies. Finally, if the participants do not find any alternative matching their opinion it may lead to them leaving the answer blank (Polit & Beck, 2010).

2.5 Procedure and data collection
To obtain authorization to carry out the study, approval from the Dean of nursing at KCMC University and every Head of the involved clinical departments was obtained. The involved wards were the medical clinic, surgical clinic, E.R. and I.C.U. at KCMC. A total of 54 questionnaires were distributed in the chosen wards. This was to be able to give out questionnaires to all nurses currently working at the time when the authors were attending the morning meetings. They were handed out at their respective morning meetings and a brief presentation was also given in order to get the nurses more involved and more interested in participating in the study. The authors handed out the questionnaires themselves to the nurses along with an informative letter (see Appendix 1), where the importance of the nurses’ participation was emphasized and accentuated (Olsson and Sörensson, 2011). Since there was no reason for the authors to know the identity of the participants, the questionnaire could be answered anonymously and there was no need for encryption.

The head of the departments were contact persons in their respective department and would collect questionnaires from their staff. The participants were then given time to answer the questionnaire. According to Olsson & Sörensson (2011), a normal frequency of responders is about 60% within ten days after the first send out of a questionnaire. It takes two to three reminders to achieve a 90% response rate assuming that the responders found the subject interesting and the questionnaire well developed. Accordingly, to follow the recommendations of Olsson & Sörensson (2011) the authors showed up two to three times in morning meetings to remind the staff to answer and hand in the questionnaires. The collection ran for 28 days and resulted in 32 usable questionnaires for data analysis.
2.6 Data analysis
Each questionnaire was given an identity number for easier management and to reduce bias when handling data in Statistical Package for Social Sciences (SPSS). The data was analysed using the statistical program SPSS, where data can be analyzed and described with numbers, percentage, distribution and central tendency (mean and median).

The data is mainly presented with a descriptive method using tables showing frequencies. This was applied to illustrate the prevalence and frequencies of violence in the sample; how many of the participants that were exposed during the previous twelve months and also how violence affected nurses’ work with patients. To present data of the violence-exposed group, only questionnaires with reported violence in the past year were included. This resulted in 16 questionnaires with presentation of offenders and types of violence in frequencies and percent.

2.7 Ethical considerations
All data collection was handled with confidentiality and the questionnaires were answered anonymously. This was done to ensure that participants not would hesitate to state their true experiences and opinions (Polit & Beck, 2010). The participation in the study was also completely voluntary, which was stated in the informative letter (appendix 1).

The participants may have felt answering questions about previous violent experiences to be unpleasant. If the participant had experienced violence before, there is a possibility, when answering questions, of inducing flashbacks, which can be traumatising. According to the World Medical Association (2008) and their Declaration of Helsinki a study must not evoke psychological stress in the participants. However, to further enlighten the subject and get deeper knowledge, it is important to pursue studies that indicate if psychological stressful experiences is a significant problem in health care and thus has to be dealt with (World Medical Association, 2008).

The act concerning the Ethical Review of Research Involving Humans (SFS 2003:460, 2008) states that work performed at undergraduate level, are not defined as research, and therefore there is no need for scrutiny by an ethically committee. However, approval of the study was necessary, both by the head of the clinical department where the study was performed, as well as by the examiner of this essay.
3. RESULTS

The questionnaire was distributed to 54 nurses working in four different hospital wards at KCMC. The response rate was 59% with a total of 32 questionnaires completed and included in the study for analysis. The majority of the participants were female (n = 25) compared to males (n = 4) and there were three participants that did not state their gender. The multi-choice answers for the question of age was divided into five groups where 30-39 years (n = 15) were most common, and followed by 50-59 years (n = 8), 40-49 years (n = 4), ≤ 29 years (n = 3) and non-responders (n = 2).

3.1 Nurses’ experiences of being exposed to, and the frequency of, violence in their workplace

The results showed that violence and threat toward nurses occurs at KCMC in Tanzania. Out of the nurses that were eligible for the study (n = 32), 16 had experienced violence in their workplace at some point in their career (table 1). It was more common to have experienced violence once or twice rather than several times (table 1). In one of the included questionnaires this question was left blank and therefore resulted in one missing answer.

