Work Place Violence and Quality of work Life among Nurses at Urban and Rural Health care setting

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ABSTRACT

Introduction, Workplace violence in the healthcare sector is a worldwide concern, with healthcare workers being at a high risk. On average, nurses are three times more at risk than other occupational groups to experience violence in the workplace. So, the aim of this study was concerned with 1-assessing of workplace violence among nurses at urban and rural health care setting 2- assessing of nurse's quality of life at urban and rural health care setting, 3-comparing workplace violence and quality of life between urban and rural health care setting. **Subject and methods** A descriptive comparative research design was used, study setting included Fayoum university hospital and Fayoum general hospital which representing rural, and Ain shams university hospital, ALazhr specialized hospital which representing urban setting, a total of (n122) sample size included supervisors, head nurses, and staff nurses. Data collection tools which used were Quality of Nursing Work Life and Work place violence self-administered questionnaire. **Results**, by comparison the result revealed that, there is a high significant difference related to work place, physical attacked, and verbally abused, also there is a high significant difference related to Safety measure and Work life/home life dimension. There is strong relation was found between nursing qualification and quality of work life total dimensions. **Conclusion:** the study answer research questions that, workplace violence affects nurses' quality of work life at both urban and rural health care setting. Also, a high significant difference related to gender, Work place, physical attacked, and verbally abused. There is strong relation between Safety measure and Work life/home life dimension. **Recommendation:** It is recommended that, prevention program held from strong commitment Administration, clear written program policy for job safety and securing which communicated to all personnel. And the need for a monitoring system is used to assess the effectiveness of prevention actions.

Keywords: Workplace violence, quality of life, urban and rural health care setting.

Introduction

Workplace violence in the health care sector may lead to poor quality of care, turnover and absenteeism of healthcare professionals, reducing health services available to the public, unhealthy work environment, improper societal behaviors, increasing health costs, and deterioration of staff health. Prevalence of workplace violence in healthcare settings remains unacceptably high. Workers in health care settings are at higher risk of verbal and physical abuse than any other occupational group **(Chen et al, 2015, and O'Brien et al, 2009).**

There are many definitions of workplace violence, with some defining it only in terms of actual or attempted physical assault, and others defining it as any behavior intended to harm workers or their organization. Given that non-physical abuse, such as verbal abuse and threats, can have severe psychological and career consequences, a broad definition of

workplace violence. WHO define of workplace violence as, "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation**" (National Crime Victimization Survey, 2013).**

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors. Homicide is currently the fourth-leading cause of fatal occupational injuries in the United States. **O'Brien et al, 2009).**

Many studies in recent years have investigated the impact or effect of violence on the individual as well as the organization. Future studies focusing on the individual need to incorporate the impact of violence on private life and the financial situation of victims. When considering the organizational effects of exposure to various forms of violence, more attention should be directed to cost implications. In addition, the cumulative effects of repeated violence on both individuals and organizations need addressing. Of interest is the impact beyond health impairment which may contribute to an organizational climate of fear **(Ryan, and Maguire, 2006).**

Research has identified factors that may increase the risk of violence for some workers at certain worksites. Such factors include exchanging money with the public and working with volatile, unstable people. Working alone or in isolated areas may also contribute to the potential for violence. Additionally, time of day and location of work, such as working late at night or in areas with high crime rates, are also risk factors that should be considered when addressing issues of workplace violence. Among those with higher-risk are workers who exchange money with the public, delivery drivers, healthcare professionals, public service workers, customer service agents, law enforcement personnel, and those who work alone or in small groups **(Crumpton and Michael, 2014).**

It was reported by **Namie, (2014)** that, in most workplaces where risk factors can be identified, the risk of assault can be prevented or minimized if employers take appropriate precautions. One of the best protections employers can offer their workers is to establish a zero-tolerance policy toward workplace violence. This policy should cover all workers, patients, clients, visitors, contractors, and anyone else who may meet company personnel. Violence at work has become an alarming phenomenon worldwide. The real size of the problem is largely unknown and recent surveys show that current figures represent only the tip of the iceberg. Being alert to these behaviors and their risk factors may help nurses predict that an incident of workplace violence is likely to occur. While the existence of physical violence at the workplace has been always recognized, the existence of psychological violence has been long underestimated and is only now receiving due attention.

