Workplace Violence among Nurses in Public Hospitals in Vietnam: A Cross-sectional Study

Sinh Minh Do, Anh Thi Lan Mai, Mai Thi Thuy Vu*

Abstract: Workplace violence causes negative impacts on the health of nurses, and the prevalence of workplace violence against nurses is rising globally. Studies to date in Vietnam have only concentrated on describing the frequency of types of violence within a specific healthcare facility with small sample sizes. This study aimed to determine the prevalence, impact and responses to workplace violence among registered nurses in public hospitals in Vietnam. This was the first nationwide study that has been carried out. A cross-sectional study design using an online questionnaire was conducted to achieve the study objectives with 2543 nurses working in 163 public hospitals. The frequency distribution and percentages were employed to describe the prevalence of workplace violence and nurses' responses. The researchers also used the average value of the total score of each question to rank the impacts of workplace violence on nurses.

The rate of workplace violence was 30.8%, of which physical and psychological violence were 5.3% and 29.7%, respectively. Among the types of psychological workplace violence, verbal abuse was the most common. The primary violent offenders were patients and caregivers. The biggest impact of workplace violence on nurses included always feeling stressed at work, decreased job satisfaction, and signs of stress or depression. The most common methods of responding to workplace violence were telling the perpetrator to stop or trying to defend themselves. These findings provide information for hospital leaders, health administrators and the Ministry of Health to reduce workplace violence against nurses. This can be done by increasing training on workplace violence management for nurses, creating a safe working environment to decrease the potential risks, and developing an appropriate system for reporting and responding to workplace violence incidents.

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Introduction

Workplace violence (WPV) is a growing global public health problem, increasingly studied for its immediate and long-term impacts on worker health.[1,2] Although WPV affects workers in all occupations, it is thought to be particularly common in the healthcare sector and is related to professional characteristics, long working hours, continuity, shift work, labor, frequent exposure to death lack of human resources, facilities and equipment.[1] WPV causes negative impacts on the delivery of health care services, which

are a decline in the quality of health care, and the decision of healthcare workers to leave the healthcare industry.[3]

Nurses represent a significant proportion of the healthcare workforce, and providing 24-hour patient care services, they spend most of their work hours in direct contact with patients. As a result of these factors, they are particularly vulnerable to WPV.[4] There is ample evidence that while nurses are primarily responsible for the health care of patients, they are victims of violence at a significantly higher rate than other healthcare professionals.[5]

The prevalence of WPV in nurses varies across countries and regions. A meta-analysis of 41 studies from 13 different countries in Southeast Asia and Western Pacific Region found that the overall prevalence of WPV was 58%.[6] A recent investigation in Europe revealed that 54% of nurses had experienced psychological violence, and 20% had experienced physical violence.[7] Workplace violence against nurses may be further exacerbated by the impact of COVID-19.[2,8] The high number of COVID-19 cases and accompanying deaths have put enormous pressure on healthcare workers throughout the world. Due to public concern that healthcare workers are a source of infection, the COVID-19 outbreak has increased the risk of stigma and violence against professionals in the workplace, including being avoided or outcast.[9] According to the recent research, perpetrators causing WPV against nurses included, but were not limited to patients, patients' relatives, co-workers, or managers, among which the main culprit were patients and their family, with the level of disparities varied by region and healthcare facility.[2,6-8]

The experience of WPV has been reported to increase levels of stress, burnout and fear or insecurity in nurses' workplaces.[4] WPV is also associated with nursing absenteeism, job dissatisfaction, intention to leave their job or career, as well as symptoms of post-traumatic distress.[10] These negative impacts also affect nurses' work and quality of care because WPV has been shown to reduce nursing productivity and increase the likelihood of medical problems or adverse events.[11]

Although WPV is very common and causes many impacts, it seems that the nursing approach to this problem is inadequate or not strong enough. Various studies showed that over 50% of nurses with WPV did not take any action after the incident. This rate is especially high in the type of verbal violence.[12-14] One of the simplest and most effective responses is to report WPV, although this measure is not chosen by many nurses.[14] Nurses believe that reporting the prevalence of WPV is useless or irrelevant and that reporting leads to negative outcomes;[15] or is an unimportant matter, not knowing whom to report to, feeling ashamed, or afraid of being fired.[14]

In Vietnam, there is some evidence for the prevalence of WPV among registered nurses (47%-75%).[16-18] However, these studies were conducted with a limited scope in a specific health facility, with a small sample size (201-540 people). In addition, new studies only focus on describing the frequency of types of violence but have not clearly described the impact of violence as well as how nurses respond to violence. Thus, it can be seen that compared to the impact of the problem, the available data are not enough to inform policy development.

