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Workplace Conflict among Nurses, Patients, and their Families in the Eastern Province Hospital, KSA

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Background

Workplace conflict among nurses, patients, and their families is a significant challenge in healthcare settings, particularly in high-demand environments like hospitals. In the Eastern Province Hospital, KSA. Nurses often face pressure from both patients and their families, which can lead to misunderstandings, dissatisfaction, and burnout. Understanding the root causes and developing conflict resolution strategies can help create a more collaborative and supportive healthcare setting. **Methods:** A cross-sectional study was adopted, and 405 nurses from Dammam Medical Complex, Qatif Central Hospital, Maternity and Children's Hospital, and Almana General Hospital, Kobar, Dammam, and Al Hassa were selected using a convenient random sample approach. A self-administered questionnaire was used to collect the data from the selected settings. **Results:** Two-thirds of nurses (64.5%) reported experiencing verbal or *physical violence* at least occasionally, indicating that this is a significant issue in healthcare environments. *Regarding cultural violence*, 66.5% reported personal experiences of this form of violence. For *sexual violence*, 59.8% of nurses reported experiencing this form of violence. *In terms of mental violence*, 65.9% of nurses reported experiencing mental, psychological, or emotional violence at least rarely, with 9.1% experiencing frequent incidents.

Conclusion: Nurses are the most frequent victims of workplace violence occurs almost equally across all shifts.

Keywords: Violence, Conflicts, Nurses, Patients, Families

Introduction

The workplace is an environment where individuals come together to perform tasks, collaborate, and achieve shared objectives. In the healthcare sector, this environment includes hospitals, clinics, outpatient care centers, and specialized facilities, such as birthing centers and psychiatric care units. These workplaces significantly influence professional relationships and organizational culture. Effective communication and a positive atmosphere are crucial for fostering the productivity and satisfaction of healthcare workers, patients, and

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their families. Nurses play a pivotal role among these professionals by providing care, support, and education to patients across diverse healthcare settings (1-3).

Despite the critical role of healthcare workplaces, various factors can disrupt their functionality, one of which is workplace conflict. Conflict or violence in healthcare settings can manifest between nurses themselves or between nurses, patients, and their families. The World Health Organization (WHO) defines violence as the intentional use of physical force or power, whether threatened or actual, against oneself, another person, or a group, with a high likelihood of causing harm, psychological distress, or deprivation (4). In healthcare environments, conflicts are multifaceted and may include psychological, verbal, physical, and sexual forms of violence.

The nature of healthcare work, characterized by its complexity, high stakes, and emotionally charged interactions, inherently poses risks for conflict. Power imbalances, hierarchical structures, and the vulnerability of patients contribute to tensions among nurses, patients, and families (5). Furthermore, systemic challenges such as heavy workloads, staffing shortages, and time constraints exacerbate these conflicts. Nurses, overwhelmed by their responsibilities, may struggle to meet the expectations of patients and families, who are often under significant stress due to their health conditions (6).

These workplace conflicts have far-reaching consequences. For patients, unresolved tensions can result in delayed diagnoses, treatment disruptions, and diminished continuity of care (7). They can also undermine trust in healthcare providers and lead to reduced compliance with treatment recommendations (8). Furthermore, conflicts can have negative effects on the well-being and performance of healthcare professionals. (8)

For nurses and other healthcare professionals, prolonged exposure to workplace conflict can lead to burnout, job dissatisfaction, and increased turnover, ultimately affecting the quality of care delivery (9). Furthermore, studies have shown that such conflicts can contribute to absenteeism, reduced productivity, and significant mental and physical health challenges for healthcare workers (10). At an organizational level, workplace conflicts can inflate healthcare costs through inefficiencies and errors and tarnish the reputation of healthcare institutions. Recruitment and retention of qualified healthcare workers have become increasingly challenging, intensifying workforce shortages (11). In Saudi Arabia, a study conducted by Alghanim (2019) highlighted a troubling prevalence of workplace violence in healthcare settings, particularly in Riyadh, emphasizing the need for systemic interventions to mitigate these issues (12).

The present study aims to assess workplace conflicts between nurses, patients, and their families in a hospital in the Eastern Province of Saudi Arabia. By exploring the nature, causes, and consequences of these conflicts, the study seeks to inform strategies to improve workplace relationships, enhance patient care, and foster a healthier work environment for nurses.