During the twelve months prior to the data collection, a total of 14 nurses stated that they had experienced an exposure of violence or threat. The frequency of violence was more likely to occur once or twice rather than several times during the past year (table 1; figure 1).

Table 1. Prevalence and frequency of violence.

<table>
<thead>
<tr>
<th>Experience of victim of violence or threat of violence at the workplace</th>
<th>n=32</th>
<th>Several times n (%)</th>
<th>Once or twice n (%)</th>
<th>Never n (%)</th>
<th>Unanswered n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever</td>
<td>7 (22)</td>
<td>9 (28)</td>
<td>15 (47)</td>
<td>1 (3)</td>
<td></td>
</tr>
<tr>
<td>During the past year</td>
<td>5 (16)</td>
<td>9 (28)</td>
<td>18 (56)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.2 Type of violence
A total of 14 nurses answered what type of violence they had been exposed to. The type of violence that the nurses most commonly were exposed to was “verbal threat/aggression” (n = 11). Other types of violence were “scratching/pinching” (n = 1), “slapping/hitting” (n = 1) and “use of object or weapon” (n = 1) where the weapon was described as a needle.

3.3 Workplaces of exposed nurses
The workplaces are presented with each ward and the numbers of exposed and non-exposed nurses. The result showed that in E.R. none out of three responders had experienced violence compared to the medical clinic where the reported exposure was nine out of 15 (table 2). Two of the participants did not specify their workplace.

Table 2. Nurses’ experience of victim of violence or threats at different workplaces.

<table>
<thead>
<tr>
<th>Have you been a victim of violence or threat of violence at work during the past year?</th>
<th>Workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 30</td>
<td>E.R.</td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
</tr>
</tbody>
</table>
3.4 Sources of violence
Out of the nurses who had reported experiencing violence or threat in the past year, 15 nurses answered the question about the source of aggression. The most common source of aggression was from “patient relative/visitor” (n = 9) followed by “patient” (n = 4) and “staff” (n = 2) (figure 2). One of the respondents reported violence from both “patient relative/visitor” and “staff”.

![Figure 2. The source of violence (n = 15).](image)

3.5 Violence affecting nurses’ work with patients
According to the majority of the participants (n = 7), the most common outcome of a violent incident was being more careful and on guard while working with patients (table 3). One participant chose the option “other” and described the outcome as “I feel very bad, aggressive and depressed”. There were three responders that left the question blank.

| How has the violent incident affected you in your work with patients? | n = 16 |
|---|---|---|---|---|---|
| Not at all | I am more careful, on my guard | I enjoy my work less | Other | Unanswered |
| n (%) | n (%) | n (%) | n (%) | n (%) |
| 3 (19) | 7 (44) | 2 (13) | 1 (6) | 3 (18) |
3.6 Exposed nurses’ health during the last month prior data collection
The reported health status of the exposed nurses were; “Good” (n = 8), “Fair” (n = 3), “Very good” (n = 2) and there was one non-responder. None of the participants stated their health status as “Quite poor” or “Very poor”. Since decreased self-experienced health is a possible outcome after violent situations the nurses exposed to violence the previous year, they were asked of how they experienced their health during the last month prior to data collection.

3.7 Education on managing violence
Reviewing nurses’ education on managing violence, the authors chose to include both the non-exposed and exposed group. This was done to see how a specific hospital in Tanzania focuses on preventative measures for workplace related violence. There were four nurses that stated they had received education about how to manage violence during the past year. The same quantity (n = 4) received education more than one year prior to data collection and 20 participants stated that they had never received such education. There were four non-responders to this question.

4. DISCUSSION
4.1 Summary of results
The results showed that 16 out of 32 nurses had experienced violence in their workplace at any time during their career. It was more common for the nurses to have experienced violence “once or twice” (n = 9) rather than “several times” (n = 7). During the past year prior to data collection 14 out of 32 participants reported experiences of exposure to violence. During that time period it was also more common to have experienced violence “once or twice” (n = 9) rather than with “several times” (n = 6). The most commonly reported type of violence was “verbal threat/aggression” (n = 11).