Literature Review

According to the International Labor Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI), workplace violence is 'Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.'[19,p.3] WPV is divided into two groups: physical violence and psychological violence.[19]

The University of Iowa Injury Prevention Research Center classified WPV into four basic types.[20] Type 1 'Criminal Intent,' the perpetrator of the violence does not have a legal relationship with the health care facilities where the nurses work. Type 2 'Customer/ Client,' the perpetrators of violence are patients and their relatives. Type 3 'Worker-on-Worker,' the perpetrator of violence against nurses are colleagues at the nurse's workplace. Type 4 'Personal Relationship,' the perpetrator of the violence does not have a working relationship with the nurse.

Workplace violence is identified as deriving from society, organizations and individuals, and shows a complicated relationship between these parties. To be more specific, stress accumulated from such physically demanding jobs as nurses, along with pressure from social issues and health sector reforms, have fueled violence. On the individual level, healthcare workers tend to consider the patient's personality as the leading contributor to violence, followed by the socio-economic situation of the country, and then the organization of work and working conditions.[19]

According to Occupational Safety and Health Administration (OSHA),[21] the shortage of health workers, overcrowding in hospitals, and the lack of WPV prevention programmes are all barriers to the control of WPV. Risk factors for violence vary between different health care settings, depending on location, size and type of care. Violence can occur anywhere in health care settings, but most commonly occurs in psychiatric units and emergency departments, OSHA[21] has classified risk factors for WPV into 4 groups 'Clinical Risk Factors, Environmental Risk Factors, Organizational Risk Factors, and Social and Economic Risk Factors.

According to Walker and Avant,[22] consequences are events or incidents that occur after WPV. These consequences can be psychological, emotional, physical, and occupational for nurses and the organization in which they work. In terms of the psychological and emotional spheres, consequences may include but are not limited to stress, burnout and fear or insecurity in nurses' workplaces.[4] Nurses may be slapped, pushed, hit, kicked, or have things thrown at them. As a result, they may suffer fractures, headaches, wounds and other injuries related to physical harassment.[23] WPV can increase nurses' absence from work, decrease job satisfaction, increase high turnover rates and very low productivity, and cause a higher frequency of employee errors.[5,6] These are the professional consequences of WPV against nurses.[10,11] WPV is associated with a high turnover rate, which in turn affects health system service delivery.[24]

Previous research has suggested that the management strategies employed by nurses in response to WPV are diverse, with the most common method being immediately used is asking the perpetrator to stop.[2,13] After an incident takes place, releasing emotions is a crucial way for many nurses; they share the problems with friends, family members, co-workers, and supervisors. However, some studies also demonstrate that a significant number of nurses consider keeping calm, ignoring violent comments or actions, accepting violence as part of the job, and seeking help to be important approaches.[25,26] While some nurses adopt additional solutions, such as using counseling services, calling for help from nursing unions and associations, many other nurses opt to switch positions, change jobs, or sue the perpetrator.[7,12]

The Ecological Occupational Health Model of Workplace Assault[27] was selected as this study's theoretical foundation. The risk factors, effects, and strategies for managing workplace violence were explored using this model. Some characteristics, such as risk factors for violence, were not taken into account in the current study. The impact of violence and self-coping strategies for violence were among the factors considered. The model was modified in accordance with the Vietnam study.