Psychological violence is currently emerging as a priority concern at the workplace leading to a new awareness and re-evaluation of the importance of all psychological risks at work. Additionally Sexual harassment the unwanted conduct that is perceived by the victims as placing conditions of a sexual nature on their employment, or that might, on reasonable grounds, be perceived by the victims as an offence, a humiliation or a threat to their well-being **(Almalki, FitzGerald and Clark, ,2012).**

The success of any organization is highly dependent on how it attracts recruits, motivates and retains its workforce. Today's organizations need to be more flexible so that they are equipped to develop their workforce. Therefore, organizations are required to adopt a strategy that improves the employees' quality of work life (QWL) to satisfy both the organizational objectives and employee needs. The term QWL refers to the philosophy or a set of principles, which holds that people are trustworthy, responsible and capable of making a valuable contribution to their organization **(Kashani, 2012).**

Quality of work life is the extent to which an employee is satisfied with personal and working needs through participating in the workplace while achieving the goals of the organization. Quality of work life has been found to influence the commitment and productivity of employees in health care organizations, as well as in other industries. However, reliable information on the QWL of primary health care (PHC) nurses is limited (**Mosadeghrad, 2013).** Quality of work life is defined as "the degree to which registered nurses can satisfy important personal needs through their experiences in their work organization while achieving the organization's goals". Therefore, the concept of employee satisfaction is about more than simply providing people with a job and a salary. It is about providing people with a place where they feel accepted, wanted and appreciated **(Khani, Jaafarpour, and Dyrekv and mogadam, (2008).**

Quality of work life is influenced by many factors such as salary, personality, occupational accidents, occupational stress, safety regulations and labor discipline, work setting health conditions, welfare facilities and job prospects. Thus, changes in any of these factors may affect the QWL and influences the performance and commitment of employees in various industries, including health care organizations **(Esmaeilpour; Salsali, and Ahmadi, 2011).** According to **(Kashani, 2012)** a happy employee is productive, dedicated and committed. On the other hand, failure to manage these factors can have a major impact on employee behavioral responses.

Reviewing previous studies of Quality of work life identified differing numbers of factors that have an impact on the QWL of nurses. One such factor was the lack of work-life balance. Rotating schedules were found to negatively affect their lives so they were unable to balance work with family needs. Additionally, nurses thought on-site child care and day care for the elderly were important for their QWL **(Canarino**, et **al, 2008**]. The nature of nursing work was another factor that affects the QWL of nurses. The results of existing studies on the QWL of nurses indicated dissatisfaction of nurses in terms of heavy workload, poor staffing, and lack of autonomy to make patient care decisions, and performing non-nursing tasks (El-**Gilany, El-Wehady, and Amr, 2010**).

Another factor that influences the Quality of work life of nurses is the work context, including management practices. Potential sources of dissatisfaction with management practices include lack of participation in decisions made by the nurse manager, lack of recognition for their accomplishments, and lack of respect by the upper management (**Abbas et al., 2010**). External factors such as salary and the image of nursing were of concern in the literature regarding the QWL of nurses, and were reported sources of dissatisfaction for nurses in various organizations and countries. **El-Gilany; El-wehady, and Amer, (2010)** found that extrinsic predictors of QWL such as pay and financial benefits explained 40% of the variance in QWL satisfaction.