Furthermore, the majority (n = 20) of the participating nurses had never received education about how to manage violent situations in their workplace. The typical source of violence was “patient relative/visitor” (n = 9). The most common outcome for nurses affected by violence was “being more careful and on guard while working with patients” (n = 7) and the majority of nurses who had experienced violence during the past 12 months reported their health status the past month as “Good” (n = 8). Due to the small sample no statistical comparisons between nurses per hospital wards could be made.
4.2 Discussion of results

4.2.1 Comparison of nurses’ experiences of workplace-related violence

The major findings of this study confirmed that workplace-related violence towards nurses’ does occur at KCMC in Tanzania. Furthermore the study showed that 16 of the 32 nurses’ had experienced violence in their workplace which is a higher prevalence then from the study by Arnetz et al. (1996) where 30% out of 2690 participants had experienced violence. Since this was the first study regarding violence towards nurses in Tanzania, no comparison of the results could be done with similar studies to confirm the prevalence in Tanzania. Therefore this result could be seen as a possible reflection of the KCMC’s nursing population’s experiences and be taken in consideration while doing further research of the subject; workplace-related violence among nurses in Tanzania.

In this study there were results showing that 44% out of the nurses had experienced violence the past 12 months, which was supported with the findings by Menckel & Viitasara (2002) whom showed 51% prevalence during a twelve month period. The participants in the Swedish study were municipal personnel caring mainly of the elderly or developmentally impaired patients. The Tanzanian nurses’ working in four general wards are bound to facilitate all kinds of patient groups and it is most likely that they would have worked with similar patients as in the Swedish study; therefore there was an opportunity to compare the results.

4.2.2 Verbal violence as the most common type of violence

The conducted study showed that there was an indisputable higher chance of being exposed to verbal threats/aggression rather than physical violence. Verbal threats and aggression is an often occurring event, as showed in a study by Gacki-Smith et al. (2009) where almost 20% of nurses in emergency departments reported verbal abuse more than 200 times during a 36 months period. Verbal violence was also shown to be more frequent than physical violence by Clements et al. (2005). Non-physical violence could be a contributory factor to violence, as a phenomenon, getting low levels of public awareness and therefore low priority in workplaces within health care. In this study usage of objects as a weapon was not as common (7%) as in the study conducted in Nigeria by Ogundipe et al. (2012). This relatively low use of objects as weapons could be explained by the rigorous security checks upon entering the hospital premises and also that the hospital was sparsely furnished, making it more difficult to use random objects as weapons.
4.2.3 Workplaces of exposed nurses

Examining specific departments, nurses working within the E.R. show that none of the responding nurses had experienced violence, which contradicts results by Ogundipe et al. (2012) showing a 65% prevalence among nurses working in E.R. The risk factors presented in the study by Ogundipe et al. (2012) was also present at KCMC’s E.R., including overcrowded emergency rooms, long waiting times and understaffed departments, however no violence was reported. There were only three participants that stated their workplace as in the E.R. This could be a result of that the nurses working in emergency departments did not fully understand the abbreviation E.R., as the term “casualty ward” was used by nurses at KCMC for naming their emergency department. The responders may therefore have chosen the closest alternative, which was “Medical clinic”, thus explaining the larger group of nurses stating they belonged to that workplace. At the medical clinic, a majority of the nurses had experienced violence the past year. In the examined I.C.U. two out of three responders reported violence-exposure within the past year, which confirms results in other studies showing working in an I.C.U. are a contributory risk factor (Hahn et al., 2012; Chen et al. 2012). Previous studies have shown a high prevalence of violence-exposed nurses in both psychiatric and geriatric care (Gacki-Smith et al., 2009; Hegney et al., 2006) but due to the lack of wards allocated to these specialties in the KCMC, the patients who would normally be admitted to such wards were cared for in general wards, therefore the result may have been affected with a higher prevalence.

