Original Article

Exploring the Factors Related to Workplace Violence among Nurses in Two Districts of Aceh Province

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ABSTRACT

OBJECTIVE: To investigate how the demographics of nurses, the organizational culture within their workplaces, and the incidence of workplace violence are interrelated.

METHODOLOGY: With a cross-sectional design, this quantitative research study encompasses hospital nurses in Aceh Besar and Banda Aceh and is registered with the Regional Representative Council of the INNA. A total of 203 respondents were selected utilizing the Cohen Formula with a snowball sampling method. The data was collected through a questionnaire consisting of three parts: respondent demographics, a scale of workplace violence experienced by nurses, and organizational culture.

RESULTS: This study examines the correlation between various demographics and employment - including gender, age, education, employment status, monthly income, marital status, employment status, type of hospital, and area of work - with the incidents of workplace violence in Aceh Besar and Banda Aceh. The findings indicate significant associations between nurse's demographic characteristics and workplace violence, particularly in hospital environments ($p = 0.042$) and specific work areas ($p < 0.001$). Other demographic factors and organizational culture (0.701) did not significantly correlate.

CONCLUSION: This study examines WPV prevalence among nursing staff in Aceh Besar and Banda Aceh hospitals. It highlights that underreporting and misconceptions contribute to lower reported incidence rates. Findings show WPV rates depend on the work environment and hospital type, aligning with literature on high-stress jobs. Although organizational culture may indirectly affect WPV, this study recommends improved reporting mechanisms and communication training to create safer workplaces.

KEYWORDS: Violence, Nurses, Hospital Setting, Harassment, Nursing Profession

INTRODUCTION

The issue of workplace violence (WPV) against healthcare workers is a growing concern. Healthcare workers are particularly vulnerable to experiencing violence in their workplaces. The prevalence of WPV varies across different countries and work settings, making it challenging to compare studies due to differences in research methodologies and questionnaires used[1]. A recent comprehensive review addressing WPV against nurses in various regions revealed that, on average, 31.8% of nurses experienced physical violence, 62.8% endured non-physical violence, 47.6% reported bullying, and 17.9% faced sexual harassment[2]. This type of violence has a considerable impact on the physical and mental well-being of the majority of nurses[3].

Research conducted in the past indicates that WPV has a significant impact on the sleep quality and psychological well-being of healthcare professionals[4]. Common emotional responses to such violence include feelings of sadness and anger. Specifically, violence directed towards nurses has been linked to higher rates of absenteeism, personal and professional life disruption, increased stress levels, errors in administrative trust, and elevated levels of staff burnout and turnover. These consequences ultimately affect the quality of healthcare services[5–7].

Understanding WPV impacts on nurses requires consideration of various demographic factors [8]. This study identifies critical variables that highlight vulnerable populations and contributing factors. Gender is significant, with male nurses facing more physical aggression while female nurses encounter more non-physical harassment[9,10]. Age also matters, as younger, less experienced nurses are more at risk for WPV due to limited conflict management skills[11]. Educational attainment influences responses to WPV; higher education may correlate with better violence management skills[12]. Employment status complicates dynamics, with full-time nurses experiencing greater WPV exposure [3]. Socioeconomic factors, like income, affect resilience and stress tolerance in handling WPV incidents. Marital status is relevant as married nurses may face additional stressors impacting their mental health resilience post-WPV[13]. Duration of employment is essential; newly employed nurses are more susceptible to WPV risks due to inexperience[13]. Additionally, the type of hospital, including public versus private and specialized versus general settings, shows differing WPV rates. Finally, specific hospital areas, especially high-stress environments like emergency rooms or psychiatric units, correlate

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with higher WPV rates due to patient acuity and stress levels[14].

In hospitals, instances of WPV experienced by nurses are often left unaddressed by the nurses themselves and hospital management[5]. Two primary factors contribute to WPV, particularly in hospital settings. Internally, these include the severity of patients' illnesses, high patient volumes, and inadequate facilities and infrastructure in health services, such as poor lighting, unsafe hospital access, a shortage of security staff, and insufficient human resources. Externally, factors include a culture that tacitly or overtly endorses violent behavior, ready access to weapons in the community, and a high local crime rate[15].

The latest statistics reveal that 600 health workers have endured physical and mental violence during the COVID-19 pandemic, with a particularly distressing case reported at Siloam Brawijaya Hospital Palembang [16]. Incidents of violence against health workers in Aceh, particularly during armed conflicts, remain worryingly frequent. A 2019 report indicated that officials in Aceh Province were suspected of committing acts of violence against nurses at hospitals[17]. Furthermore, INNA Chairman Harif Fadhillah noted 7-8 cases of violence against nurses in Indonesia between 2020 and 2021[3], carried out by individuals from various segments of society, including local government officials[16]. Given these trends, the researcher explores the "Factors related to the Incidence of WPV in Hospital Nurses in Aceh Besar and Banda Aceh, Aceh."