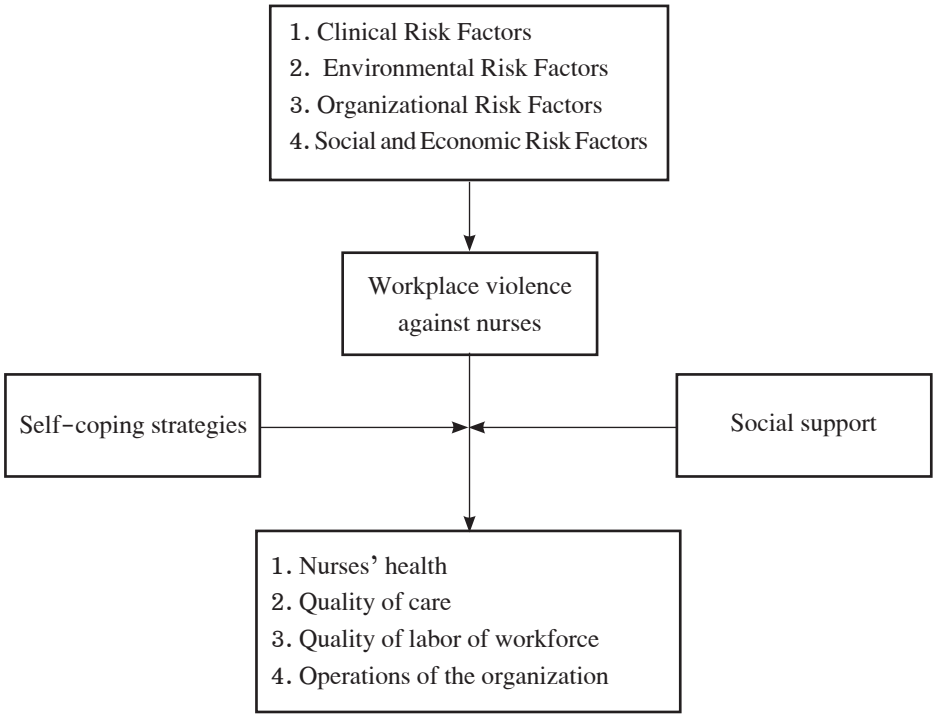

Figure 1. The study's theoretical framework, based on the model of Levin, Hewitt, and Misner[27]

In summary, WPV is a global public health concern that has been studied in many countries around the world, including Vietnam. However, existing studies in Vietnam have some limitations. With small or relatively small sizes, the level of representativeness was low. In addition, most of the studies did not declare the process of building and testing measuring tools, thereby affecting the validity and reliability of research findings. The findings mostly described the situation of WPV without investigating responses, nurses' views on risk factors and measures to help control violence. All of which led to a lack of data for the development of policies to control WPV.

Study Aim

To determine the prevalence, impact, and response to WPV among registered nurses in public hospitals in Vietnam

Methods

Study design: A cross-sectional study was used to examine sample characteristics and was essentially useful for this study in gathering information on prevalence, impact, and nurses' response to WPV. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guideline for cross-sectional studies.

Sampling and Participants: Vietnam is divided into three regions: the North (25 provinces), the Central part (19 provinces) and the South (19 provinces). We randomly selected ten provinces in the North, eight provinces in the Central, and eight provinces in the South as study sites. Since not every province in Vietnam has a central hospital, so from the list of hospitals, we randomly selected three central public hospitals in the North, two central public hospitals in the South, and two central public hospitals in the central region. In

each selected province, from the list of hospitals, we randomly selected one grade I, two grade II and three grade III hospitals. In total, 26 grade I, 52 grade II and 78 grade III hospitals were selected. The total number of hospitals selected equated to 7 + 26 + 52 + 78 = 163 public hospitals. It was estimated that the total number of nurses in 163 hospitals was approximately 18,000.

The selection criteria were registered nurses who had worked for at least 12 months by the time of the survey and agreed to participate in the study. Exclusion criteria were nurses working in the mental health sector (psychiatric hospitals and hospital psychiatric departments).

Ethical considerations: Ethical approval for this study was provided by the Biomedical Research Ethics Committee of Nam Dinh University of Nursing (Certificate No. 473/GCN-HDĐ, dated 03/3/2022). Prior to the study, participants had time to find out information via invitations sent beforehand to decide whether or not they would participate. The invitations gave details of the purpose and meaning of the study, the survey duration, the criteria for selection and exclusion of participants; the benefits to participants and the community from the study; the method of storing and securing participants' records; the right to refuse to participate or withdraw from the study at any time without providing a reason. The survey was anonymous, and the privacy of personal information was guaranteed. Implementation ensured compliance with the ethical principles outlined in the 1975 Declaration of Helsinki, as revised in 2013.

Instruments: There were three instruments used to obtain the data, they were: 1) the Nurse Demographic and Characteristics, 2) the Workplace Violence and Response (WPV-R) Questionnaire, and 3) the Workplace Violence Impact (WPV-I).

Both WPV-R and WPV-I questionnaires in the original English were translated with permission into Vietnamese according to Sousa and Rojjanasrirat guidelines.[28] The questionnaires were then validated by six experts. The selected experts ensure the following criteria: (i) had at least five years of work experience related to hospital quality management or the field of occupational health in the health industry or participated in the work, managed, inspected, and supervised the implementation of regulations and professional technical processes of nurses; and (ii) had conducted or published at least one research work in scientific journals. After being tested for content validity, the toolkit was continued to be sent to 51 nurses who met the study's selection criteria to check the reliability. These nurses were not involved in the formal study.

The Nurse Demographic and Characteristics: was developed by research team and included job position, job title, and working seniority.