4.2.4 Sources of violence

As seen in figure 2, the most common source of violence was reported coming from “patient relative/visitor” (n = 9), followed by “patients” (n = 4) and “staff” (n = 2). The result in this did not correlate with Arnetz & Arnetz (2001), where nurses reported that most of the violence primarily originated from patients (76%) and secondly patient relatives (20%). Additionally, Chen et al. (2012) showed that violence from patient and patient relatives were practically equally common. One possible reason for such a difference between the sources “patient” and “patient relatives” could possibly be explained as a result of KCMC being a tertiary hospital, where there could be significantly more beds, higher demand for bed space and more ill patients than in non-referral hospitals. Severe illness could result in a more emotionally unstable patient relative/visitor, this situation could subsequently lead to violence, and as stated by Chen et al. (2012), nurses are at a greater risk of becoming involved because of their close working proximity to the patient.
The violence reported as being performed by staff was also higher in the study of Chen et al. (2012), with 48% having experienced violence from medical colleagues and 30% from other nurses. Chen et al. (2012) stated the operation room to be one of the environments where nurses are most exposed to verbal violence by colleagues. A comparison is difficult to perform, as this study did not include any nurses working within the field of operations.

4.2.5 Violence affecting work with patients
Most of the nurses described their experience of violence or threats towards them to have affected their work with patients. Most nurses (n = 7) reported to be more careful and on their guard while working, which was supported by Arnetz & Arnetz (2001) that showed a more careful behavior from almost half of the nurses who had experienced violence within the past year. Still, a behavior like being more careful and on their guard while working points towards an increased fear of patients, which has been shown to be one of the typical outcomes after experiencing violence (Whelan, 2008).

Out of the respondents, two had answered that they enjoy their work less after the experience of violence, which is also supported by Arnetz & Arnetz (2001). The same type of reaction was also recorded as a problem by Ogundipe et al. (2012). In Arnetz & Arnetz (2001) was this described as a possible reason for staff burnout, which could define this phenomenon as a public health problem. This problem was especially prominent in one of the responders; in an open-ended question this responder described being affected as such: “I feel very bad, aggressive and depressed”. According to the authors, this kind of symptom could be seen as a sign of staff burnout.

Three nurses responded as not being affected at all by their experience of violence or threats at the workplace. It is the authors hypothesis that this response could be the result of not generalizing the violent incidents over all patients, but instead having the feeling that the incident with the violent patient/visitor was an isolated event. When analyzing the frequency of violence it is important to take into consideration the factor described by Chen (2012), that some nurses choose not to report violence in the workplace due to not wanting to avoid their job responsibilities.

4.2.6 Exposed nurses’ health during last month prior data collection
There were two nurses who described their health the past month as “fair”. This result suggests the possibility that the nurses did not let these incidents affect their health outside the
job since none of the respondents answered with “quite poor” or “very poor”. This gives an indication that the violence had not influenced the nurses’ health in such level that they perceived their own health to be low. However, this kind of assumption requires further investigation in order to validate it, especially since no significance was found between the health of exposed and non-exposed.

4.2.7 Education of managing violence

Even though a previous study by Martindell (2012) showed the importance of education of violence prevention there was a very low experience of such education in the group of examined nurses. It was only four nurses that stated that they had received education within the past year and they worked on two different wards. This raises questions about where they received such education and why a limited number were educated on those departments and none on others. Having education on violence prevention is of the utmost importance to increase safety amongst nurses and yet it tends to be very uncommon in the studied hospital, which implies that the Tanzanian health care system has room for improvement in this area. Since the low “Government health spending per person and year” (Gapminder, 2010), financing such preventative education may have low priority for the government because of the significant scarcity of funding available in the health sector.