Justification of the study:

Today, there is an increased evidence that nursing staff is at such a high risk of

exposure to violent behaviors in the workplace; it is now considered to be a major occupational hazard worldwide. The prevalence of verbal abuse and physical abuse in Hong Kong hospitals was 73% and 18% respectively, indicating that workplace violence against nurses is a significant problem in Hong Kong. **(Moustafa& Gewaifel, 2013)** Also there is a Previous study was conducted in 2009 among 416 randomly selected nurses in obstetrics and gynecology departments in 8 hospitals in Cairo, Egypt the results revealed that most of, many of nurses (86.1%) had been exposed to workplace violence **(Samir, Mohamed, Moustafa and Abou Saif. 2012).** So, researchers had emphasis on the need for investigating workplace violence at rural comparing with urban setting to clarify effect of workplace violence on the quality of nurse's work life.

Aim of the study:

This study aimed to assess the relation between Workplace violence and QWL through:

1- Assessing the quality of work life among nurses

2- Determining factors contributing to work place violence as perceived by nurses

3- Finding the relation between workplace Violence and quality of work life among nurses.

Subjects and Methods

Research design:

A descriptive comparative study design was utilized in carrying out the study, where all the variables were collected at the same point in time.

Research Question

- Is there difference between rural, urban workplace violence and nurses‘ quality of work life?, - Does workplace violence affect nurses‘quality of work life?

Setting:

The study was conducted at Fayoum university hospital and Fayoum general hospital which representing rural setting, Ain Shams university hospitals and Alazhr specialized hospital which representing urban setting.

Study subject

A total of 122 nurses (66 from urban setting and 56 from rural setting) included supervisors, head nurses, and staff nurses who working in the pre-mentioned hospitals were eligible for inclusion in the study with the only inclusion criterion of working full time in the study setting during the time of the study and no less than one year of experience

Sampling and data collection

Sample size:

The study sample consisted of (122) nurses. The nurses were recruited consecutively using a simple random sampling technique. The sample included nurses from medical (30), surgical (33), emergency (15) departments and intensive care (34) units.

Instrument:

A Self-Administered Questionnaire was used in this study, it includes two parts: 1-***Quality of nursing work Life*** and ***2-Work place violence***. The first part was ***Quality of Nursing Work Life*** self-administered questionnaire sheets that include two sections as follows. **The first** section included nurse's

demographic characteristics such as age, marital status, qualification, experience, etc. **The second** section included ***Quality of Nursing Work Life Scale:*** it is standardized scale used to assess the quality of nursing work life, developed by **Brooks, (2001).** It has 42 questions categorized into four dimensions. The work/home life dimension consisted of 7 items such as balancing work and family needs arranging child care while at work, and hospital policy offering child care. The work design dimension included 10 items such as feeling job satisfaction, having enough time to do the job efficiently, and having enough staff at work., the work context dimension had 20 items such as supervisor providing efficient supervision, opportunities for self-development at work, communication with other care providers, having comfortable room for nurses, and having the chance to continue study through work. The last dimension of work world consisted of 5 items such as salary being suitable to job, and feeling own work influences patients live and their families.

The second part was ***Work place violence*** self-administered questionnaire sheets which used to assess the work place violence, this part was adopted from ***WHO* (2003)** and modified by the researchers. It consisted of (71) questions categorized into four dimensions physical work place violence consisted of 16 items, psychological work place violence 1- verbal abuse consisted of 16 items, 2- bulling abuse consisted of 16 items, and 3- sexual abuse consisted of 16 items, health sector employer consisted of 4 items, and opinions on work place violence consisted of 13 items.

Scoring system:

The quality of work life response for each of the items is on a five point Likert type scale: "agree," and "disagree," and the responses "strongly agree," "and "strongly disagree" in each section were scored 5 to 1 respectively. The scores of each dimension were summed up and then converted into a percent score. while work place violence response for each of the items is on a four point Likert type scale: "very," "moderate," "little" "and "not at all" in safety measures section were scored 4 to 1 respectively.

Tool validity

The tools were judged by a jury group consists of five experts, their opinions were regarding the tools format, layout, parts, and the clarity of the words of the statements, minor modifications were done.