Methods:

Study Design

The workplace violence among nurses, patients, and their families in selected hospitals in the eastern region of KSA was investigated using a descriptive cross-sectional study design.

The setting

Dammam Medical Complex, Qatif Central Hospital, Maternity and Children's Hospital, and Almana General Hospital, Kobar, Dammam, and Al Hassa branches & nurses who refused to be part of the research were excluded from the study.

Sample

405 Nurses in selected hospitals in the eastern region of KSA made up the study's was determined using the http://www.raosoft.com/samplesize.html website. A convenient sample approach was implemented to assign nurses from different levels of education and positions.

Eligibility Criteria

- All nurses aged 23 years and above who are qualified with a diploma degree in nursing or higher
- working in all wards of the mentioned hospitals,
- nurses in managerial positions with no less than 6 months of experience

Exclusion Criteria

. All nurses who have less than 6 months of experience or are not working.

Tools

A self-administered questionnaire was developed through a review of prior research (13) and modified by the researcher after a review of the literature. Experts evaluated the tool's content validity. The test-retest reliability was assessed using Cronbach's α, which yielded a result of 0.968. The questionnaire is structured using a Likert scale, with response options ranging from 0 (Never), 1 (Rarely), 2 (Occasionally), to 3 (Frequently). The questionnaire begins with demographic information, including age, gender, hospital name, highest academic qualification, years of experience, position, and work area. It is then divided into three main sections:

1. *Exposure to Nurse-Patient and Family Conflict*: This section contains eight items and assesses the nurses' exposure to different types of violence in healthcare settings, either directly experienced or witnessed. The types of violence include verbal/physical, spiritual/cultural, sexual, and mental/emotional. Responses are recorded on a scale from 0 (never) to 3 (frequently). Respondents rate their experiences using a scale of 0 (never), 1–8 (rarely), 9–18 (occasionally), and 17–24 (frequently).

2. *Nurses' Experiences with Patient and Family Conflict*: This section includes 18 items focusing on nurses' experiences or observations of verbal, physical, cultural, spiritual, or sexual violence and identifies whether males or females are the more frequent perpetrators. Ratings are based on a scale: 18 (strongly disagree), 19–36 (disagree), 37–54 (agree), and 55–72 (strongly agree).

3. *Reporting Violence*: This section consists of four items: the most common times when violence occurs, whether incidents are reported, the timing of incident report submissions, frequency, and reporting violence.

Statistical Analysis

Data was entered and analyzed using the Statistical Package for the Social Sciences (SPSS) version 22 and *JAMOVI* software. For the Descriptive statistics, frequency, percentages, mean, and standard deviation (SD) were calculated.

Ethical Consideration

The IRB was obtained before conducting the research. The questionnaire includes an introduction clarifying to the participants that it is anonymous to ensure privacy and confidentiality. Participation is voluntary; they can feel free not to answer any questions. Finally, their information will not be used for anything harmful to them.

Results

Table 1 shows that the sample consists of 405 nurses, most female (70.1%) and a significant proportion (28.9%) aged 23-29. More than half (56.6%) work in governmental hospitals, while the remainder are in private facilities. The majority (65.9%) hold a bachelor’s degree, though a smaller percentage have higher education, with 5.4% having a PhD and 16.3% holding a diploma. Many nurses (30.1%) have less than 1 year of experience. The most common position is professional nurse (34.8%),

followed by staff nurse (26.2%), while only 8.1 % are directors of nursing.

Table 1 also provides insights into violence occurrence and nurses' experiences reporting violence in healthcare settings. Violence is not confined to a specific time of day. Violence occurs almost equally across all shifts: morning (33.1%), afternoon (34.3%), and night (32.6%), indicating a constant risk. While most nurses (77.3%) agreed that they usually reported violent incidents, 22.7% still do not, which may indicate barriers such as fear of retaliation, lack of time, or perceived ineffectiveness of the process. Additionally, the majority of nurses (71%) identified that they reported the violent incident immediately once it happened, and over half (52.2%) described preferring to report the incident immediately after it happened. However, 36.4% waited for multiple occurrences before acting. A small minority (11.4%) delays reporting until violence becomes recurrent.

