ปัจจัยที่สัมพันธ์กับความรุนแรงในที่ทำงานของพยาบาลประเทศภูฏาน
Factors Related to Workplace Violence as Perceived by Nurses in Bhutan

นิพนธ์ต้นฉบับ **Original Article**

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วารสารไทยเภสัชศาสตร์และวิทยาการสุขภาพ2564;16(4):301-308.

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บทคัดย่อ

วัตถุประสงค์: เพื่อศึกษาผลกระทบและปัจจัยที่สัมพันธ์กับความรุนแรงในที่ทำงานของพยาบาล ประเทศภูฏาน **วิธีการศึกษา:** กลุ่มตัวอย่างเป็นพยาบาลที่ปฏิบัติงานที่โรงพยาบาลระดับตติยภูมิจำนวน 190 ราย เครื่องมือวิจัยประกอบด้วยแบบบันทึกข้อมูล แบบสำรวจความรุนแรงในที่ทำงานของพยาบาลวิชาชีพ แบบสอบถามสิ่งแวดล้อมที่ทำงาน แบบสอบถามบุคคลิกภาพ แบบสอบถามสมรรถนะของพยาบาล และแบบเอกสิทธิ์เชิงวิชาชีพ สถิติวิเคราะห์ข้อมูลประกอบด้วยสถิติพรรณา ไคสแควร์ และสหสัมพันธ์พ้อยท์ไบซีเรียล **ผลการศึกษา:** ปัจจัยด้านหอผู้ป่วย สมรรถนะและภาระงานของพยาบาลมีความสัมพันธ์กับความรุนแรงในที่ทำงานของพยาบาลอย่างมีนัยสำคัญทางสถิติที่ระดับ 0.05 **สรุป:** การลดความรุนแรงในที่ทำงานของพยาบาล ผู้บริหารทางการพยาบาลหรือผู้ออกแบบนโยบายควรพัฒนาสมรรถนะและจัดภาระงานให้เหมาะสมกับลักษณะผู้ป่วยและควรคำนึงถึงการจัดสภาพหอผู้ป่วย

คำสำคัญ: ความรุนแรงในที่ทำงาน, พยาบาล, ประเทศภูฏาน

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Abstract

Objective: To investigate the impact and factors related to workplace violence as perceived by nurses working in Bhutan. **Method:** Data were collected using sets of self-reported questionnaires consisting of workplace violence survey, Short Version of Nursing Professional Competency Scale, Practice Work Environment–Nursing Work Index Scale, Revised Eysenck Personality Questionnaire short scale, Autonomy and Control scale and Workload Perception Questionnaire. Descriptive statistics, chi-square testand point biserial test were used for data analysis. **Results:** It was found that current work unit, nursing competency and workload perception had significant relationships with workplace violence (*P*-value < 0.05). **Conclusion:** In order to minimize workplace violence against nurses, nurse administrators and concerned policy makers should improve nursing competency and balance nursing workload under work unit condition.

Keywords: workplace violence, nurses, Bhutan

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Introduction

Workplace violence is one of the most complex and threatening occupational hazards in healthcare settings. Compared to other healthcare personnel, nurses are found to be one of the most vulnerable groups exposed to all kinds of violence at workplace. Many studies have found that nurses were subject to verbal and physical abuse so frequently that these events are now accepted as “part of the job”.[1,2] Violence against medical staffs has become a widespread and a growing problem worldwide.[3,4] Workplace violence (WPV) is one phenomenon that cannot be ignored because of its impact on many stakeholders including the patient, nurse and organization. WPV in hospital is a serious health threatening factors for the patients since nurses who are abused at their care centres could suffer from various symptoms which could further the quality of care they provide. Ultimately the patient needs go unmet resulting in poor patient outcomes like increased occurrence of medication errors, pressure ulcers and falls etc.[5]