Pilot study

A pilot study was conducted on 10% of nurses (19 nurses) from different departments to assess the clarity off the questions. The tool was finalized based on the results of the pilot. The subjects who participated in the pilot study were not included in the main study sample.

Fieldwork

The fieldwork was started after finalization of the data collection tool; the data collection was done during the period of October 2014 to January 2015. The researcher met with the director and heads of departments of the selected settings, with official letters indicating the purpose of the study, and its rationale, their permissions were obtained to start the data collection process. A meeting with nurses was held to explained purpose of the study and procedure of filling to them. A total of 240 questionnaires were distributed among working nurses at pre-mentioned hospitals, a total of (192) questionnaires were collected resulting in an overall (80%) response rate. By reviewing the return responses total of (122) questionnaires were completed and 70 of incomplete questionnaires were excluded.

Ethical considerations

Approval were obtained from faculty of nursing ethical committee, the aim of the study was explained to staff nurse, with emphasis on the confidentiality of any obtained information. A verbal consent was secured from each subject after explanation of the rights to refuse participation Ethical approval for this study was obtained from the university's administrators of the hospitals. The questionnaires had an introductory section explaining the purpose of the study, the freedom of choice to fill the questionnaire, and assurance of anonymity of respondents.

Statistical analysis

Data entry and statistical analysis were done using SPSS 16.0 statistical software package. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variables, and means and standard deviations for quantitative variables. Qualitative categorical variables were compared using chi-square test, and ANOVA test. Statistical significance was considered at p-value <0.05.

Results

Demographic data indicates that the age of the nurses in the study sample ranged between 19 and 50 years with mean 9.7 years, 83.33% of the nurses were married in urban and 64.29% in rural, about 21.21% of urban sample were having a bachelor degree while 37.50 of rural, 17.4% of them were head nurses. Their experience ranged between less than one year and 35 years, with mean 8.7 years. The study result was presented all the significant as following

Table (1): Demographic Comparison between Urban and Rural Setting of study sample (n=122)

Demographic		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Gender	**Male**	11	16.67	20	35.71	5.799	<0.016*
	Female	55	83.33	36	64.29		
Work place	**Neonate unit**	2	3.03	10	17.86	25.115	<0.001*
	ICU	19	28.79	11	19.64		
	ER	16	24.24	26	46.43		
	Medical surgery unit	11	16.67	8	14.29		
	Obestric unit	2	3.03	0	0.00		
	Dialysis unit	8	12.12	1	1.79		
	ALL	8	12.12	0	0.00		
	No	1	1.52	1	1.79		
patients most frequently work with	**Children**	3	4.55	17	30.36	33.890	<0.001*
	Adolescents	3	4.55	1	1.79		
	Elderly	39	59.09	27	48.21		
	Adults	21	31.82	3	5.36		
patients sexes most frequently work with	**Male**	5	7.58	8	14.29	7.167	<0.028*
	Female	2	3.03	8	14.29		
	Male and Female	59	89.39	40	71.43		

Table (1): by Comparing the Demographic between Urban and Rural Setting of study sample table shows that, there is a high significant difference related to gender (5.799,P<0.016*), Work place (25.115,P<0.001*), patients most frequently work with (33.890,P<0.001*), and patients sexes most frequently work with (7.167,P<0.028*).

Table (2): Comparison between Urban and Rural Setting related to physical work place violence of study sample (n=122)

Physical Workplace Violence		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Have you been physically attacked in your workplace?	Yes	4	6.06	26	46.43	26.623	<0.001*
	No	62	93.94	30	53.57		
Attacked person	Patient/client	0	0.00	3	11.54	9.870	<0.043*
	Relatives of patient/client	2	50.00	21	80.77		
	Staff member	1	25.00	1	3.85		
	External colleague/worker	1	25.00	0	0.00		
	Public	0	0.00	1	3.85		
Action taken to investigate the causes of the incident?	Management / employer	3	75.00	6	23.08	8.365	<0.039*
	Union " association "	0	0.00	17	65.38		
	Police	0	0.00	2	7.69		
	Other	1	25.00	1	3.85		
The consequences taken for the attacker	None	1	25.00	12	46.15	15.089	<0.002*
	Care discontinued	0	0.00	10	38.46		
	Reported to police	1	25.00	4	15.38		
	Don't know	2	50.00	0	0.00		
Causes of not reported the incident	It was not important	0	0.00	6	23.08	15.165	<0.002*
	Afraid of negative consequences	4	100.00	3	11.54		
	Useless	0	0.00	16	61.54		
	Did not know who to report to	0	0.00	1	3.85		
	No	3	75.00	22	84.62		