Table 2 illustrates that approximately two-thirds of nurses (64.5%) reported experiencing verbal or *physical violence* at least occasionally, indicating that this is a significant issue in healthcare environments. Approximately 10% reported frequent incidents. Additionally, 71.1% of participants reported they witnessed violent incidents against their colleagues. *regarding cultural violence*, 66.5% reported personal experiences of this form of violence, and similarly, nearly two-thirds (64.9%) of nurses witnessed cultural violence for their colleagues. Around 12.1% of respondents said they experienced frequent cultural incidents. For sexual violence, 59.8% of nurses reported experiencing sexual violence, and 60.3 % of their colleagues. About 13.6% of nurses said they had experienced common sexual violence incidents. *In terms of mental violence*, 65.9% of nurses reported experiencing mental, psychological, or emotional violence at least rarely, with 9.1% experiencing frequent incidents. In addition, 66.2% of them witness mental violence incidents against their colleagues.

The total score for the violence incidents for each participant was calculated and categorized as follows: Never (0), Rarely (1–8), Occasionally (9–16), and Frequently (17–24). **Table 3** indicates how frequently the participants have experienced incidents of violence. The most common category was "occasionally experienced violence" (49.4%), while "frequently experienced violence" was the least reported (7.4%). This pattern suggests that workplace violence is not an isolated or infrequent occurrence, but extreme or sustained violence is relatively less common. Across all categories, females consistently reported higher frequencies of violence except in the "frequently" category, where males and females reported equally. This highlights a potential gender disparity in the exposure to or perception of workplace violence. Younger participants (<30 years) dominated the "never," "rarely," and "occasionally" categories, indicating a higher vulnerability to workplace violence in this age group. The "frequently" category had a slightly higher representation of participants aged 30–45 years (4.2%), suggesting that middle-aged professionals may face more sustained or repeated exposure.

Table 1: Socio-demographic data, violence occurrence, and reporting patterns

		Frequency	%
1. Socio-demographic data			
Gender	Female	284	70.1%
	Male	121	29.9 %
Age	23- 29	117	28.9 %
	<23	109	26.9 %
	41-45	31	7.7 %
	30-35	77	19.0 %
	36-40	56	13.8 %
	>46	15	3.7 %
Hospital Type	Governmental Hospital	229	56.6 %
	Privat Hospital	176	43.4 %
Education Levels	PHD	22	5.4 %
	Master's degree	50	12.3 %
	Bachelor's degree	267	65.9 %
	Diploma	66	16.3 %
Year of Experiences	>20years	28	6.9 %
	16- 20 Years	32	7.9 %
	11-15 Years	67	16.5 %
	6- 10 Years	80	19.8 %
	1-5 Years	76	18.8 %
	6 months-<1year	122	30.1 %
Nurses Position	Director of Nursing	33	8.1 %
	Nurse supervisor or head nurse	59	14.6 %
	Professional nurse	141	34.8 %
	Staff Nurse	106	26.2 %
	Nursing Technician	66	16.3 %
2. Violence Occurrence and Reporting Patterns			
The most common time of violence	Morning	134	33.1 %
	Afternoon	139	34.3 %
	Night	132	32.6 %
Usually report violent incidents	Yes	313	77.3 %
	No	92	22.7 %
The usual time to report the incident	Immediately	277	71.0 %
	Later	113	29.0 %
How frequently do you report violent incidents	After 1 time	202	52.2 %
	2-3 times	141	36.4 %
	More than 3 times	44	11.4 %