The Workplace Violence and Response questionnaire (WPV-R)*:* This questionnaire assessed the prevalence of and responses to WPV and was developed based on the Survey Questionnaire Workplace Violence in the Health Sector scale.[29] The questionnaire is divided into two parts, Physical Violence and Psychological Violence, with 17 items to assess the nurses' experience with WPV in the past 12 months up to the time of the survey. The physical violence part consists of five questions, and the workplace psychological violence includes 12 questions with four categories, including verbal violence, bullying, sexual harassment and racial or religious discrimination. Participants were asked to answer whether they experienced violence in the workplace in the past years (Yes or No), for example, "Have you experienced physical abuse at work in the last year?" If yes, they would continue to report who the perpetrator was and choose how to respond to violence from the list of response strategies available in the questionnaire. The S-CVI/UA value of the questionnaire was 0.89. The test-retest reliability of the questionnaire was performed seven days apart and the reliability value (Cohen's Kappa coefficient) was 0.822

The Workplace Violence Impact Questionnaire (WPV-I) assesses the impact of WPV on nurses and was developed based on the guidelines on coping with violence in the workplace by the International Council of Nurses.[30] The scale consists of 12 items

about nurses' experiences of the impact of each WPV, for example, "Feeling stressed at work" or "Reducing job satisfaction." The level of occurrence of problems consists of three levels, including not appearing (= 1), appearing at a mild or little level (= 2), and appearing at a severe level (=3). The S-CVI/UA value of the questionnaire was 0.82. The Cronbach's alpha coefficient reliability of the questionnaire was 0.799 in the main study.

Data Collection: The online questionnaire was completed by nurses in 26 selected provinces in Vietnam from March to May 2022. Invitations and research tools were sent to 163 public hospitals in 26 selected provinces. The hospital's nursing room was then asked to forward invitations and research tools to the nurses. Participants access the link or the Quick Response code of the questionnaire through the "Kobotool Box" platform. We tracked the questionnaires collected in real time and effectively managed the data using an online management platform through a website link to our survey. After completing the questionnaire, the data management platform received the corresponding logs and recorded the response time of the participants. A total of 2543 nurses participated in answering questions for WPV.

Statistical Analysis: Data analysis was performed using IBM-SPSS version 20.0. The frequency distribution and percentages were used to determine the demographic variables, the prevalence of WPV and nurse's responses. The method for setting the Likert scale's cut-off point was not explained, nor were the directions for doing so obvious. The researchers ranked the effects of WPV on nurses in this study using the average value of the total score for each question (the higher the average score, the bigger the impact).

Results

A total of 2543 nurses from 163 public hospitals in 26 provinces of Vietnam participated in the survey. The majority of nurses were female (81.1%), aged 30-39 years old (56.1%) and married (96.4%). The proportion of nurses with college and university degrees were similar, about 38.0%, higher than that of nurses with intermediate and graduate degrees (**Table 1**).

Table 1. Nurses' characteristics (n = 2543)

Variable	Characteristic	Number	%
Sex	Male	480	18.9
	Female	2063	81.1
Age group	18-29	596	23.4
	30-39	1427	56.1
	≥ 40	520	20.4
Marital status	Not married yet	2451	96.4
	Married	79	3.1
	Divorced/separated/widow	13	0.5
Professional qualifications	Intermediate	382	15.0
	College	998	39.2
	University	970	38.1
	Post-Graduate	193	7.6
Living area	North	1627	64.0
	Central	442	17.4
	Southern	430	16.9
	Did not declare	44	1.7

Table 1. Nurses' characteristics (n = 2543) (Cont.)

Variable	Characteristic	Number	%
Workplace	National hospital	646	25.4
	Grade I hospital	851	33.5
	Grade II hospital	620	24.4
	Grade III hospital	426	16.8
Working years	1–10 years	544	21.4
	11–20 years	1455	57.2
	20 years	544	21.4
Work unit	Emergency department, Medical examination department	470	18.5
	Other	2073	81.5
Violence prevention training	Yes	456	17.9
	Not yet	2087	82.1

In the past 12 months, the prevalence of WPV in nursing was 30.8% (783/2543), of which physical violence was 5.3% (135/2543). The psychological WPV was 29.7% (755/2543), of which verbal abuse was the most common type; less common was the type of violence related to sexual harassment and racial harassment (Table 2).

Table 2. Prevalence and types of workplace violence experience among nurses (n = 2543)

Types of violence	Number	%*
Total workplace violence	783	30.8
Physical violence	135	5.3
Psychological workplace violence	755	29.7
Verbal abuse	717	28.2
Bullying/mobbing	308	12.1
Sexual harassment	28	1.1
Racial harassment	28	1.1

* Percentage of nurses who experienced workplace violence in the 12 months by the time of the survey was calculated by dividing the total number of nurses experiencing violence by the total number of nurses participating in the study (n = 2543).

The main perpetrator causing WPV was a member of a patient's family, followed by the patient. Two groups of people who also often caused violence in nurses were listed as colleagues (doctors and nurses) and managers (hospital chief nurse and head of nursing), in which psychological violence had a higher rate (**Table 3**).