Table (2): by Comparing Physical Workplace Violence between Urban and Rural Setting of study sample table shows that, there is a high significant difference related to physical attacked (26.623, P<0.001*), attacked person (9.870, P<0.043*), investigated taken action (8.365, P<0.039*), the consequences for the attacker (15.089, P<0.002*), and did not report (15.165, P<0.002*).

Table (3): Comparison between Urban and Rural Setting related to verbal abuse violence of study sample (n=122)

Verbal abuse		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Have you been abused in your workplace?	Yes	22	33.33	47	83.93	31.564	<0.001*
	No	44	66.67	9	16.07		
	Sometimes	7	31.82	21	44.68		
	Once	8	36.36	6	12.77		
Who verbally abused you?	Patient/client	7	31.82	8	17.02	10.012	<0.040*
	Relatives of patient/client	10	45.45	35	74.47		
	Staff member	4	18.18	1	2.13		
	Management / supervisor	1	4.55	1	2.13		
	External colleague/worker	0	0.00	2	4.26		
Do you consider this to be a typical incident of verbal abuse in your workplace?	Yes	13	59.09	40	85.11	5.694	<0.017*
	No	9	40.91	7	14.89		
	Afraid of negative consequences	5	22.73	6	12.77		
	Useless	9	40.91	18	38.30		
	Did not know who to report to	2	9.09	2	4.26		

Table (3): by Comparing verbal abuse Violence between Urban and Rural Setting of study sample table shows that, there is a high significant difference related to verbally abused (31.564, P<0.001*), verbally abused person (10.012, P<0.040*), and consider this to be a typical incident of verbal abuse (5.694, P<0.017*).

Table (4): Comparison between urban and rural regarding presence of safety measures to deal with violence (n= 122)

Items		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Special equipment or clothing	Yes	34	51.52	39	69.64	4.142	<0.042*
	No	32	48.48	17	30.36		
Changed shifts	Yes	30	45.45	36	64.29	4.326	<0.038*
	No	36	54.55	20	35.71		
Reduced periods of working alone	Yes	34	51.52	26	46.43	0.314	0.575
	No	32	48.48	30	53.57		
Training	Yes	36	54.55	13	23.21	12.374	<0.001*
	No	30	45.45	43	76.79		
Investment in human resource development	Yes	28	42.42	12	21.43	6.060	<0.014*
	No	38	57.58	44	78.57		
	No	53	80.30	44	78.57		

Table (4) Shows comparison between urban and rural regarding safety measures to deal with violence table demonstrates that, there is a high significant difference ($p<0.001$*) related to Training, meanwhile a significant difference ($p<0.014$*) related to Investment in human resource development, Changed shifts ($p<0.038$*), and Special equipment ($p<0.042$*) items.

Table (5): Comparison between urban and rural regarding presence of safety measures to deal with violence (n= 122) (cont.)

		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
workplace changes occurrence	**None " restructuring / reorganization**	55	83.33	53	94.64	4.534	0.209
	Staff cuts " increased staff numbers	5	7.58	2	3.57		
	Restriction of resources " additional resources	3	4.55	1	1.79		
	Other	3	4.55	0	0.00		
impact of changes on work	**None**	47	71.21	38	67.86	14.854	0.005*
	Worsened	1	1.52	5	8.93		
	Improved	7	10.61	1	1.79		
	patients/clients worsened	2	3.03	9	16.07		
	patients/clients improved	9	13.64	3	5.36		

Table (5) Shows comparison between urban and rural regarding safety measures to deal with violence table demonstrates that, there is significant difference ($p<0.005$*) related to impact of changes on work.