4.3 Discussion of method

4.3.1 Response rate

In this study the response rate was 37 out of 54 nurses (59%). This response rate was less than the authors have calculated, and did it impossible to present the result in more than descriptive terms. This small sample size could be a reason for the higher prevalence, due to the decreased statistical power. There was a possibility of external data loss due to the risk that nurses who had been exposed to violence would feel bad while reminiscing the traumatic experience and that would make them unwilling to participate. The reason for this low response rate could, according to the authors’ hypothesis, also be a result of a study subject that is not frequently talked about, especially not within the health care system. The authors believe that many nurses feel that violence is something that comes as a part of their job because they work in close physical proximity to patients who are in a vulnerable position in life. Seeing violence as something that could come with the job could be a factor that contributes to the decision to not participate in the study. It is not seen as an issue, and therefore it is possible that the result show a lower frequency of violence than are the reality.
Another viewpoint, looking at the non-responding group, would be the stressful environment that is often present when working within health care, where nurses simply might not have time to answer the questionnaire. If that is the case the authors’ doubt that a reduced amount of non-responders would have affected the main results in the study. Reasons for the internal data loss could in part be because participants did not see all questions relevant to them or the subject. It could also have been affected by stressful work with little time over for answering the questionnaire or difficulties in understanding English.

It is of the authors’ beliefs that several participants experienced semantic difficulties going through the questionnaire that could have affected the results. This assumption was made looking into the questionnaires that was excluded due to ”less than one year of working experience”, where in that case the respondents was supposed to skip the following questions and hand it in. However, in all five excluded questionnaires, more questions were answered than requested which indicate the possibility of existing misunderstandings in the included questionnaires.

4.3.2 Limitations of the study
The authors’ opinion on the limitations of this study was that there were too few participants to be able to generalise it well. Insufficient time for the data collection was also an obstacle for gathering enough data. A culture difference is also a factor that could have been a problem for this study, with the authors coming to the morning meeting from another country and presenting a study about violence at their ward. Therefore the study might not feel as appealing to participate in compared to if the study is done on the hospitals own directives.

A major reason for choosing quantitative methods on this study was that no other study like this had ever been made in Tanzania before. The main goal was therefore to see if workplace-related violence towards nurses even did exist and to achieve a generalisable result during a short time period, quantitative methods with questionnaires were chosen. Using a quantitative study method with questionnaires reduces the risk of misunderstandings compared to an interview, since it was asked with simple English which is preferable in a bilingual nation. Having fixed alternatives as an answering method also minimises the risk of misinterpret the answers given by the participants. Some of the questions were however open-ended alternatives, which would have been better suited with the use of a qualitative study method, for example interviews, to get a deeper understanding about the exact feeling the nurses had. Another downside with quantitative methods is that when not being able to collect a
substantial amount of participants, the opportunity to achieve a significant result that can be trusted might be reduced.

4.3.3 Future research within the area
This study was carried out at the hospital KCMC in northern Tanzania. Since the study was a small single-site location study, it is not possible to generalise the result to all nurses in Tanzania. To have the possibility to generalize the result over a larger population in Tanzania it’s crucial to use perform multi-site methods should be performed for a greater validity, in both public and private hospitals.

This study used convenience sampling as the authors had a limited time for data collection; nurses were chosen based on who the authors came in contact with during their internship at KCMC. Nevertheless, the downside of using convenience sampling is that the sample population might have an alternative experience then the target population. The ultimate sampling method according to the authors would have been achieved by using consecutive sampling, and thus contacting every nurse working at the hospital during the period that the authors had their internship within the hospital. Performing the study at both private hospitals and public hospitals with a consecutive sampling method would increase the generalisability of the study.

4.3.4 Nursing implications
Nurses’ understanding of the interaction between caregivers and caretakers are essential for a good quality of care. The fundamental ground of this study is underlying in the integration that is needed between the nurse and the patient for a good care. The health status and safety of nurses are important, not only for themselves but also for patients and society. This study therefore contributes to new knowledge of the workplace-related phenomena violence towards nurses at the hospital KCMC in Tanzania that can be useful when discussing the subject workplace-related violence.