Regarding the impact of WPV on nurses, many studies have found that WPV has both physical and psychological impact.[2,3] Nurses face symptoms like exhaustion, sleeping disorder, stress, continuous headache, symptoms of amnesia, alcohol consumption, smoking and death. Emotional responses like anger, sadness, fear, self-reproach, and job dissatisfaction are also common among nurses.[3] As a consequence, a nurse may not be able to provide quality nursing care and decide on relocating themselves within a facility or to another healthcare facility or leave nursing profession altogether.[6] At organizational level, WPV causes immense financial burden. A study found that nurses who are

constantly bullied at their workplace have very high intention to leave their jobs.[7] Poor job performance, low productivity, poor job satisfaction, high staff turnover rate and poor staff morale are prevalent in organizations with increased WPV incidences.[2] Another study found increased job errors, low organizational commitment, staff shortage and increase in health care costs.[8] Organization will need to invest more on new recruitment, orientation and this can in long run lead to huge financial burden. Chronic exposure to insults and rude behaviours while performing one's duty and caring for patients not only jeopardizes nurses' physical, emotional and psychological health, but also ruins effective communication between patients and the nurses.[9] Nurses are therefore unable to provide quality care due to demoralization, dissatisfaction, leading to leaving their profession. Organization and the nursing administrators thus have a huge role to play in preventing and minimizing WPV against nurses. One has to realize the urgency of WPV phenomena and its deadly impact on not just their nurses but the quality of care and the patient outcomes, extensive amount of time nursing staffs spending with patients and their attendants in particular, and factors enhancing nurses' job performance rather than inhibiting them.

Based on literature review four important factors were perceived to make nurses' more vulnerable to WPV victimization. Firstly, with the nature of their work, nurses spend extensive amount of their time providing direct care to patients and family members. Secondly, nurses are usually the first and the most available personnel throughout the hospital forming a significant population thus putting them at increased risk to WPV exposure. Thirdly, their presence in stressful situations like accidents, deaths, long waiting hours for physicians to do rounds, transferring patients to a ward or another hospital, predisposes nurses to even more risk of violent behaviours from patients or their family members.[9,10] Lastly, factors like long working hours, having to continuously control conditions, exhaustion, overcrowding of hospital, repeated requests by patients and their companions for special privileges, lack of security personnel, and frequent confrontation of difficult and stressful situations increase the risk for WPV exposure. The above mentioned are some of the factors which predispose nursing staffs to WPV but not limited to since other factors like environmental/organizational, cultural beliefs and others may play fair share of role in influencing WPV against nursing staffs. Theoretically there is a negative relationship between nurses' age and WPV victimization.[11] This is due to their limited work experience in real clinical setting and WPV, they lack skills in predicting violent ques from perpetrators thus becoming easy victims of WPV. Gender wise, female nurses are considered to be more associated to violence and harassment especially of sexual nature.[11] Moreover, the education level and nursing competency are negatively associated with WPV, meaning WPV decreases as the level of education of the nurse advances. Personality of nurses also plays an important role in influencing violence experience. Extravert personality trait was negatively associated with WPV while neurotic personality trait is positively associated with WPV toward nurses.

Organizational factors like work environment if considered unfavourable is found to elevate different kinds of WPV and vice versa.[11] Many organizational factors were studied and found to influence WPV against nurses. Some of these factors include work environment, work setting/ unit, managerial support, adequacy of both staffs and resources, workload, etc. Many research concluded with same findings. For nurse work units, working in emergency unit was found to be strongly, significantly, positively associated with WPV due to the criticality of situation.[2-4,6-8] But few studies found otherwise; emergency unit nurses reported the lowest WPV at only 10% compared to WPV reported from neonate unit at 80%.[12]

Nurses' workload was however found by many studies to be positively associated with WPV, meaning the heavier the workload, the more risk they have in experiencing WPV. This is supported by the previous factors on staff adequacy. When staffing is inadequate, it means higher workload for the ones on duty. They are pressurized to work more with fewer resources and time pressure. In order to prioritize the resources and their time to critical patients, many other patient needs go unmet. This causes frustration among these patients and eventually lead to violence.[1,3,4,9,10]

Bhutan is a developing country and many factors are found to impact health care system. Rapid economic development affects the health care system with an increase in demand for high quality health care services.[14] The increasing rate of migration from rural to urban area has doubled the number of care seekers at many urban health care centres.[14] Growing population with existing nursing shortage.[15] All the three referral hospitals are under conversion process to autonomous body. These are some

pressing issues that directly impact nursing performance. With the existing nursing shortage in the country[15] and the issues mentioned above, it is found to only influence nursing work performance. There is an established relationship between nursing staff shortage and WPV. Many incidents of WPV against nursing precipitates from nursing shortage. Due to shortage of nursing staffs, many patient needs go unmet. There is poor quality of care and nurses spent limited time with their patients. This makes the care receivers dissatisfied with the care provided, which leads to WPV. Nursing shortage is a national burden. Shortage of nurses despite the increased supply indicates problem with the retention strategies and other factors. WPV is thus considered one factor leading to nursing shortage in the country. There is a need to determine factors impacting WPV against nurses in Bhutan in this changing times in order to provide suggestions to nurse administrators accordingly to combat this problem. It was hypothesized that nurses' age, gender, level of education, personality trait, nursing competency, work environment, work unit, professional autonomy and workload perception were associated with workplace violence as perceived by nurses working in Bhutan.