Table (6): Comparison between urban and rural regarding study sample opinion of safety measures to deal with violence (n= 122)

opinion of safety measure items		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Restrict exchange of money at the workplace	**Very**	31	46.97	14	25.00	13.062	0.005*
	Moderate	14	21.21	14	25.00		
	Little	11	16.67	5	8.93		
	Seldom	10	15.15	23	41.07		
Increased staff numbers	**Very**	24	36.36	9	16.07	8.475	0.037*
	Moderate	28	42.42	31	55.36		
	Little	5	7.58	10	17.86		
	Seldom	9	13.64	6	10.71		
Check-in procedures for staff	**Very**	31	46.97	10	17.86	12.266	0.007*
	Moderate	26	39.39	30	53.57		
	Little	5	7.58	9	16.07		
	Seldom	4	6.06	7	12.50		
Reduced periods of working alone	**Very**	21	31.82	6	10.71	20.946	<0.001*
	Moderate	21	31.82	11	19.64		
	Little	11	16.67	6	10.71		
	Seldom	13	19.70	33	58.93		
Training	**Very**	31	46.97	6	10.71	37.579	<0.001*
	Moderate	17	25.76	11	19.64		
	Little	13	19.70	8	14.29		
	Seldom	5	7.58	31	55.36		

Table (6) Shows comparison between urban and rural regarding study sample opinion **of** safety measures to deal with violence table demonstrates that, there is a high (P<0.001*) related to reduced periods of working alone and training, as significant difference (p<0.005*) related to restrict exchange of money at the workplace.

Table (7): Comparison between urban and rural regarding Work life/home life dimension (n= 122)

1- Work life/home life dimension		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Policy for vacations is appropriate for me and for my family	**Strong Agree**	20	30.30	6	10.71	11.431	<0.022*
	Agree	18	27.27	18	32.14		
	Sometime	18	27.27	24	42.86		
	Disagree	7	10.61	2	3.57		
	Strong Disagree	3	4.55	6	10.71		
Important to have support for taking care of elderly parents	**Strong Agree**	18	27.27	4	7.14	9.930	<0.042*
	Agree	14	21.21	10	17.86		
	Sometime	15	22.73	17	30.36		
	Disagree	14	21.21	17	30.36		
	Strong Disagree	5	7.58	8	14.29		
Important to have on-site ill Child car**e**	**Strong Agree**	14	21.21	6	10.71	10.826	<0.029*
	Agree	18	27.27	14	25.00		
	Sometime	18	27.27	25	44.64		
	Disagree	12	18.18	3	5.36		
	Strong Disagree	4	6.06	8	14.29		

Table (7): shows comparison between urban and rural regarding Work life/home life dimension table clarify that, there is significant difference (P<0.022*) related to Policy for vacations is appropriate for me and for my family, important to have support for taking care of elderly parents (P<0.042*) related and Important to have on-site ill Child car (P<0.029*).

Table (8): Comparison between urban and rural regarding Work design dimension (n= 122)

Work design dimension		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Enough time to do jobs	**Strong Agree**	23	34.85	9	16.07	10.175	0.038*
	Agree	24	36.36	22	39.29		
	Sometime	15	22.73	13	23.21		
	Disagree	4	6.06	10	17.86		
	Strong Disagree	0	0.00	2	3.57		
Recognition of accomplishments	**Strong Agree**	31	46.97	17	30.36	10.275	0.036*
	Agree	23	34.85	29	51.79		
	Sometime	9	13.64	7	12.50		
	Disagree	3	4.55	0	0.00		
	Strong Disagree	0	0.00	3	5.36		

Table (8): shows comparison between urban and rural regarding Work design dimension table clarify that, there is significant difference (P<0.038*) related to enough time to do jobs and (P<0.036*) related to recognition of accomplishments.