Table 3. Number and percentage of perpetrators causing violence against nurses

Subject	Physical violence (n = 133)		Psychological violence (n = 683)	
	Number	%	Number	%
Patient's relatives	105	78.9	462	67.7
Patient	50	37.6	271	39.7
Manager	13	9.8	116	17.0
Colleague	12	9.0	126	18.4
Unknown	5	3.8	78	11.4

The study examined nurses' perceptions of the impact of WPV in 12 aspects. The results indicated that the highest impacts of WPV included always feeling stressed at work, reducing job satisfaction, signs of stress/depression, reducing work efficiency/performance, and intending to change jobs/reposition of work (**Table 4**).

Table 4. Ranking impact of workplace violence from the nurses' perceptions

Impacts	Medium score	Ranking
Feeling stressed at work (n = 730)	1.89	1
Reducing job satisfaction (n = 732)	1.79	2
Presenting of signs of stress/depression (n = 732)	1.76	3
Reducing efficiency/work efficiency (n = 730)	1.62	4
Intending to change job/move position (n = 731)	1.58	5
Feeling of loss of confidence (n = 731)	1.50	6
Relationships with family/colleagues deteriorated (n = 731)	1.43	7
Feeling that the situation of self-violence worries family and co-workers (n = 728)	1.28	8
Physically injured (n = 732)	1.26	9
No longer trusted at work (n = 731)	1.24	10
Reducing income due to absenteeism and/or violence (n = 733)	1.19	11
Had to take a temporary break from work (n = 731)	1.14	12

There were similarities in the way nurses responded to physical violence and mental health. The most commonly used approach to both types of violence was to telling the perpetrator to stop or try to defend themselves. The rate of nurses reporting to the competent authorities about physical violence reached 44.6%, but in psychological WPV, this was only 26.3% (**Table 5**).

Table 5. Number and percentage of nurses' responses to workplace violence

Method	Physical violence (n = 132)		Psychological violence (n = 733)	
	Number	%	Number	%
Tell the perpetrator to stop/Try to defend themselves	65	49.2	297	40.5
Report to the competent authority	59	44.6	193	26.3
Talk to colleagues	50	37.9	222	30.3
Keep quiet after the incident	40	30.3	186	25.4
Try to pretend it did not happen (after it did)	21	15.9	146	19.9
Search advice	14	10.6	95	13.0
Tell family and friends	9	6.8	78	10.6
Change job position	1	0.8	9	1.2
Sue the abuser	1	0.8	1	0.1
Other	10	7.6	56	7.5

About half of the nurses reported that they never reported violence because reporting was futile/unhelpful. Nearly a third of nurses indicated the reason they never reported because the problem was not important. Further reasons were fear of negative consequences, not knowing whom to report to, shame, and guilt (**Table 6**).

Table 6. Number and percentage of reasons for not reporting workplace violence

Reason for not reporting	Physical violence (n = 72)		Psychological violence (n = 527)	
	Number	%	Number	%
Useless/no use	36	50.0	238	45.2
The problem is not important	22	30.6	203	38.5
Fear of negative consequences	13	18.1	78	14.8
Don't know whom to report to	16	2.2	93	17.6
Feel ashamed	4	4.6	31	5.9
Feeling guilty	0	0	4	0.8

Discussion

WPV Prevalence among Nurses in Public Hospitals in Vietnam

WPV in nursing is a common problem in healthcare settings that has been and will continue to exist worldwide.[5] This study revealed that the prevalence of WPV among nurses in the 12 months prior to the interview was 30.8%, which was lower than that of published studies in Vietnam. Data published in 2019 indicated that the nursing rate with WPV was 61.4%.[17] Another study in 2020 showed that the WPV rate was 47.0%.[16] A survey report at a central hospital in the northern region in 2017 revealed that the rate of WPV in nursing was up to 72.7%.[31]

The lower percentage of nurses with WPV in this study, compared with previous studies in Vietnam, may be related to the time of data collection. While the reference studies had a period of data collection before the COVID-19 pandemic, the retrospective period of nurses' experience with WPV in this study ran from February 2021 to May 2022. This time coincides with the third and fourth pandemic phases, the peak period of COVID-19 in Vietnam. From April 27, 2021, to January 31, 2022, Vietnam recorded 2,020,694 COVID-19 cases and 35,445 deaths in 52/62 provinces and cities across the country (much higher than the first and second pandemic phases). Due to the application of measures to prevent and control the pandemic, as well as the psychology of the people, the number of patients coming to medical facilities for examination and treatment was less than before COVID-19 occurred. Statistics show that, in 2021, there were 118.721 million cases of people receiving medical examination and treatment with health insurance.[32] However, in 2020 there were 176.6 million cases, and in 2019, 184.1 million cases. Besides, this time also coincided with the traditional Vietnamese New Year (Lunar New Years of 2021 and 2022), when the number of patients visiting and examining at medical facilities is lower than at other times of the year. Public health measures in COVID-19 that have statistically significantly reduced the medical complexity of hospitalized patients are also confirmed in recent studies in Turkey.[33] The decrease in the number of patients coming for examination and treatment has reduced hospital overload and reduced work pressure for nurses. In addition, differences in results between studies may be related to the size and scope of each study.

