Original article

Prevalence, risk factors for, and impacts of workplace violence on nurses in a medical school in Thailand

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Objectives To determine the prevalence of, risk factors for and impacts of workplace violence experienced by nurses in a medical school in Thailand.

Methods A cross-sectional study was conducted of registered nurses in a medical school hospital in Thailand in 2020. Each participant completed a self-reported online questionnaire (ILO/WHO/ICN/PSI Geneva 2003 modification). Multiple logistic regression analysis was used to examine the risk factors for workplace physical violence and verbal abuse.

Results A total of 816 nurses were recruited. The reported prevalence of workplace violence against nurses in the previous 12 months was 39% (verbal abuse 38%, physical violence 8%). The most common perpetrators of verbal abuse were colleagues (32%) and patients (29%), while patients were the primary source of physical violence (84%). Risk factors associated with any form of workplace violence included young age (20-39 years), higher education (masters or doctoral degree), perceived insufficient number of staff, and working in an emergency unit ($p < 0.05$). Five percent of the victims reported absences from work resulting from verbal abuse. Among victims of physical violence, 18% received injuries of which 8% required medical treatment.

Conclusions Workplace violence against nurses is a common occupational hazard that affects their physical and psychological well-being. Implementation of programs, e.g., training for younger nurses on violence management skills, reporting systems as well as efforts to ensure a safe work environment should be strengthened. **Chiang Mai Medical Journal 2021;60(4):437-47. doi: 10.12982/CMUMEDJ.2021.39**

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Introduction

Currently, workplace violence, including verbal abuse, threats, and physical assaults, is considered one of the major threats in hospitals, and they can occur at any time. Healthcare workers around the world are at high risk for workplace violence (1,2), e.g., they are four times more likely to be victims compared to other types of workers. The World Health Organization (WHO) reported that 8 to 38% of healthcare workers and worldwide are threatened or exposed to verbal abuse (3). The most prevalent form of healthcare violence is perpetrated by patients and visitors, while co-workers are also often perpetrators (1,3). Although there is growing concern about workplace violence for healthcare workers in many countries, the incidence is hugely underreported (1,4). The National Institute

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for Occupational Safety and Health (NIOSH) defines workplace violence as violent acts, whether in the form of physical violence or verbal abuse, directed against persons at work or on duty (5). Verbal abuse is defined as any expression of intent through spoken or written words to inflict personal-psychological harm, while physical violence is the use of physical force, whether including the use of objects or not, against another person or group (2,5). Nurse professionals are at higher risk of exposure to workplace violence than other healthcare workers. This may be due to many factors such as earlier and longer interactions with patients and more direct and close contact with patients compared to other health professions (4,6-9). Workplace violence not only affects psychological and physical well-being, but it also affects the organization (3). A single incidence of workplace violence can lead to disruption of patient care including long waits, patients not receiving full effective treatment, loss of budget for medical care, and decreased victim job motivation. It can lead to increased rates of absenteeism, burnout as well as decreased productivity and early retirement in the health sector (2,10,11). A study by Wanpen and colleagues found that workplace violence against nurses resulted in a reduction in job satisfaction (76.2%), retirement (15%), and absenteeism (10%) (11). Previous studies in Thailand have reported on the high prevalence of workplace violence against nurses in different levels of hospitals. Thaddao found that the prevalence of workplace violence among nurses in community hospitals was 85.5% (12). Similarly, Wanpen et al. reported that the prevalence of workplace violence against emergency room (ER) nurses in a tertiary care hospital was 84.7% (11). Napatsawan et al. found a prevalence among nurses in secondary care hospital ERs of 61.7%, with the most common type being verbal abuse (13). Furthermore, the amount of violence in hospitals reported in various media such as newspapers, television, websites or social media, has tended to increase over time (2,5).