METHODOLOGY

Study Design, Population, and Sample

This study utilizes a quantitative, cross-sectional research design [18]. This study focuses on the population of hospital nurses registered with the Regional Representative Council of the Indonesian National Nurses Association (DPD-PPNI) in Aceh Besar and Banda Aceh. The sample size of 203 respondents is calculated using Cohen's formula [19]: N = 19.76 / 0.1 + 5 + 1, rounded to 203.

The sampling method was snowball sampling [18]. The study identifies nurses in Aceh Besar and Banda Aceh hospitals who meet inclusion criteria. Initial contacts, or "seeds," are chosen via direct contact or hospital administrations. These nurses will refer colleagues familiar with WPV, a sensitive issue often underreported. Referrals help involve trusted individuals, potentially increasing reluctant participation. A non-probability technique in which existing study subjects recruit future subjects from among their acquaintances. The inclusion criteria specified that the target group consisted of registered nurses in the DPD PPNI Regency/City, nurses with hospital work areas, and individuals who demonstrated their willingness to participate as respondents. Data were collected from June 1 to June 21, 2024.

Instrument

The data collection tool comprises three parts of the questionnaire, each carefully developed, adapted from a standard questionnaire, or modified from existing ones.

Part A aims to identify the characteristics of the respondents and their workplaces, including age, gender, religion, ethnicity, marital status, employment status, workplace institution, and work experience. The choice of answers varies according to the type of question item.

Part B, in the form of a questionnaire on the scale of WPV in nurses, was developed and modified based on research[20]. This questionnaire consists of 5 question items with a choice of answers to violent incidents with a score of 0, "1-2 times" score of 1, "3-4 times" score of 2, and "5 times" score of 3. The total score or the sum of the values of each item ranges from 0 to 15, where the level of violence is divided into four categories according to their values, namely None = 0, Low = 1-5, Medium = 6-10, and High = 11-15≥[17].

Part C contains 14 statements for the Organizational Culture variable, which is compiled using the Likert scale with five alternative answer choices, namely a Strongly Agree (SS) score of 5, Agree (S) score of 4, Neutral (N) score of 3; Disagree (TS) score 2; and Strongly Disagree (STS) score 1 [21].

Data Analysis

Data analysis uses a reliable computerized program to determine central tendency, frequency distribution, percentage, and inferential statistics. Additionally, the researcher employs various testing methods for hypothesis testing analysis [18], including:

Product Moment Test: This test assesses the association between two variables when the data is on an interval or ratio scale.

Spearman Rank Test: This test is utilized when the data to be correlated is derived from different sources, is ordinal, and the variables are not necessarily normally distributed.

The chi-square test examines the relationship between two categories of variables, typically displayed descriptively in a contingency table (Cross-Tabulation).

Ethical Statement

Following a rigorous ethical review process, this research study obtained approval from the Ethical Clearance team at the Faculty of Nursing, Universitas Syiah Kuala (Ref. No. 113002100724).

RESULTS

The research findings are predicated upon the quantitative data amassed during the period spanning from June 1 to June 21, 2024.

Demography of Respondent

Table I: Demographics of Respondents (n=203)

Demography	Frequency	%
Gender		
Woman	156	76.8
Man	47	23.2
Age (Years) [22] (Min-Max= 22-51; M= 33.92±5.84)		
17-25 (Early teens)	11	5.4
26-35 (Early Adult)	108	53.2
36-45 (Late Adult)	76	37.4
46-55 (Early Senior)	8	3.9
Last Education		
Diploma	92	45.3
Bachelor of Nursing	8	3.9
Nurse Profession	100	49.3
Master of Nursing	3	1.5
Employment Status [13]		
PNS/ASN	67	33.0
PPPK	59	29.1
Contract	66	32.5
Honorer/Person	11	5.4
Monthly Income		
Below is the Regency/City Minimum Wage	89	43.8
Above the Regency/City Minimum Wage	114	56.2
Marital Status		
Unmarried	163	80.3
Marry	39	19.2
Janda/Duda	1	.5
Working Period (Years) [13] (Min-Max= 2-30; M=9.01±5.71)		
< 6 (Junior)	60	29.6
6-10 (Medior)	66	32.5
> 10 (Senior)	77	37.9
Hospital Type		
Government	160	78.8
Private	43	21.2
Area of Work		
IGD	42	20.7
Intensive Care	36	17.7
Polyclinic	29	14.3
Inpatient Room	96	47.3