Table 2: Nurses' frequent exposure to violence

	0 Never	1 Rarely (1-3 times)	2 Occasionally (4-6 times)	3 Frequently (≥7 times)	Mean	SD
I. Verbal or Physical violence						
1. How frequently have you experienced incidents of physical or verbal violence from patients, their family members, or others in the healthcare setting	144 (35.6%)	124 (30.6%)	97 (24%)	40 (9.9%)	1.08	0.993
2. How frequently have you witnessed incidents of physical or verbal violence directed at your colleagues by patients, their family members, or others in the healthcare setting?	117 (28.9%)	140 (34.6%)	111 (27.4%)	37 (9.1%)	1.17	0.95
II. **Cultural violence**						
3. How frequently have you experienced incidents of cultural violence from patients, their family members, or others in the healthcare setting?	136 (33.6%)	112 (27.7%)	112 (27.7%)	45 (11.1%)	1.16	1.016
4. How frequently have you witnessed incidents of cultural violence directed at **your colleagues** by patients, their family members, or others in the healthcare setting?	142 (35.1%)	109 (26.9%)	105 (25.9%)	49 (12.1%)	1.15	1.036
III. Sexual violence						
5. how frequently have you experienced incidents of sexual violence from patients, their family members, or others in the healthcare setting?	163 (40.2%)	91 (22.5%)	96 (23.7%)	55 (13.6%)	1.11	1.084
6. How frequently have you witnessed incidents of sexual violence directed at your colleagues by patients, their family members, or others in the healthcare setting?	161 (39.8%)	95 (23.5%)	102 (25.2%)	47 (11.6%)	1.09	1.053
IV. **Mental, Psychological, and Emotional Violence**						
7. How frequently have you experienced incidents of Mental, Psychological, and emotional violence from patients, their family members, or others in the healthcare setting?	138 (34.1%)	132 (32.6%)	98 (24.2%)	37 (9.1%)	1.08	0.971
8. How frequently have you witnessed incidents of Mental, Psychological, and emotional violence directed at your colleagues by patients, their family members, or others in the healthcare setting?	137 (33.8%)	136 (33.6%)	98 (24.2%)	34 (8.4%)	1.07	0.956

Table 3: Frequency of Violence Incidents Experienced by Participants Across Gender and Age Groups

Violence categories	Frequency	Gender	Frequency	Age	Frequency
Never	45 (11.1%)	female	38 (9.4%)	< 30	32 (7.9%)
		Male	7 (1.7%)	30-45	10 (2.5%)
				>46	3 (0.7%)
Rarely	130 (32.1%)	female	108 (26.7%)	< 30	81 (20.0%)
		Male	22 (5.4%)	30-45	45 (11.1%)
				>46	4 (1.0%)
Occasionally	200 (49.4%)	female	123 (30.4%)	< 30	104 (25.7%)
		Male	77 (19.0%)	30-45	92 (22.7%)
				>46	4 (1.0%)
Frequently	30 (7.4%)	female	15 (3.7%)	< 30	9 (2.2%)
		Male	15 (3.7%)	30-45	17 (4.2%)
				>46	4 (1.0%)
Total	405				

Table 4 indicates that there is a significant difference among demographic variables. Age group differences in violence responses are statistically significant (X^2=15.96, P=0.01). Participants aged 30–45 years were most likely to experience occasional violence (21/37, 0.6), while those under 23 years reported a higher proportion of never experiencing violence (24/61, 0.4). This suggests that middle-aged professionals may face greater workplace stress and violence exposure.

The years of experience significantly influence violence responses (X^2=28.73, P<0.01). Participants with 6 months to less than 1 year of experience reported the highest proportion of rare violence (89/307, 0.3) and occasional violence (6/37, 0.2). This indicates that less experienced nurses may be more vulnerable to workplace violence.

Significant differences exist across professional positions regarding violence responses (X^2=48.48, P<0.01). Professional nurses reported the highest proportion of occasional violence (13/37, 0.4), likely due to their frequent interactions with patients and families. Conversely, supervisory or managerial roles reported lower frequencies, indicating that hierarchical positions may provide some protection against direct exposure to violence.

Education level correlates significantly with violence responses (X^2=22.49, P<0.01). Nurses with bachelor's degrees reported the highest frequency of rare violence (210/307, 0.7). This trend may reflect the prevalence of bachelor's-trained nurses in patient-facing roles, increasing their exposure to workplace violence.