Methods

In this correlational study with cross-sectional design. The participants were the nurses working at hospitals under the jurisdiction of Ministry of Health, Bhutan. Sample size was calculated using G*Power 3.1 software.[16] Using a conventional power estimate of 0.80, with an alpha level set at 0.05, and effect size of 0.238[17], a sample size of 182 nurses was needed for a correlation analysis. Attrition rates was estimated at 12% from previous studies with Bhutanese nurses[18], therefore 204 nurses were required. Inclusion criteria of participants were nurses who worked for at least 12 months in their current workplace prior to data collection and provided direct patient care. Regardless of their gender, participants had to be 20 to 60 years old and willing to participate in the study. However, nurses who were holding administrative responsibility were excluded. The recruitment of the participants started with simple random sampling to select the referral hospitals from three regions; West, Central and East. The nurses from the three hospital of each region represented nurses working in Bhutan. Then, proportionate sampling was used to obtain following participants: 129, 37 and 38 nurses from Western, Central and Eastern region, respectively. Lastly, sample was selected by systematic random sampling. This process involved selecting every k^{th} individual on the list, with starting point selected randomly to increase generalizability.

Research instruments

A questionnaire o 7 sections was used to collected data. The first section asked about demographic characteristics of the participants including age, gender, marital status, unit/ward, years of working experience in nursing profession and their level of education. The second section asked about workplace violence. Workplace violence was defined as a situation where nurses 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, wellbeing or health. Workplace violence was measured by **the Workplace Violence Survey**.[19] It had 4 dimensions namely physical violence, verbal abuse, bullying/mobbing and sexual harassment. Each dimension had one question, which asked the violence in the last 12 months. These items were "Have you been physically attacked in your workplace?," "Have you been bullied/ mobbed in your workplace?," "Have you been verbally abused in your workplace?," and "Have you been sexually harassed in your workplace?" The response was yes and no with score of 1 and 0, respectively. The answer of "Yes" in any dimension meant the nurse experiences violence, while those with the answer of "No" in all dimensions meant the nurse experiences non-violence.

The second section asked about **impact of workplace violence** which was defined as the marked effect or influence on nurses' after experiencing workplace violence. It was measured by **the Workplace Violence Survey**.[19] Each of the 4 dimensions of violence has 4 items, which asked the impact since the person was attacked. Examples of items included "How bothered have you been by repeated, disturbing memories, thoughts, or images of the attack?," "How bothered have you been by avoiding thinking about or talking about the attack or avoiding having feelings related to it?," "How bothered have you been by being "super-alert" or watchful and on guard?," and "How bothered have you been by being feeling like everything you did was an effort?" The response for each item was a 5-pointrating scale ranging from 0 "not at

all" to 4 "extremely." The scale had a high internal consistency reliability with a Cronbach's alpha coefficients of 0.82.

The third section asked about **nursing competency** which was defined as the ability of a nurse to demonstrate and integrate knowledge, critical thinking, affective, and psychomotor values and skills to perform particular professional care activities both ethically and safely. It was measured by the **short version of the nurse Professional Competence Scale**.[13] It has 35 items with six subscales namely nursing care, value-based nursing care, medical and technical care, care pedagogics, documentation and administration of nursing care and development, leadership and organization of nursing care. The response is a 7-point Likert scale ranging from 1 "very low degree" to 7 "very high degree" with higher scores representing higher competency. Internal consisteny reliability in this study was found (Cronbach's alpha coefficient of 0.80).

In the fourth section, **work environment** was assessed. Work environment was defined as the factors that enhance or attenuate a nurses' ability to practice nursing skilfully and deliver high quality care and was essessed using the **Practice Environment Scale-Nursing Work Index (PES-NWI)**.[12] PES-NWI consists of 31 items with five subscales namely (1) nurse participation in hospital affairs, (2) nursing foundations for quality of care, (3) nurse manager ability, leadership, and support of nurses, (4) staffing and resource adequacy, and (5) collegial nurse-physician relations. Response is a 4-point Likert scale ranging from 1 "strongly disagree" to 4 "strongly agree" to identify factors present in the work environment that support nursing's ability to deliver high quality care. A higher score represents a favorable nursing practice environment. Internal consistency reliability was high with a Cronbach's alpha coefficient of 0.97.