Table I provides an overview of the demographic characteristics of the survey respondents. The evaluation encompassed age, gender, education level, and employment status. Of the 203 survey participants, 156 were women, constituting 76.8%. The age group with the highest representation was individuals aged 26 to 35, comprising 53.2% of the respondents. Nursing emerged as the most prevalent highest education level, with 49.3% (100 people). Most respondents had been working for over ten years, with 37.9% or 77 individuals earning a monthly income above the minimum wage set by the Regency/ City (114 or 56.2%). Most of them were employed as civil servants/ASN employees. Furthermore, most participants were unmarried (80.3% or 163 people), and the majority (78.8%) worked in government hospitals. Additionally, 47.3% of the 96 respondents worked in inpatient rooms.

Incidents of Workplace Violence

Table II: Incidents of Workplace Violence Against Nurses (n= 203)

Incident Report	Frequency	%
Min-Max= 0-12; M=2,57±2,76		
Never	133	30.7
Low	239	55.2
Moderate	52	12
High	9	2.1

The data presented in **Table II** indicates that most participants, precisely 55.2%, reported incidents of WPV falling into the Low category. In contrast, only 12% reported Moderate incidents, and just 2.1% reported High incidents. This data underscores the critical need to address WPV promptly and implement robust precautions to prevent similar incidents in the future.

Relationship of Demography Respondent with Incidents of Workplace Violence

Table III: Relationship of Respondent Characteristics with Events WPV (n=203)

Demography Respondent	P-value for each Data Analysis Type		
	Pearson Correlation	Spearman Rank	Chi-Square
Age	0.241		
Working Period	0.252		
Education		0.083	
Employment Status		0.361	
Monthly Income		0.861	
Gender			0.681
Marital Status			0.204
Hospital Type			0.042
Work Area			0.000

The data presented in **Table III** explores the relationship between individual characteristics and the incidence of WPV. This table provides a comprehensive analysis of how various demographic factors influence the frequency of WPV occurrence. This information is vital for organizations looking to prevent WPV and ensure the safety of their employees. By examining trends and patterns in the data, companies can develop effective measures to mitigate WPV and enhance employee well-being.

The Relationship between Organizational Culture and Incidents of WPV

Table IV: The Relationship of Organizational Culture on WPV (n=203)

	Correlations	Organizational Culture (X)	WPV (Y)
X	Pearson Correlation	1	0,027
	Sig. (2-tailed)		0,701
	N	203	203
Y	Pearson Correlation	0,027	1
	Sig. (2-tailed)	0,701	
	N	203	2033

The data analysis results using the Pearson Correlation Test revealed that the Significance value (0.701) was more significant than the p-value (0.05), leading to the rejection of the alternative hypothesis (Ha) (**Table IV**). These results indicated that no significant relationship exists between organizational culture and the incidence of WPV among nurses in the cities of Banda Aceh and Aceh Besar.

DISCUSSION

The findings from **Table II** indicate that the incidence of WPV was low at 55.2%, suggesting that many of these incidents went unreported. This situation may be attributed to a prevailing misconception that such incidents are inconsequential and inevitable in the workplace [23]. Additionally, the lack of knowledge about the proper reporting channels for WPV exacerbates this issue [24]. Moreover, many nurses are hesitant to report incidents, fearing that it could lead to further investigations that may tarnish the hospital's reputation [25].

The low number of reported incidents of WPV can be attributed to several factors, including delayed reporting, concerns about potential impacts, and the absence of significant injuries [26]. However, this underreporting can hinder efforts to understand and address WPV [27]. Nurses, in particular, may be hesitant to report incidents, assuming that violence is inevitable in their line of work [27]. To proactively address and prevent WPV, hospital management must prioritize the safety and well-being of nurses [28]. Implementing a robust reporting system and providing regular updates to affected parties on the status of any incident should be standard practice [29].

Furthermore, **Table III** indicates that the incidence of WPV in nurses in Aceh Besar and Banda Aceh is associated with the type of hospital and work area. A study in Hong Kong similarly found a higher occurrence of WPV in hospital emergency rooms, possibly due to the distress, anger, and vulnerability stemming from patients' health conditions and symptoms [14]. Incidents of WPV have also been noted in other work areas, such as ICUs and inpatient wards. Research further suggests that non-physical violence is the most prevalent form of violence in various maintenance work areas [30]. Thus, it can be inferred that nurses working in inpatient rooms are not immune to WPV [31].