4.4 Conclusion
The results of this study are supported with existing research and literature that this workplace-related violence is a worldwide problem. The main findings of this study confirmed that workplace-related violence towards nurses’ does occur at KCMC in Tanzania. This study showed that 16 out of 32 participating nurses’ had experienced violence in their workplace during their career and that verbal threat/aggression was the most common type of
violence. Education regarding violence prevention is either not readily available or not taken up by nurses. Preventative education should have a higher priority placed upon it because of the emerging evidence that violence exposure in the workplace is an ongoing public health problem. Due to the small sample size, care needs to be taken when applying this result to a wider nursing population. Therefore is it crucial that further research is undertaken on this phenomenon in Tanzania.
5. REFERENCES


nurses’ perceptions in Nigeria. *Emergency medicine journal.* doi: 10.1136/emermed-2012-201541


APPENDIX 1

Letter of information
Nurses exposure and experience of violence
Questions for registered nurses working at a hospital clinic

Violence towards staff in health care is according to studies an increasing problem. Reports shows that the health care sector, including nursing, is one of the occupational fields that is most exposed to violence. Some medical specialities are more affected than others, but it occurs everywhere in the health care sector. The violence has several implications for the individual, health care system and public health. As a result, patients can be at risk of reduced quality of care. This study may help to get a greater knowledge about the subject and work as a foundation for preventing this type of phenomenon.

This problem needs more attention and research. In this study we need your help to achieve a greater understanding of the phenomena. This questionnaire is the foundation of our final essay for achieving a bachelor degree in the Nursing programme.

Your answers are the most important part of this study and it is of the upmost importance that You answer all the questions as well as possible so that we can grasp the picture of Your experiences of violence at work. It takes about 15 minutes to answer all the questions and the study is anonymous, which means that You do not write your name on the questionnaire. This study is approved by the head of the clinical department.

Please put your filled questionnaire in the box marked with “Filled questionnaires” at the clinic.

If You have any questions, don't hesitate to call or e-mail us:

Andreas Torstensson
Phone number: +46 73 622 65 48
torstensson.andreas@gmail.com

John Lönnroos
Phone number: +46 73 152 51 23
jlonnroos@gmail.com

Tutor: Caisa Öster
Phone number: +46 18 611 98 49
caisa.oster@neuro.uu.se
APPENDIX 2

Questionnaire
Taken and edited from the questionnaire used in “Implementation and evaluation of a practical intervention programme for dealing with violence towards health care workers” (J E Arnetz, B B Arnetz, 2000) with their approval.
Questions about your experience with threats and violence at work.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>□ Male</th>
<th>□ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Age</td>
<td>□ -29 yrs.</td>
<td>□ 30-39 yrs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 40-49 yrs.</td>
<td>□ 50-59 yrs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ ≥ 60 yrs.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Workplace</td>
<td>□ e.r.</td>
<td>□ medical clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ i.c.u.</td>
<td>□ psychiatric ward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ geriatric clinic</td>
<td>□ surgical clinic</td>
</tr>
<tr>
<td>4.</td>
<td>How long have you worked in the health care field?</td>
<td>□ &lt; 1 year</td>
<td>□ 1-5 yrs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 6-10 yrs</td>
<td>□ 11-15 yrs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ &gt; 15 yrs.</td>
<td></td>
</tr>
</tbody>
</table>

If the answer on question 4 is < 1 year, please skip the following questions and hand in the questionnaire.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>□ 1-5 yrs.</th>
<th>□ 6-10 yrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>How long have you worked at your present workplace?</td>
<td>□ 11-15 yrs.</td>
<td>□ &gt; 15 yrs.</td>
</tr>
<tr>
<td>6.</td>
<td>How has your health been during the last month?</td>
<td>□ very good</td>
<td>□ good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ fair</td>
<td>□ quite poor</td>
</tr>
<tr>
<td>7.</td>
<td>Have you ever been a victim of violence or threat of violence at your workplace?</td>
<td>□ no, never</td>
<td>□ yes, once or twice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ yes, several times</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Have you been a victim of violence or threat of violence at work during the past year?</td>
<td>□ no, never (Go to question 17)</td>
<td>□ yes, once or twice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ yes, several times</td>
<td></td>
</tr>
</tbody>
</table>

Questions 9-17 Apply only to those who replied “yes” to question 8. You may select more than one alternative.