Table 4: Table Cross for Violence incidents and demographic data

	N	Never (N=61)	Rarely (N=307)	Occasionally (N=37)	Test Statistic
Gender: Male	405	0.1 9/61	0.3 97/307	0.4 15/37	**X22=9.10, P=0.01[2]**
Age	405				**X26=15.96, P=0.01[2]**
<23		0.4 24/61	0.3 80/307	0.1 5/37	
23- 29		0.2 15/61	0.3 94/307	0.2 8/37	
30-45		0.3 18/61	0.4 125/307	0.6 21/37	
>46		0.1 4/61	0.0 8/307	0.1 3/37	
Years of experience	405				**X210=28.73, P<0.01[2]**
11-15 Years		0.1 6/61	0.2 48/307	0.4 13/37	
1-5 Years		0.2 12/61	0.2 61/307	0.1 3/37	
6- 10 Years		0.1 8/61	0.2 65/307	0.2 7/37	
>20years		0.1 7/61	0.1 19/307	0.1 2/37	
6months-<1year		0.4 27/61	0.3 89/307	0.2 6/37	
16- 20 Years		0.0 1/61	0.1 25/307	0.2 6/37	
Position	405				**X28=48.48, P<0.01[2]**
Staff Nurse		0.5 33/61	0.2 70/307	0.1 3/37	
Nurse supervisor/ head nurse		0.1 6/61	0.1 45/307	0.2 8/37	
Professional nurse		0.1 9/61	0.4 119/307	0.4 13/37	
Director of Nursing		0.2 10/61	0.1 20/307	0.1 3/37	
Nursing Technician		0.0 3/61	0.2 53/307	0.3 10/37	
Education level	405				**X26=22.49, P<0.01[2]**
Master degree		0.1 6/61	0.1 34/307	0.3 10/37	
Bachelor degree		0.6 37/61	0.7 210/307	0.5 20/37	
Diploma		0.3 17/61	0.2 47/307	0.1 2/37	
PhD		0.0 1/61	0.1 16/307	0.1 5/37	

N is the number of non-missing values. [1]Kruskal-Wallis. [2]Pearson. [3]Wilcoxon.

Table 5 indicates that verbal violence is perceived as the most prevalent type of violence (65.7%), such as bullying, demeaning, frightening ,intimidating, screaming, or swearing. Sexual violence is seen as the least common violence (53.1%), such as Rape, fondling, molestation, improper touching, and inappropriate sexual language.

In all forms of violence, nurses agreed or strongly agreed that patients' relatives or friends are constantly recognized as the primary cause of violence (physical violence 62.2%, mental violence 55.8%, Cultural violence 52.4%, and sexual violence 49.9%) indicating a necessity for improved communication and conflict resolution measures within healthcare settings. Males are more often associated equally with three types of violence, which are mental/emotional (56.8%), sexual (57%), and cultural violence (57.5%). In contrast, females are slightly more associated with mental/emotional violence (61.5%).

A combined 55.8% of participants agreed that nurses are frequently subjected to workplace violence. While a majority agree, 44.2% of respondents either disagree or strongly disagree, indicating that not all healthcare professionals view nurses as the primary victims, perhaps due to varying experiences across settings or roles.

Table 5: Nurses' experience with violence (prevalence and performers of different types of violence in healthcare settings)

	1 Strong Disagree	2 Disagree	3 Agree	4 Strong Agree	Mean	SD
Which type of violence is the most commonly occurring?						
Verbal violence	60 (14.8%)	79 (19.5%)	**160** (39.5%)	**106** (26.2%)	**2.77**	1
Physical violence	67 (16.5%)	120 (29.6%)	145 (35.8%)	73 (18%)	2.55	0.97
Cultural violence	46 (11.4%)	123 (30.4%)	**172** (42.5%)	**64** (15.8%)	**2.63**	0.883
Sexual violence	75 (18.5%)	115 (28.4%)	151 (37.3%)	64 (15.8%)	2.50	0.969
Mental, Psychological, and Emotional Violence	69 (17%)	102 (25.2%)	155 (38.3%)	79 (19.5%)	2.6	0.986
Are patients' relatives/friends/watchers the primary cause of violence?						
Verbal or physical violence	44 (10.9%)	109 (26.9%)	**185** (45.7%)	**67** (16.5%)	**2.68**	0.876
Cultural violence	63 (15.6%)	130 (32.1%)	155 (38.3%)	57 (14.1%)	2.51	0.919
Sexual violence	75 (18.5%)	128 (31.6%)	142 (35.1%)	60 (14.8%)	2.46	0.958
Mental, Psychological, and Emotional Violence	57 (14.1%)	122 (30.1%)	**159** (39.3%)	**67** (16.5%)	**2.58**	0.926
Is a male most commonly committing any of this violence?						
Verbal or physical violence	65 (16%)	116 (28.6%)	159 (39.3%)	65 (16%)	2.55	0.944
Cultural violence	51 (12.6%)	121 (29.9%)	**166** (41%)	**67** (16.5%)	**2.61**	0.906
Sexual violence	74 (18.3%)	100 (24.7%)	**152** (37.5%)	**79** (19.5%)	**2.58**	1.001
Mental, Psychological, and Emotional Violence	59 (14.6%)	116 (28.6%)	**157** (38.8%)	**73** (18%)	**2.6**	0.945
Is a female most commonly committing any of this violence?						
Verbal or physical violence	75 (18.5%)	125 (30.9%)	145 (35.8%)	60 (14.8%)	2.47	0.958
Cultural violence	58 (14.3%)	117 (28.9%)	**164** (40.5%)	**66** (16.3%)	**2.59**	0.926
Sexual violence	71 (17.5%)	116 (28.6%)	148 (36.5%)	70 (17.3%)	2.54	0.973
Mental, Psychological, and Emotional Violence	53 (13.1%)	103 (25.4%)	**169** (41.7%)	**80** (19.8%)	**2.68**	0.936
Are nurses having the most incidents of violence against them?	62 (15.3%)	117 (28.9%)	154 (38%)	72 (17.8%)	2.58	0.952