The nursing profession is particularly susceptible to WPV due to various factors such as the nature of the job, work environment, staffing, team dynamics, leadership, and nurse-doctor relationships [32,33]. According to the American Nurses Association (ANA), nurses are reported to be 5-12 times more likely to experience WPV events compared to other healthcare professionals [34]. The study findings did not show any significant relationship between the characteristics of the respondents and WPV, as indicated by the p-values obtained for gender (0.681), age (0.241), education (0.083), length of service (0.252), employment status (0.361), marital status (0.204), and monthly income (0.861). However, it is essential to note that inadequate communication strategies may increase the likelihood of such incidents. Fortunately, communication skills can be improved over time, which may help reduce the risk of WPV [35,36]. Previous research has suggested that nurses with a Bachelor's degree often experience WPV, and fellow nurses frequently cause these incidents within the same hospital [12].

This study's findings align with previous research, indicating no significant relationship between gender and WPV [9,10]. However, they contrast with other studies suggesting that women are more susceptible to physical or sexual WPV than men [37]. The study underscores the importance of public education on gender equality to reduce violence against all genders. In 2020, Banda Aceh initiated a campaign to promote awareness of gender justice and underscore the significance of fair treatment for all, irrespective of gender [38]. Recognition of gender justice is crucial in fostering a safe and fair society for all. Nurses prioritize gender neutrality and maintain zero tolerance for WPV, given their role as healthcare providers [39].

The Pearson Correlation test analysis (**Table IV**) shows a significance value of 0.701, exceeding the p-value threshold of 0.05, indicating no significant relationship between organizational culture and WPV among nurses in Aceh Besar and Banda Aceh. Nonetheless, this finding underscores the importance of organizational culture in fostering a safe, supportive work environment for healthcare professionals. While a direct link between WPV and organizational culture was not confirmed, the literature suggests a positive organizational ethos may indirectly reduce violence [40]. Research indicates supportive environments boost job satisfaction, employee engagement, and retention, leading to fewer violent incidents [41]. However, findings reveal that the normalization of violence poses a significant barrier to reporting [3]. Thus, management should promote a culture that encourages open dialogue about WPV without fear of retribution [13].

A robust organizational culture is cultivated by identifying and strategically integrating employee needs into cultural norms [41]. Engaged employees are viewed as strategic assets that require sustained organizational engagement, including performance-based rewards and opportunities for personal and professional growth. Moreover, a positive organizational culture diminishes aggressive behavior, violence, and mood swings among employees, enabling the organization to attract and retain highly qualified and valuable employees [42].

Instances of WPV are often underreported due to a phenomenon known as "normalization" in the workplace [3]. This normalization can lead to a perception that WPV is an unavoidable part of the job and should be tolerated rather than addressed. Employees may also refrain from reporting incidents due to a lack of reporting culture, fearing potential

repercussions on their position [39,43]. Most cases of violence go unreported due to factors such as lack of administrative support, cultural barriers, absence of evidence (as in the case of verbal abuse), and the fear of job loss. Reporting incidents is also seen as detrimental to customer service, resulting in inadequate precautions within the organization. As a result, WPV harms the relationship between employees and the organization and worsens the organizational culture. Consequently, it can be hypothesized that WPV negatively correlates with a healthy organizational culture [40].

CONCLUSION

This study highlights WPV among nursing professionals in Aceh Besar and Banda Aceh hospitals. Although the reported incidence is lower due to underreporting and misconceptions, WPV remains a significant concern in healthcare. Findings show no significant association between WPV rates and demographic factors like gender or age, but the type of healthcare facility and work environment significantly impact WPV rates. These findings support existing literature indicating higher WPV in high-stress areas, such as emergency departments and intensive care units. Additionally, organizational culture is an indirect factor in WPV; a supportive culture can reduce violence, yet no significant correlation was found between WPV and organizational culture. It suggests that while culture is essential, other factors may have a more direct effect on WPV in nursing. The study emphasizes better reporting mechanisms and communication training to combat WPV normalization and improve workplace safety.

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Data Sharing Statement: The corresponding author can provide the data proving the findings of this study on request. Privacy or ethical restrictions bound us from sharing the data publicly.

AUTHOR CONTRIBUTION

Mahdarsari M: Contributed to designing the research, interpreting the study results, and determining the implications of the research findings.
Maurissa A: Collected data and wrote the research report,
Putra A: Collected data and wrote the research report, contributed to designing the research and developing the main idea or hypothesis to be tested, and revised draft articles based on feedback from other co-authors and reviewers.
All authors are responsible for the final editing to ensure the articles conform to the journal's guidelines.

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