In our study, 2543 nurses from over 100 public hospitals from the district level to the central level in all three regions of Vietnam participated, whereas previous studies had relatively small sample sizes and were conducted in a single hospital.[16-18] Differences in economic and cultural conditions between regions, hospital classes, and sample sizes can also affect the results of the studies.

Compared with other studies of the same period, the rate of WPV in nurses in the present study was

also lower. A systematic review and meta-analysis in 2022 showed that the prevalence of general WPV was 47% among nurses.[2] In the same year, another systematic review and meta-analysis showed that the prevalence of stigmatization among health workers was 43%, and violence was 42%.[8] A recent study in Thailand found that the rate of physical violence, verbal violence, and bullying/mobbing were 12.1%, 50.3%, and 10.3%, respectively.[34] A 2021 global investigation report on 33 nations discovered a considerable rise in violence against healthcare professionals during the COVID-19 pandemic. Accordingly, over 60% of respondents discovered that there had been an upsurge in violent episodes in healthcare facilities since the start of the pandemic.[35]

The lower rate of WPV in our study compared to other studies may be due to differences in the participants, as well as the response to the COVID-19 pandemic in each country. The nurses in this study worked in a variety of positions and were not entirely direct caregivers of people infected with COVID-19, while the participants of the reference studies were nurses on the front lines of the fight against the pandemic.[2,8] With the pandemic, these nurses have faced a perfect storm of conditions that threatened their health, well-being, and ability to do their jobs.[36] Several studies have shown extreme burnout, physical discomfort after hours of working with masks and other PPEs, fear of infection, and emotional distress in nurses. Combining physical and emotional stress increases the risk of WPV in nurses.[37]

Regarding types of WPV, verbal abuse is most commonly experienced by nurses. A similar pattern has been reported in previous studies in Vietnam[17,18] as well as studies in many countries around the world.[5,38] A recent study of nurses in Thailand showed that the rate of verbal violence was 4.1 times higher than physical violence and 4.9 times higher than bullying/mobbing.[34] The reason why verbal abuse is more common than other types of violence may be that perpetrators often think that they will not incur any legal punishment.[33] Perpetrators are easily verbally abused, and most of the time, this type of violence leaves the victim with no concrete evidence to act against.[13] In addition, a large body of evidence has shown that nurses believe that verbal abuse by colleagues or patients is a reality in the healthcare setting and that they do not or rarely have specific actions against this issue.[4] This is further complicated by the existence of a number of barriers to reporting, uncertainty about what constitutes violence, the belief that perpetrators do not fully control themselves due to substance abuse or mental illness, the perception that no corrective action will be taken, or a general lack of awareness of policies and reporting systems.[4]

This study found that the main perpetrators of physical violence against nurses were caregivers (78.9%) and patients (37.6%). This result is also consistent with the findings of some studies.[25,39] Caregivers and patients were also the main perpetrators of verbal violence in this study. This pattern is similar to studies in Iran,[40] Taiwan[25] and other countries.[35] In contrast, a recent study in Thailand found that clinical nurses were the main perpetrators of verbal violence, followed by patients and caregivers.[34]

Through the above analysis, it can be seen that the rate of WPV in the present study was lower than in some previous domestic and foreign studies. However, this finding is consistent with the view that the prevalence of WPV in nursing is very common and verbal abuse more so. Therefore, to solve the problem, it is necessary for stakeholders to pay due attention to prevention and control measures to create a safe working environment for nurses and other healthcare staff.

The Impact of WPV on Nurses

Previous evidence has shown that WPV has an impact on the individual health of nurses and also on the organization in which they work.[4,24] Findings from previous studies support our study. On an individual level, nurses claim that WPV has had negative impacts on them, such as psychological (post-traumatic stress, depression), social relationships (relationships with

family or colleagues deteriorate, social and family life is disturbed), physical trauma due to violence and financial aspects (decreased income due to treatment costs or temporary absence from work). At the organizational level, the impacts of WPV include reduced work efficiency/performance, reduced job satisfaction, and intention to change jobs/reposition. Other studies confirm this.[6,41]

There is an intimate interdependence and interdependence between the challenges posed by WPV to nursing safety, well-being and health and the impacts on the organization. Whenever workers are hurt, the functioning of the organization is affected.[42] The occupational consequences of WPV are related to service delivery, as demonstrated by increased sick leave, decreased job satisfaction, high absenteeism, low productivity and increased employee errors, all of which contribute to poor service quality.[4] A nurse who feels threatened is not inspired to do better. Instead, their motivation to work will decrease, and they may choose to venture into other areas in search of security.[3] This also affects recruitment as it becomes more difficult for healthcare providers to attract workers with the right skills.[24]

Violence in the workplace has become a global problem that crosses borders and threatens the well-being of people and organizations, regardless of how many nurses or health care workers suffer the negative social and psychological consequences of their work.[1] We believe that identifying the factors that cause violence is essential for policymakers and managers, as this will help them develop strategies to control WPV. To do so, they also need to be aware of the concerns of their employees, who are at risk and therefore suffer the consequences of WPV. We also recommend that mental health services be provided to nurses reporting WPV cases.