Medical schools are one of the 'super tertiary care' hospitals were workplace safety should be given priority. There are many specialized branches of medical care, all of which have high standards, modern and sophisticated medical equipment, and large number of patients with high expectations. Many patients seek high-quality medical care regardless of the severity of their illnesses, leading to overcrowded facilities and increased workloads for hospital staff, factors that can potentially heighten the risk of workplace violence. Studies in this complex setting, however, are still limited.

The objectives of this study were to investigate the magnitude of workplace violence, the consequences and related factors in a medical school. The findings could then be used to guide risk management and preventive programs related to workplace violence in hospitals and could also be applied to other situations with a similar context.

Methods

This cross-sectional study was conducted in 2020 among different divisions of nurses in a medical school hospital in Bangkok, Thailand. Of the 1,896 registered nurses working in the hospital, 1,817 had been working in the hospital for more than one year. The sample size was estimated based on the workplace violence rate of 54% reported in a previous study (Kasara 2003) (14), with an alpha error of 0.05 and precision of 5%. A minimum sample size of 876 nurses was required. That sample size was sufficient for logistic regression analysis (n = 100+50i) with the assumption of 12 independent variables (15). All the registered nurses who had worked in the hospital for more than one year were invited to participate in the survey.

Research instruments

We used a validated questionnaire based on Workplace Violence in the Health Sector country case studies, research instruments and survey questionnaires, and the ILO/WHO/ICN/PSI Geneva 2003 (13). The questionnaire was validated by three specialists, and tested for reliability with a sample of 30 nurses, showing a relatively high internal consistency (Cronbach's alpha coefficient

of 0.831). The online self-administered questionnaire was launched through the LimeSurvey program. The questionnaire included data on demographics, working conditions (16 questions), experience of physical violence (16 questions), and verbal abuse (13 questions) over the previous 12 months.

Ethical considerations

Ethical approval was granted by the Center of Ethical Reinforcement for Human Research, Mahidol University (project identification code COA. MURA2020/1012). Each participant signed an informed consent agreement and all information was kept confidential.

Statistical analysis

Parametric statistics were applied as the data were normal distributed. The data are presented as percentage for categorical data and mean (SD) or median (IQR) for continuous data. Associations between categorical variables and continuous variables were assessed using the Chi-square test and the unpaired t-test, respectively. Multiple logistic regression analysis was used to identify risk factors for workplace violence, and odds ratios with a 95% confidence interval were reported. Outcomes variables, including physical violence, verbal abuse and all forms of violence (either physical or verbal) were analyzed in separate models. Independent variables included age, gender, marital status, education, position, job setting, work experience, shift work, work hours per week, direct interaction with patients, opinion on the sufficiency of the number of staff, and previous training on workplace violence management skills. P-values < 0.05 were considered statistically significant. All the data were analyzed using IBM SPSS statistics version 18.

Results

Demographic characteristics of participants

A total of 986 participants responded to the survey; 170 questionnaires were excluded due to incomplete data, and 816 (83%) responses with complete data were included in the analysis. The mean age of participants was 33 years (SD = 8). Seven hundred and ninety-six (97.5%) were female, and the majority (72.8%) were single and had a bachelor's degree (84.2%). Most participants worked forty-eight hours or less per week and 81% had shift work. Ninety-eight percent had direct interaction with patients. The primary departments where the majority of participants regularly worked were the inpatient care unit (40.9%), followed by the intensive care unit (ICU) and the semi-ICU (21.1%). Overall, 75% of the respondents had never been trained on violence management (Table 1).

Experience with incidents of workplace violence in any form

Of the 816 participating nurses, 319 (39.1%) had experienced at least one form of workplace violence in the previous 12 months: verbal abuse (37.9%), physical violence (7.6%) and both physical violence and verbal abuse (6.4%). Nurses in the emergency unit reported the highest prevalence of both physical violence (58.4%) and verbal abuse (24.7%), followed by those in the intensive care unit of 44.2% and 8.1%, respectively (Table 2).