Regarding threatening or violent incidents during the past year:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>□ patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Who was aggressive towards you?</td>
<td>□ staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ patient relative/visitor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ other</td>
</tr>
</tbody>
</table>

|   |   | □ verbal threat/aggression |
|---|---|□ biting |
| 10. | Which of the following have you been a victim of? | □ slapping/hitting |
|    |    | □ pushing |
|    |    | □ restraining |
|    |    | □ use of object or weapon – describe | □ spitting |
|    |    | □ pleasant experience |
|    |    | □ other – describe | □ scratching/pinching |
|    |    | □ punching |
|    |    | □ kicking |
11. Did you sustain any physical injury as the result of a violent incident?  
| □ no, none | □ yes, serious injury | □ yes, mild injury |

12. Have you taken sick leave as the result of a violent incident?  
| □ no | □ yes |

13. How did you react to the violent incident(s)?  
| □ no reaction | □ I felt angry | □ I felt afraid | □ I felt sad | □ I felt disappointed | □ other – describe |

14. Did you receive help/support after a violent incident?  
| □ no | □ I felt no need for help | □ yes |

15. If you answered “yes” to question 14: from whom did you receive help/support?  
| □ supervisors | □ co-workers | □ someone outside the workplace |

16. How has the violent incident affected you in your work with patients?  
| □ not at all | □ I feel afraid | □ Other – describe | □ I am more careful, on my guard | □ I enjoy my work less |

17. Have you been educated about how violence towards health care personnel can be managed?  
| □ no, never | □ yes, during the past year | □ yes, more than one year ago |

At your workplace…
APPENDIX 3

Original questionnaire

Taken from the questionnaire used in “Implementation and evaluation of a practical intervention programme for dealing with violence towards health care workers” (2000, J E Arnetz, B B Arnetz).
**Questions about your experience with threats and violence at work.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sex</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>2. Age</td>
<td>□ -29 yrs. □ 30-39 yrs. □ 40-49 yrs. □ 50-59 yrs. □ ≥ 60 yrs.</td>
</tr>
<tr>
<td>3. Workplace</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>4. Profession</td>
<td>□ physician □ registered nurse □ practical nurse □ nurses’ aide □ home health care aide □ mental health care practical nurse □ psychologist □ psychological nurse □ other ______________________________________________________________________ □ social worker</td>
</tr>
<tr>
<td>5. Do you have a supervisory position?</td>
<td>□ no □ yes</td>
</tr>
<tr>
<td>6. How long have you worked in the health care field?</td>
<td>□ 0-5 yrs □ 11-15 yrs. □ 6-10 yrs □ &gt; 15 yrs.</td>
</tr>
<tr>
<td>7. How long have you worked at your present workplace?</td>
<td>□ 1-5 yrs. □ 11-15 yrs. □ 6-10 yrs. □ &gt; 15 yrs.</td>
</tr>
<tr>
<td>8. Have there been any organizational changes at your workplace during the last year (you may select more than one alternative)</td>
<td>□ no changes □ downsizing of staff □ change in work schedules □ fewer patients □ workplace closed down □ other ______________________________________________________________________ □ new recruitment of staff □ direct admission of patients □ increased number of patients □ reassignment of staff □ don’t know</td>
</tr>
<tr>
<td>9. How has your health been during the last month?</td>
<td>□ very good □ fair □ very poor □ good □ quite poor</td>
</tr>
<tr>
<td>10. Have you ever been a victim of violence or threat of violence at your workplace?</td>
<td>□ no, never □ yes, once or twice □ yes, several times □ yes, once or twice</td>
</tr>
<tr>
<td>11. Have you been a victim of violence or threat of violence at work during the past year?</td>
<td>□ no, never (Go to question 20) □ yes, once or twice □ yes, several times</td>
</tr>
</tbody>
</table>

**Questions 12-19 Apply only to those who replied “yes” to question 11. You may select more than one alternative.**

Regarding threatening or violent incidents during the past year:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Who was aggressive</td>
<td>□ patient □ patient relative/visitor</td>
</tr>
</tbody>
</table>
13. Which of the following have you been a victim of?