Table (9): Comparison between urban and rural regarding Work world design dimension (n= 122)

Work world design		Groups				Chi-Square	
		Urban		Rural			
		N	%	N	%	X^2	P-value
Job is secure	**Strong Agree**	15	22.73	2	3.57	19.210	0.001*
	Agree	9	13.64	18	32.14		
	Sometime	8	12.12	15	26.79		
	Disagree	10	15.15	10	17.86		
	Strong Disagree	24	36.36	11	19.64		
Nursing work positively impacts lives of others	**Strong Agree**	21	31.82	9	16.07	9.576	0.048*
	Agree	19	28.79	13	23.21		
	Sometime	15	22.73	20	35.71		
	Disagree	3	4.55	9	16.07		
	Strong Disagree	8	12.12	5	8.93		

Table (9): shows comparison between urban and rural regarding Work world design dimension table clarify that, there is a high significant difference (P<0.001*) related to Job is secure and significant difference (P<0.001*) related to Nursing work positively impacts lives of others.

Table (10): Relation between safety measure and quality of work life dimension urban and rural (n= 122)

Items	Groups						T-Test	
	Urban			Rural				
	Mean	±	SD	Mean	±	SD	T	P-value
Safety measure	33.227	±	7.189	28.696	±	6.281	3.674	<0.001*
Work life/home life dimension	24.924	±	5.816	22.625	±	5.324	2.262	<0.026*
Work design dimension	38.167	±	5.822	36.643	±	5.435	1.485	0.140
Work context design	77.152	±	15.566	75.964	±	13.454	0.446	0.656
Work world design	16.636	±	5.267	16.357	±	3.700	0.333	0.740

Table (10): demonstrates relation between safety measure and quality of work life dimension urban and rural table revealed that, there is a high significant difference (P<0.001*) related to Safety measure and Work life/home life dimension (P<0.026*).

Table (11): Relation between Demographic and quality of work life total dimensions (n= 122)

Demographic		Total dimension				T-Test or ANOVA	
		N	Mean	±	SD	T or F	P-value
Gender	**Male**	31	160.387	±	20.709	1.479	0.142
	Female	91	152.429	±	27.393		
Marital status	**Single**	59	154.424	±	23.021	1.295	0.278
	Married	60	153.300	±	28.647		
	Divorce	3	178.000	±	21.932		
Nursing qualification	**Diploma**	39	161.333	±	26.423	4.902	< 0.009*
	Technical institute	53	156.113	±	25.100		
	Bachelor or higher	30	142.567	±	23.738		
Work Experience years	**Under 1 Year**	29	152.034	±	27.658	0.982	0.432
	1-5 Years	55	154.127	±	24.670		
	6-10 Years	19	152.632	±	27.269		
	11-15 Years	7	155.857	±	14.960		
	16-20 Years	4	145.500	±	25.093		
	Over 20 Years	8	173.000	±	33.032		
Position	**Bedside nurse**	100	154.090	±	24.069	0.158	0.854
	Supervisor nurse	20	156.900	±	34.972		
	Director nurse	2	148.000	±	32.527		
Work place	**Neonate unit**	12	147.500	±	31.828	0.762	0.601
	ICU	30	154.133	±	27.963		
	ER	42	154.143	±	22.409		
	Medical surgery unit	19	161.105	±	25.807		
	Obestric unit	2	126.500	±	6.364		
	Dialysis unit	9	154.667	±	28.909		
	ALL	8	158.625	±	28.309		

Table (11): demonstrates relation between demographic and quality of work life total dimensions table revealed that, there is a high significant difference (P<0.009*) related to nursing qualification.