Personality trait was assessed in the fifth section. Personality trait referred to the reflection of persons' characteristics patterns of thought, feeling and behaviours and was evaluated using the **Revised Eysenck Personality Questionnaire Short Scale (EPQ-RS)**.[17] EPQ-RS contains 12 items of extraversion measuring an individual's sociability and 12 items measuring emotional dysfunction/ neuroticism. The respondents were asked to answer "Yes" or "No" with scores of 0 and 1, respectively. Higher scores represent more tendency of the corresponding trait. Internal consistency reliability for extraversion and emotional dysfunction/ neuroticism were acceptable with Kuder-Richardson-20 coefficients of 0.61 and 0.84, respectively.

In the sixth section, **professional autonomay** was measured. Professional autonomy was defned as the extent to which individuals can choose how they carry out their work. Professional autonomay was measued using the **Autonomy and Control Scale** which was adapted from perceived work characteristics for health services research.[20] The response was a 6-point Likert scale ranging from 1 "not at all" to 5 "completely" with higher score representing high autonomy. Internal consistency reliability for autonomy/control accpeatble with a Crobach's alpha coefficient of 0.88 in a previous study.[20] A borderline reliability was found in this present study (Cronbach's alpha coefficient of 0.64).

In the last section, **workload perception** was measured. Workload perception was defined as nurses' perception of being at work environment that arises from the nurse's workload such as inadequate time to complete nursing tasks and having to work very fast and hard. Workload perception of the nurses was measured using questionnaire adapted from the Quantitative Workload Inventory.[17] QWI is a five-item scale. Respondents were asked to indicate the frequency of the occurrence of each statement. There were five response choices ranging from 1 "less than once per month or never" to 5 "several times per day". The responses were then summed and divided by 5 to provide a mean score. Higher scores represent a high level of workload. In this study, internal consistency reliability was high with a Cronbach's alpha coefficient of 0.86.

Ethical consideration

The research proposal was approved by the Institutional Review Board (IRB), Burapha Univeristy, Thailand (approvale number: G-HS 004/2563). Upon approval, proposal was forwarded to the Research Ethics Board of Bhutan (REBH), Ministry of Health (Ref.No.REHB/Approval/2019/111). After this approval, permissions were obtained from the directors of three referral hospitals under the study with the letter seeking permission for data collection along with the purpose of the study.

Data collection procedure

The researcher first contacted Ministry of Health (MoH) for obtaining information on all the nursing superintendents who were currently working under the selected hospitals for this

study. Nursing superintendents were approached and asked to act as research coordinator to complete data collection. The name list of the participants was informed to the nursing superintendents in each hospital. The research coordinators explained the purpose of the study, inclusion and exclusion criteria, the voluntary basis of participation and the importance of providing informed consent before starting the questionnaire to all the participants. To ensure anonymity and confidentiality, the participants were not asked for their name but codes were used to identify the participants and questionnaires were kept in the secure place. The questionnaires were collected after two weeks from its distribution date.

Data analysis

All data were entered into Minitab 17. The demographic characteristics of the participants were analysed by descriptive statistics including frequency with percentage and mean with standard deviation. A point-biserial correlation test and Chi-square test were used to explore the relationship between factors and WPV. All statistical significance was set at a type I error of 5%.

Results

A total of 190 of 204 required participants completed the questionnaire resulting in a response rate of 93.14%. Female nurses were the majority of the participants (54.9%) (Table 1). The average age of participants was 30.97 (SD = 6.443) years. The largest group of participants was in the age group of 20 – 29 years (54.63 %). Participants at diploma level were the majority of the participants (60.18%). Most of participants were married (54.62%), currently working in inpatient department (68.51%), and had less than 10 years of work experience (59.25%) (Table 1).

Impact of workplace violence against nurses

The impacts of WPV against nurses revealed that 35.18% of the nurses had moderate levels of repeated, disturbing memories, thoughts, or images of attack. Also 34.26% of the participants also reported of being super alert or watchful and on guard at moderate level. 32.41% of the participants reported feeling like everything they did was an effort at a moderate level. There were 5.56% of the participants avoiding thinking about the attack or having feelings related to it at extreme levels.

Table 1 Demographic characteristics of participants (N = 190).