Characteristics of workplace violence incidents within the previous 12 months

Eighty percent of the victims had encountered 2 to 3 episodes of verbal abuse. More than half of the victims (58.1%) had been exposed to physical violence at least once and 6.5% of them had been threatened with a weapon. However, 27% of the victims considered these as normal workplace events. For most of the participants who had experienced physical violence, the violence had been perpetrated by patients (83.9%) or followed by patients' relatives (8.1%). The most common source of verbal abuse was from colleagues (32%), followed by patients (28.8%) and patients' relatives (22.4%). Some nurses also reported members of other health professions as perpetrators (10.4%). The violence most commonly occurred on weekdays, during the morning shift, and inside the hospital (data not shown).

Table 1. Demographic characteristics of participants (n=816)

Characteristics	n (%)
Demographics data	
Age (years)	
Mean (SD)	33 (8.0)
20-29	383 (46.9)
30-39	274 (33.6)
≥ 40	159 (19.5)
Gender	
Male	20 (2.5)
Female	796 (97.5)
Marital status	
Single	594 (72.8)
Married/living with partner/separated/ divorced/widowed	222 (27.2)
Education	
Bachelor degree	687 (84.2)
Master degree/doctoral degree	129 (15.8)
Occupational factors	
Working experience (years)	
1-5	293 (35.9)
6-10	243 (29.8)
≥10	280 (34.3)
Working hours per week (hours)	
≤ 48	593 (72.7)
> 48	223 (27.3)
Shift work	
Yes	663 (81.2)
No	153 (18.8)
Position	
Supervisor/nurse inspector nurses/ head nurses	64 (7.8)
Practical nurses	752 (92.2)
Job settings	
Operating and labor room (OR/LR)	84 (10.3)
Inpatient care unit (IPD)	334 (40.9)
Outpatient care unit (OPD)	149 (18.3)
Emergency and accident unit (ER)	77 (9.4)
Intensive care and semi-intensive c are unit (ICU/Semi-ICU)	172 (21.1)
Directly interact with patients	
Yes	799 (97.9)
No	17 (2.1)
Opinion on sufficiency of the number of staffs	
Sufficient	535 (65.6)
Not sufficient	281 (34.4)
Previous training in workplace violence management skills	
Yes	202 (24.8)
No	614 (75.2)

As to factors contributing to workplace violence, the majority of the participants reported that stress or pressure from work was the most common contributing factor to verbal abuse (27.2%) followed by poor communication (24.4%). For physical violence, the contributing factors included working with mentally ill patients (43.2%) and poor communication (17.2%) (Table 3).

Risk factors for workplace violence

Multiple logistic regression analysis found that factors independently associated with workplace violence of at least one form and of verbal abuse included younger age (20-39 years), higher education, working in the emergency unit, and working in a ward with an insufficient number of nurses (Tables 4,5).

Factors significantly associated with physical violence included work experience of less than 6 years, higher education, wards with an insufficient number of nurses, and working in the emergency unit or in an intensive care unit (Table 4).

Participants' response to workplace violence and incident reporting

The types of responses by the victims after an incidence included taking no action (71.2%), followed by reporting to a senior staff member (31.7%) and telling a colleague (29.1%). For, physical violence, the victims generally told the person to stop (53.2%) followed by taking no action (45.2%) and telling another colleague (40.3%). However, the majority of victims did not report the incident. The main reasons for not reporting included: it was useless (43%) and it was not important (21.4%) for verbal abuse, with similar reasons for not reporting the physical violence incidents. However, most of the victims said that they felt the incident could have been prevented (data not shown).