Nurses' Responses to WPV

Although WPV is very common, it seems that the nursing approach to this problem is not adequate or strong enough.[12,13] Consistent with this, in the present study, although the strategies to respond to WPV were varied, the effectiveness and efficiency of responses need to be considered. The most common method used by nurses immediately when experiencing violence is to ask the perpetrator to stop or try to defend themselves, but less than 50% of nurses do this. Some previous studies also coincide with the findings in our study.[13,40] After an event, emotional release is an important method for many nurses to share the incident with colleagues and family or seek advice. However, a significant number of nurses remained silent after the incident. Several recent studies have shown that keeping calm, ignoring comments or actions, accepting violence as part of the job, and seeking help are important measures.[42] There are a small number of nurses who have used the option of changing jobs, changing jobs or suing the person who caused their violence. This is also the second solution described in previous reports.[12]

A remarkable finding from this study was that the percentage of nurses who did not report their violence was quite high (55.4% for physical violence and 73.7% for psychological WPV). This result is also quite similar to many previous studies.[14,38] The most common reason given by the nurses in this study for not reporting was that this was useless or unhelpful, or that the problem was not important. This may be due to the perception that violence in the health care setting is "part of the job."[38,42] The view that violence is part of the work of nurses and should only be reported when a serious event occurs, leads to a lack of institutional support and conceals the severity of the problem.[12] By using the "do nothing and keep quiet" approach to coping, nurses give perpetrators of violence a clear indication that the behavior is acceptable.[15] Therefore, not reacting to the incident or pretending nothing happened or the reaction is limited to self-defense or asking the perpetrator to stop, will increase the severity of WPV and make detection more difficult.[3,38] It is imperative that nurses are aware of the different types of violence they may experience in the workplace and report these incidents, as they can have a major impact on their health, quality of life, and work.[38]

Another common reason for not reporting violence in this study was fear of negative consequences. This may be due to fear of reprisal, which has been described as the reason for not reporting WPV in previous studies.[23] In addition, nurses who decide to report are concerned they will be accused of causing the situation and continue to be a victim or have had a previous negative experience of reporting and nothing was done.[42] These results suggest that hospitals need to establish clear guidelines for WPV and have appropriate management strategies. The nurses in the current study also said that they did not report violence because they did not know whom to report. This finding is also consistent with many previous studies,[38] and iterates the need for hospitals and healthcare facilities to train and educate staff on WPV, especially new employees.

Training nurses to recognize, prevent, and manage violence is important to prevent WPV. Training improves nurses' communication skills, confidence and understanding of clients, avoids escalation and promotes the spread of the situation, thereby reducing the risk of WPV. Good communication skills have a significant impact on patient satisfaction,[43] minimizing disruptive behavior, improving self-efficacy, and reducing burnout.[44] However, as in some previous studies, less than a fifth of the nurses in our study reported having attended training/training courses on WPV recognition, prevention and management. This lack of training is reflected in the way nurses handle incidents caused by WPV. This can be explained by lack of evidence of the extent of the problem, inadequate implementation of existing guidelines, inadequate occupational health and safety departments or a lack of manpower to carry out any instructions.[43]

Strengths and Limitations of the Study

This was the first survey on the prevalence of WPV, as well as its impact and response among public nurses in Vietnam at the national level. The large sample size significantly increases the statistical power to extrapolate to the population. However, we lack evidence for the long-term psychological consequences of violence against nurses. Besides that, this study explored how nurses cope with violence on their own, but did not explore the role of stakeholders in supporting nurses in responding to violence. In the future, there is a need for different studies investigating long-term psychological consequences of violence against nurses to offer supportive measures. It is also necessary to study the roles of stakeholders (Ministry of Health, hospital leaders, socio-political organizations, and professional associations) in controlling violence against nurses.