Discussion

Violence in the workplace is a severe issue that impacts nurses all around the world. Nurses, patients and their families, hospitals, and the community are among the parties involved. Nurses are negatively impacted physically and emotionally by workplace violence. It has detrimental effects on patients and organizations, in addition to nurses. It is highly common for nurses to underreport WPV, which exacerbates the issue (1).

The results show that nurses encounter and observe a troubling number of different types of violence in healthcare environments. This highlights a crucial problem with important ramifications for patient care, professional performance, and occupational health. Ten percent of nurses said they frequently experienced verbal or physical aggression, while the majority said they did so at least occasionally. These results are consistent with a 2017 study carried out in Egypt that found that 65.7% of nurses, 45.3% of doctors, and 71.4% of coworkers are at an increased risk of workplace violence because of things like high levels of stress, long workdays, and patient-related aggression. (14) Likewise, 64% of nurses in South-East Asia had been exposed to WPV (15).

Significant amounts of cultural violence were also documented; around two-thirds of nurses reported having directly experienced it or seen its impact on colleagues. This type of violence undermines the equity and inclusivity of healthcare settings and may involve prejudice based on cultural background or ethnicity. Prior studies conducted in China (2019) have connected cultural violence to higher turnover intentions and lower job satisfaction among healthcare workers (16). The findings showed that WPV had a positive correlation with both job burnout ($r = 0.150$, $P < 0.01$) and turnover intention ($r = 0.238$, $P < 0.01$), It had a negative correlation with social support ($r = -0.077$, $P < 0.01$) and job satisfaction ($r = -0.228$, $P < 0.01$). The necessity for focused interventions, such as diversity training and the encouragement of inclusive workplace policies, is further highlighted by the frequency of cultural incidents (17).

Between 12% and 25% of nurses worldwide report experiencing sexual harassment, with regional differences. According to this study, sexual violence against coworkers is still a chronic and concerning problem, as reported by over half of nurses, with incidences involving nurses occurring frequently. In line with a 2020 study from Italy, which found that 53.4% of nurses experience sexual harassment at some point in their careers, this study emphasizes the need for more robust preventative measures and support networks. Sexual assault in healthcare settings has been linked to significant psychological distress, poorer job performance, and a reluctance to disclose events because of stigma or fear of reprisals, according to studies (18).

Mental violence was reported by frequent incidents & witnessed by approximately two-thirds of nurses, pointing to the prevalence of psychological stressors in healthcare. This form of violence, which may include bullying, harassment, or emotional abuse, has been linked to poor mental health outcomes, reduced teamwork, and compromised patient safety. This comes in agreement with a study conducted in Saudi Arabia (2022) reported that the nurses feel dejected and hopeless when they encounter patient aggression. (19,20)

Women frequently encounter greater rates of violence, especially verbal abuse, harassment, and physical aggression, as a result of their positions and cultural norms, according to gender differences in workplace violence in healthcare settings. Gender disparities may, however, lessen in severe violent occurrences, indicating that serious incidents are immune to sociocultural prejudices. (21,22)

Regarding gender disparities, this study found that, except for the "frequently" category, where male and female nurses reported similar exposure, female nurses reported higher rates of violence. Age and workplace violence have a statistically significant

connection (X2=15.96, P=0.01), which highlights the particular difficulties that each age group faces. Due to their greater representation in patient-facing roles and cultural norms that may encourage targeted aggression, women in healthcare are frequently more vulnerable to verbal abuse, harassment, and physical aggression in the workplace, according to a study conducted in Mozambique in 2022 (4,23). Due to the severity of the episodes surpassing sociocultural biases, extreme violence may not discriminate based on gender, as indicated by the parity in the "frequently" group.