Discussion

Nurses as the major group of health service providers need to have a satisfactory quality of work life to give desirable care to the patients. Workplace violence is one of the most important factors that cause decline in the quality of work life. This study was aimed 1-assessing of workplace violence among nurses at urban and rural health care setting 2- assessing of nurse's quality of life at urban and rural health care setting, 3-comparing workplace violence and quality of life between urban and rural health care setting. The study results demonstrated that most of the study sample were female and almost one quarter of them were from emergency in urban settings the study revealed that, less than half of the nurses were physically abused in the rural settings, wherever less than tenth from the urban , at the same time the most of the patients that the nurse had worked with were elderly people and were from both sexes in both settings.

These study findings revealed that many of the nurses were attacked by relatives of the clients in rural settings and half in urban. This finding disagrees with other studies as **Canarino, (2008)**, who found that the major sources of workplace violence was patients themselves followed by relatives, also the

study revealed that, most of, nurses were verbally abused in rural settings this in some bit of similarity with **Moustafa& Gewaifel, (2013)** who stated that, about three quarter of registered nurses were exposed to verbal violence. While, less than half of the study sample in urban settings were verbally abused in this study.

The results revealed that, the action taken for the incidence were three quarter from management and more than two third from union association (police) but in the same time half of study sample in urban settings didn't know if there is any action taken or not and on the other side less than half of them from rural settings stated that no consequences had been taken, however two third of study sample didn't report the incidence to others because it would be useless. Therefore **Martino, (2007)** stated in his designed guidelines that the work place policies should make it clear that management will not tolerate any activity deliberately designed to humiliate or embarrass other workers.

The study results demonstrated that three quarter of nurses in rural settings hadn't received any training programs relating to the work place violence The study results demonstrated that, the management of their settings didn't take any action towards any incident, whereas **Namie, (2014)** who specified that, the management of the health sectors must take many actions to prevent any type of violence such as their awareness be on the potential of violence and steps that can be taken to lessen the possibilities of an incident as code of conduction of employees assistance program. Also, the study results showed that, there no any Investment in human resource development in both urban and rural settings.

Safety measures help keep every employee in the work place safe from violence and harm, this in congruence with the nurse's opinions regarding the safety and security measures such as restriction exchange of money, reduced periods of working alone also is one of the risk factors, in the same time as perceived by the study sample that the staff numbers should be increased.

Improving the quality of the work life of the nurses simultaneously improving the overall productivity of the organization, the findings of this study revealed that the vacations policy was important both in urban and rural settings, this in dissimilarity with **Almalky, (2012)** who stated that, many of the respondents in primary health care reported their needs to have on-site child care services for sick children during work hours. Another potential source of dissatisfaction with management practices include lack of participation in decisions and, lack of recognition for their accomplishments, this in similarity with these finding results which revealed that, more than half in rural and less than half of nurses in urban setting had agreed on the importance of recognition for their accomplishments. Furthermore, safety measures are in significant relation with the work life in both settings among the two groups.

Understandably, experiencing violence has a negative impact on job satisfaction and performance. Moreover, violence at hospitals can lead to shortage of health care workers and undermine the quality of health care services. Because of experiencing abuse in the workplace, a nurse may decide to relocate within a facility to another health care facility, or may leave nursing altogether. Furthermore, these result findings revealed that 32.14% in rural settings agreed with job secure.

Conclusion

Based on the study finding it can be concluded that, workplace violence negatively affects nurses‘ quality of work life at both urban and rural health care setting

which answered the research question. Also, a high significant difference related to gender, work place, physical attacked, and verbally abused, there is strong relation between Safety measure and quality of work life dimensions, and finally strong relation between nursing qualification and quality of work life total dimensions. The need for conducting training programs related all types of violence to deal with.

Recommendation:

These results finding recommended that:

1- The need for a monitoring system which assesses the numbers, types and severity of violence and injuries within the work place, and which can be used to assess the effectiveness of prevention actions.

2- Prevention program held by strong commitment administration and clear written program policy for job safety and security.

3- Consider the family aspect of their nurses. Childcare facilities, support for nurses who have elderly parents, convenient working hours, and sufficient vacations should be made available for nurses. These advantages will help nurses to balance work with their family requirements.

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