- □ staff
- □ verbal threat/aggression
- □ biting
- □ slapping/hitting
- □ pushing
- □ restraining
- □ use of object or weapon – describe _________________
- □ other – describe _________________
- □ spitting
- □ scratching/pinching
- □ punching
- □ kicking
- □ unpleasant experience

14. Did you sustain any physical injury as the result of a violent incident?

- □ no, none
- □ yes, serious injury
- □ yes, mild injury

15. Have you taken sick leave as the result of a violent incident?

- □ no
- □ yes

16. How did you react to the violent incident(s)?

- □ no reaction
- □ I felt angry
- □ I felt afraid
- □ I felt sad
- □ I felt disappointed
- □ other – describe _________________

17. Did you receive help/support after a violent incident?

- □ no
- □ I felt no need for help
- □ yes

18. If you answered “yes” to question 14: from whom did you receive help/support?

- □ supervisors
- □ co-workers
- □ someone outside the workplace

19. How has the violent incident affected you in your work with patients?

- □ not at all
- □ I feel afraid
- □ Other – describe _________________
- □ I am more careful, on my guard
- □ I enjoy my work less

20. Has anyone at your workplace registered a violent incident using the VIF-checklist?

- □ no, never
- □ yes, once or twice
- □ yes, several times
- □ don’t know

21. Have you personally registered a violent incident using the VIF-checklist?

- □ no, never
- □ yes, once or twice
- □ yes, several times

22. Approximately what percentage of the violent incidents at your workplace were

- □ 0% (no incidents have been registered)
- □ less than 10%
- □ between 10-25%
- □ 100% (all incidents have been registered)
- □ violence towards staff has not occurred

During the course of the VIF-Project in the past year…

□ no, never
□ yes, once or twice
□ yes, several times
□ don’t know

□ no, never
□ yes, once or twice
□ yes, several times

□ 0% (no incidents have been registered)
□ less than 10%
□ between 10-25%
□ 100% (all incidents have been registered)
□ violence towards staff has not occurred
registered using the VIF-checklist? □ between 25-50% □ between 50-75% □ don’t know

23. Have violent incidents been discussed amongst staff together with your supervisor? □ violence towards staff has not occurred □ violence towards staff has occurred but has not been discussed □ violence towards staff has been discussed on occasion □ violence towards staff has been discussed regularly

24. Have violent incidents been discussed spontaneously (informally) amongst the staff at your workplace? □ violence towards staff has not occurred □ violence towards staff has occurred but has not been discussed □ violence towards staff has been discussed on occasion □ violence towards staff has been discussed regularly

Do you feel that the VIF-Project has given you improved knowledge about…

25. what types of violent incidents are most common at your workplace? □ no, not at all □ no, not especially □ yes, somewhat □ yes, to a degree

26. which situations can imply increased risks for violence towards staff? □ no, not at all □ no, not especially □ yes, somewhat □ yes, to a degree

27. how a potentially dangerous situation can be avoided/attenuated? □ no, not at all □ no, not especially □ yes, somewhat □ yes, to a degree

28. how you can handle a patient or other person who becomes aggressive towards you at work? □ no, not at all □ no, not especially □ yes, somewhat □ yes, to a degree

What do you think about the following statements:

29. The victim of a violent incident is helped by a general discussion of the incident with the other staff? □ strongly disagree □ disagree □ agree □ strongly agree

30. I have better knowledge about violence towards health care staff now, compared to one year ago. □ strongly disagree □ disagree □ agree □ strongly agree

31. My workplace has □ strongly disagree □ agree

What do you think about the following statements:
better routines for managing violence towards health care staff now, compared to one year ago. □ disagree □ strongly agree

32. The VIF checklist is a good instrument for registering incidents of violence and threats. □ strongly disagree □ disagree □ agree □ strongly agree

At your workplace…

33. Have you been educated about how violence towards health care personnel can be managed? □ no, never □ yes, more than one year ago □ yes, during the past year

34. How would you rate the stress level during the past year? The level of stress has… □ decreased a great deal □ decreased somewhat □ been unchanged □ increased somewhat □ increased a great deal