Younger nurses (less than 30 years of age) reported higher rates of workplace violence in the "never," "rarely," and "occasionally" categories concerning years of experience, suggesting that early-career professionals are more vulnerable. These responses were statistically significantly influenced by violence (X^2=28.73, P<0.01). According to a previous study conducted in China in 2021, younger healthcare personnel may have a harder time handling violent situations or setting limits because of their inexperience and lower hierarchical position (24,25). The slightly greater percentage of middle-aged professionals (30–45 years old) in the "frequently" category, on the other hand, might be the result of accumulated workplace pressures or increased exposure as a result of their leadership roles and longevity.

Nurses reported the highest frequency of occasional violence (40%), which is likely attributed to their patient-facing responsibilities. This is consistent with earlier Taiwanese research from 2022 that found that healthcare workers, especially nurses, are more likely to experience workplace violence because of their interactions with patients and their families (26,27). Nurses frequently deal with emotionally sensitive situations, such as agitated patients and family members, which might turn violent.

On the other hand, those in management or supervisory positions reported less exposure to violence. Given that hierarchical occupations usually include less direct engagement with patients and their families, this finding might reflect the protective impact of such positions. Moreover, individuals in managerial positions often operate in environments with fewer opportunities for violent incidents, such as administrative offices, and may have more control over their work settings (5,28). These results highlight the necessity of specialized treatments to help frontline workers and the significance of job function in influencing exposure to workplace violence.

The relationship between workplace violence and educational attainment emphasizes the complexity of this problem even further. The largest percentage of rare violence was reported by bachelor's degree-holding nurses (70%). The greater percentage of nurses with bachelor's degrees working directly with patients may be the cause of this development, as it exposes them to more potentially violent situations. Furthermore, these results might suggest that more educated nurses are better able to defuse tensions, which would lessen the intensity and occurrence of violent incidents (29).

But the outcomes can also reflect larger shifts in the workforce. In order to prepare nurses for frontline positions, which include a higher level of risk by nature, bachelor's degree programs frequently emphasize clinical practice and patient relations (30). These findings highlight the necessity of improved education and support networks for nurses with bachelor's degrees to lessen the hazards brought on by their greater exposure to violence.

Conclusion:

The findings indicate significant associations between workplace violence and demographic factors such as age, years of experience, education level, and professional position. About two-thirds of nurses (66.4%) reported experiencing violence occasionally, with verbal violence identified as the most common form and sexual violence seen as the least common, indicating a significant issue in healthcare environments. Female nurses, younger

professionals, and those with less experience appear to be disproportionately vulnerable to workplace violence. Furthermore, nurses in patient-facing roles, such as staff nurses, reported higher exposure to violence compared to those in supervisory or managerial positions. Violence occurs almost equally across all shifts, with most nurses reporting violent incidents immediately. Nurses agreed that patients' relatives or friends are constantly recognized as the primary cause of violence, indicating a necessity for improved communication and conflict resolution measures within healthcare settings

Limitation

This study has several limitations. The reliance on self-reported data introduces potential recall bias and underreporting due to fear of judgment or retaliation. Additionally, the findings may not be generalizable to all healthcare settings, as the sample primarily consisted of nurses from specific institutions and depended on a convenience sample. Furthermore, certain contextual factors, such as institutional culture, leadership styles, or local community dynamics, were not explored, which may have influenced the results.

Recommendations:

Several recommendations are proposed to address workplace violence in healthcare settings. Hospitals should implement clear and anonymous reporting mechanisms and robust follow-up procedures to ensure nurses feel secure in reporting incidents without fear of retaliation. Regular training programs should be developed to equip nurses with skills for conflict resolution, de-escalation, and understanding the reporting process. To mitigate violence during understaffed shifts, healthcare facilities should increase nurse-to-patient ratios and deploy security personnel, particularly during afternoon and night shifts. Mental health support, including counselling and stress management resources, should be readily available to help nurses cope with the psychological impact of workplace violence. Strict zero-tolerance policies should be enforced, clearly communicating to patients and families that violence against healthcare workers will result in immediate action. Lastly, periodic assessments of workplace violence incidents and policy revisions are essential to adapt to emerging trends and ensure alignment with global best practices for nurse safety and patient care.

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