Characteristics	Number	%
Age (Years), range = 22 – 56, mean =30.974, *SD* = 6.443		
22 - 29	99	52.11
30 - 39	63	33.14
40 - 49	26	13.70
50 - 59	2	1.05
Gender		
Female	112	58.94
Male	78	41.06
Marital status		
Single	75	39.47
Married	113	59.47
Divorced/widowed	2	1.06
Level of education		
Certificate	21	11.05
Diploma	112	58.95
Bachelors	48	25.26
Masters	9	4.74
Working experience (years), range = 1 – 31, mean = 1.72, SD = 0.93		
0 - 10	153	80.52
11 - 20	25	13.15
21 - 30	11	5.81
31 - 40	1	0.52
Work unit		
Inpatient department	139	73.16
Outpatient department	22	11.58
Emergency department	29	15.26

Description of the study variables

The mean score of sum of nurse professional competence scale was 210.46 ± 22.83 points indicating relatively high levels of competency reported by the participants (Table 2). The mean of the total scores for the work environment was 57.55 (*SD* = 12.56) indicating the response favorable practice/work environment. The mean total scores for the autonomy and control scale was 18.97 (*SD* = 4.86) indicating having quite moderate levels of autonomy and control over their work. As for the workload perception of the nurses, the results revealed that nursing staffs had relatively high levels of workload perception in general and in all the items with mean total scores of 20.16 ± 0.69 points (Table 2). For the personality trait, higher scores represented more tendency of the corresponding trait and majority of the participants fell under the extraversion personality (n = 100) followed by neuroticism personality (n = 90) (Table 3).

Table 2 Description of the study variables (N = 190).

Variables	Possible range	Actual range	Mean	*S.D.*
Nursing competency	35 - 245	159 - 245	210.46	22.83
Work environment	0 - 93	34 - 92	57.55	12.56
Professional autonomy	6 - 30	7 - 30	18.97	4.86
Workload perception	5 - 25	19 - 23	20.16	0.69

Relationship between factors and workplace violence against nurses

There were no significant differences between age, gender, level of education, marital status, and personality trait among nurses who had workplace violence and non-workplace violence (*P*-value > 0.05). Only current working unit was found to be significantly associated with workplace violence (*P*-value < 0.05) (Table 3).

Table 3 Relationships between workplace violence against nurses and demographic characteristics and personality trait (N = 190).

Factors	N (%) by workplace violence status		χ^2	*P*-value
	Workplace Violence	Non-Workplace violence		
Age			-0.133	0.068
20-29	59 (54.63%)	43 (52.43%)		
30-39	29 (26.85%)	31 (37.80%)		
40-49	19 (17.59%)	7 (8.54%)		
Gender			0.000	1.000
Female	63 (58.33%)	49 (59.75%)		
Male	45 (41.66%)	33 (40.24%)		
Education			0.053	0.466
Certificate	7 (6.48%)	14 (17.07%)		
Diploma	65 (60.18%)	48 (58.53%)		
Bachelors	34 (31.48%)	17 (17.07%)		
Masters	2 (1.85%)	6 (7.31%)		
Marital status			-0.118	0.104
Single	48 (44.44%)	25 (30.48%)		
Married	59 (54.62%)	56 (68.29%)		
Divorced/ Widowed	1 (0.92%)	1 (1.21%)		
Work unit			0.31	0.012
Inpatient department	74 (68.51%)	59 (71.95%)		
Outpatient department	7 (6.48%)	15 (18.29%)		
Emergency department	27 (25%)	8 (9.75%)		
Personality trait			0.000	0.663
Extraversion	58 (53.70%)	42 (51.21%)		
Neuroticism	50 (46.29%)	40 (48.78%)		

In terms of psychosocial factors, it was found that nursing competency and workload perception were associated significantly with workplace violence, negative and positively, respectively (*P*-value < 0.05 for both); while work environment and nursing professional autonomy were not (Table 4).

Table 4 Relationships between workplace violence against nurses and psychosocial factors (N = 190).