Conclusion and Implications for Nursing Practice

Based on a large sample, this study investigated the prevalence of WPV types among nurses in public hospitals in Vietnam. The prevalence of WPV in the present study was lower than in some previous studies, but concurs with the view that the prevalence of WPV in nursing is very common. Research results also show that nurses have experienced many different forms of WPV, including verbal abuse, bullying/mobbing, physical violence, sexual harassment and racial harassment. The main perpetrators of WPV are sick people and their loved ones. WPV has caused many negative impacts on the health of nurses (the highest impacts of WPV included always feeling stressed at work, reducing job satisfaction, signs of stress/depression, reducing work efficiency/performance, or intending to change jobs/reposition of work). However, the nursing response does not seem to be commensurate with the impact of the problem. To help solve the problem, we propose that it is necessary to raise the awareness of nurses about WPV. This can be done through the organization of training courses, workshops, seminars, and conferences on workplace violence for nurses. Hospital administrators should develop policies to encourage nurses to report their experiences of workplace violence and provide them with post-violence support services. In addition,

they should also develop policies and implementation solutions to establish a safe working environment for all health workers and should be strengthened to develop a safe working environment.

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ความรุนแรงในสถานที่ทำงานของพยาบาลในโรงพยาบาลของรัฐในเวียดนาม : การศึกษาแบบภาคตัดขวาง

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บทคัดย่อ: ความรุนแรงในที่ทำงานก่อให้เกิดผลกระทบทางลบต่อสุขภาพของพยาบาล และความชุกของความรุนแรงในที่ทำงานต่อพยาบาลกำลังเพิ่มสูงขึ้นทั่วโลก การศึกษาวิจัยในเวียดนามที่ผ่านมาจนถึงปัจจุบันนี้ มุ่งเน้นการอธิบายความถี่ของประเภทความรุนแรงในสถานบริการพยาบาลเป็นบางแห่งในกลุ่มตัวอย่างขนาดเล็ก การวิจัยครั้งนี้ มีวัตถุประสงค์เพื่อศึกษาความชุก ผลกระทบ และการตอบสนองต่อความรุนแรงในที่ทำงานของพยาบาลวิชาชีพในโรงพยาบาลของรัฐ ในประเทศเวียดนาม ซึ่งเป็นการศึกษาที่ดำเนินการทั่วประเทศเป็นครั้งแรก รูปแบบการวิจัยเป็นการศึกษาภาคตัดขวางและใช้แบบสอบถามออนไลน์ที่สำรวจในพยาบาลจำนวน 2543 รายที่ทำงานในโรงพยาบาลของรัฐ 163 แห่ง ผู้วิจัยใช้สถิติบรรยายในการแจกแจงความถี่และร้อยละ เพื่ออธิบายความชุกของความรุนแรงในที่ทำงานและการตอบสนองของพยาบาล และใช้ค่าเฉลี่ยของคะแนนรวมของแต่ละคำถามเพื่อจัดอันดับผลกระทบของความรุนแรงในที่ทำงานที่มีต่อพยาบาล

ผลการวิจัยพบอัตราความรุนแรงในที่ทำงานร้อยละ 30.8 โดยเป็นความรุนแรงทางร่างกายและจิตใจ พบร้อยละ 5.3 และ 29.7 ตามลำดับ ส่วนประเภทของความรุนแรงทางจิตใจในที่ทำงานนั้น การล่วงละเมิดทางวาจาเป็นสิ่งที่พบมากที่สุด ผู้กระทำความรุนแรงหลักคือ ผู้ป่วยและผู้ดูแลของผู้ป่วย ผลกระทบที่มากที่สุดของความรุนแรงในที่ทำงานต่อพยาบาล ได้แก่ ความรู้สึกเครียดในที่ทำงาน ความพึงพอใจในการทำงานลดลง และ มีอาการแสดงของความเครียดหรือภาวะซึมเศร้า วิธีที่พยาบาลใช้บ่อยที่สุดในการตอบสนองต่อความรุนแรงในที่ทำงานคือ การบอกให้ผู้กระทำความผิดหยุดกระทำ หรือพยายามป้องกันตนเอง ผลการศึกษานี้เป็นการให้ข้อมูลสำหรับผู้นำโรงพยาบาล ผู้บริหารด้านสุขภาพและกระทรวงสาธารณสุขเพื่อใช้ในการลดความรุนแรงในที่ทำงานต่อพยาบาล ซึ่งสามารถทำได้โดยการเพิ่มการฝึกอบรมเกี่ยวกับการจัดการความรุนแรงในที่ทำงานสำหรับพยาบาล การสร้างสภาพแวดล้อมการทำงานที่ปลอดภัยเพื่อลดความเสี่ยงที่อาจเกิดขึ้น และพัฒนาระบบที่เหมาะสมในการรายงานและการตอบสนองต่อเหตุการณ์ความรุนแรงในที่ทำงาน

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คำสำคัญ: การเผชิญปัญหา ผลกระทบ พยาบาล ความรุนแรงทางร่างกาย ผลกระทบทางจิตใจ เวียดนาม ความรุนแรงในที่ทำงาน

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