Factors	Point-biserial correlation coefficient	*P*-value
Nursing competency	-0.217	0.042
Work environment	-0.062	0.395
Profession autonomy	-0.131	0.071
Workload perception	0.204	0.036

Discussions and Conclusion

WPV impacted nurses' physical and mental wellbeing both in short-term and long-term personal, emotional and professional effects.[21] Chronic exposure to insults and rude behavior while performing nursing care for patients could jeopardize and ruin effective communication between patients/families and the nurses.[9] The most common impact of WPV in our present study was "avoiding thinking about or talking about the attack or having feelings related to it" and "feeling like everything they did was an effort." The result is consistenyt with the study in Jordan which revealed that the consequence of physical violence were moderate frequent memories and thoughts about the incident (45.4%), avoiding thinking or talking about it (47.6%), feeling super-alert or watchful (57.1%) and perceiving everything as an effort (57.1%).[22] Another study found that WPV was positively correlated with anxiety (r = 0.24, *P*-value < 0.01) and depression (r = 0.12, *P*-value < 0.01).[23] Consequences of WPV against nurses in Taiwan reported that nurses considered changing their units and almost 92.7% considered leaving their current work units.[24]

Our study found only three factors to be associated with workplace violence. Firstly, nurses work unit was found to have significant influence on WPV. Nurses working in inpatient department (IPD) reported the highest WPV which is in accordance with the conceptual model. The reason might due to firstly the patients to nurse ratio in inpatient units which was very high in these hospitals. The ratio of nurse per patients was 1 nurse to 14 patients.[25] Increasing number of patients in inpatient departments with persistent nursing shortage[18] and increased demand for high quality nursing care[17] only makes the situation worse. When the number of patients assigned to a nurse increases, nurses automatically pay more attention to critical patients. This causes other patient needs not be met which can cause conflict between nurse and patients. Thus, these groups of patients and their family members can get frustrated and turn to a potential perpetrator of WPV. Another explanation for this finding might be embedded in Bhutanese culture. When the family member is hospitalized, whole family will come to visit and care for their family member. This made the ward crowded and uncomfortable for nurses to provide nursing care for their patients. Nurses have to control their work environment constantly, thus becoming easy victims of WPV. This finding is thus in accordance with our hypothesis,

Nurses working in IPD are positively, significantly associated with WPV.

Secondly, according to the model of Chappell and Di Martino[26], competency level of the victim ss an important factor associated with WPV. The more professionalism one shows at the workplace, the less chances one has in experiencing violence. Literature reviews have shown that nurses with high professional competency and knowledge experience less WPV. Finding of the present study is in accordance with a study conducted in a Jordanian Public Health Hospital which assessed the impact of workplace bullying on nursing competency among registered nurses. The study found that nurses with more clinical competencies were less likely to experience work-related bullying.[27] A qualitative study also found that nurses who lack of competency to deal with patients/relatives, nurses' superiors and physicians created conditions that were conducive to violence.[21] Nurses with low competency or inadequate preparation for certain tasks were also found to provoke harassment or discriminatory behaviors by colleagues.[28] A bully victim's perception of his or her competence was also found to be important in examining bullying as it can determine the reaction of the victim to the behavior.[29] Co-workers or supervisors with less perceived competence may bully those they believe to be competent, as job loss threat increases.[30] A competent individual does not view themselves as competent they become victims. Evidence have shown that nurses perceived themselves as powerless or incompetent becomes targets of bullying.[31]

Lastly, the study found that nurses' workload perception had significant correlated with WPV. Increasing workload perception was one of the most distressing part of the job. The present study revealed that nurses had high levels of workload perception which is consistent with earlier study conducted in Bhuta.[18] Findings of present study are consistent with the results of previous studies.[33] A study conducted in Saudi Arabia indicated that understaff during meal times and visiting hours was the most frequently factor (53.6%) for WPV.[32] Understaffing did not only cause for increased workload, but also leave nurses with attention to critical patients and limited time to interact with other patients. These can cause patients and their families felt unsatisfied, then they would provoke WPV. A study in Korea revealed that nurses perceiving greater work load but less trust or justice were more likely to expose to WPV.[33]

In terms of practical implications, the findings highlight the importance of enacting preventive strategies for workplace violence against nurses. Adequate nursing staffs are needed in the inpatient department that can reduce the workload. Then nurses are able to dedicate time to all the patients that might reduce WPV. Installation of strong security system and developing training programs to enhance relationship and communication between nurses and patients and their families that can assist nurses to prevent and manage WPV. A more comprehensive study in the future to explain the health care system factors to prevent WPV is recommended.

In conclusion, workplace violence against nurse was high in Bhutan. Results showed that work unit and workload perceptions predicted WPV against nurses. These findings can be used by nurse administrators to develop strategies to control WPV in their organization, which can have great organizational benefit in the long run. Weakness of this study related to the use of self-reported surveys which may not have captured nurses stigmatized by previous violence if they chose not to provide accurate data. Participants relied on their memories when answering the questionnaires which might affect the findings.

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