Impact on physical and mental health from the occurrence of workplace violence

After a physical violence incident, some victims (17.7%) had some degree of injury as a result of the violence with about 8% requiring some

Table 2. Prevalence of workplace violence within the past 12 months by job setting

Job settings	Total of nurses (N)	Total of the victims (%)	Verbal abuse (%)	Physical violence (%)
Operating and labor room	84	26 (31.0)	26 (31.0)	2 (2.4)
Inpatient care unit	334	118 (35.3)	114 (34.1)	22 (6.6)
Outpatient care unit	149	51 (34.2)	48 (32.2)	5 (3.4)
Emergency and accident unit	77	48 (62.3)	45 (58.4)	19 (24.7)
Intensive care and Semi-Intensive care unit	172	76 (44.2)	76 (44.2)	14 (8.1)
Total	816	319 (39.1)	309 (37.9)	62 (7.6)

Table 3. Factors contributing to workplace violence

Contributing factors**	Verbal abuse n (%)	Physical violence n (%)
Number of victims	309	62
Stress from the work situation	162 (52.4)	12 (19.4)
Poor communication	144 (46.6)	18 (29.0)
Long waiting times for patients	82 (26.5)	11 (17.7)
Working directly with people who have a mental illness	71 (23.0)	45 (72.6)
Patient dissatisfied with the service or treatment	35 (11.3)	1 (1.6)
Working directly with people who abuse drugs or alcohol	12 (3.9)	11 (17.7)
Unknown cause	74 (23.9)	7 (11.3)
Others	27 (8.7)	1 (1.6)

**Participants could select more than one option

Table 4. Risk factors for verbal abuse and physical violence

Factors	Verbal abuse (n=309)			Physical Violence (n=62)		
	Odds ratio	95% CI	*p*-value	Odds ratio	95% CI	*p*-value
Age (years)						
20-29	3.03	1.36, 6.74	0.007*	-	-	-
30-39	2.27	1.28, 4.03	0.005*	-	-	-
≥ 40 (reference)						
Education						
Bachelor degree (reference)						
Master degree/Doctoral degree	2.69	1.60, 4.54	< 0.001*	5.86	2.40, 14.29	0.023*
Working experience (years)						
1-5	-	-		4.94	1.10, 22.16	0.037*
6-10	-	-		-	-	-
≥ 10 (reference)						
Job Settings						
OR/LR (reference)						
IPD	-	-	-	-	-	-
OPD	-	-	-	-	-	-
ER	2.41	1.14, 5.12	0.022*	11.99	2.30, 62.55	0.003*
ICU/Semi-ICU	-	-	-	4.08	1.21, 17.80	0.047*
Opinion on sufficiency of the number of staffs						
Sufficient (reference)						
Not sufficient	1.96	1.41, 2.72	< 0.001*	3.42	1.89, 6.19	< 0.001*

Verbal abuse and physical violence: adjusted for age, gender, marital status, education, work experience, position, job setting, shift work, work hours per week, direct interaction with patients, opinion on sufficiency of the number of staff, and previous training in workplace violence management skills

*$p < 0.05$ considered statistically significant

Table 5. Risk factors for at least one form of workplace violence

Type of workplace violence	At least one form of workplace violence (n=319)		
Factors	**Odds ratio**	**95% CI**	***p*-value**
Age (years)			
20-29	2.73	1.23, 6.04	0.013*
30-39	2.31	1.31, 4.08	0.004*
≥ 40 (reference)			
Education			
Bachelor degree (reference)			
Master degree/Doctoral degree	2.52	1.50, 4.24	0.001*
Job Settings			
OR/LR (reference)	-	-	-
IPD	-	-	-
OPD	-	-	-
ER	2.65	1.25, 5.65	0.011*
ICU/Semi-ICU			
Opinion on sufficiency of the number of staffs			
Sufficient (reference)			
Not sufficient?	2.03	1.46, 2.81	< 0.001*

Workplace violence in at least one form adjusted for age, gender, marital status, education, work# experience, position, job settings, shift work, working hours per week, directly interact with the patient, opinion on sufficiency of the number of staffs, and previous training in workplace violence management skills
*$p < 0.05$ considered statistically significant

Table 6. Impact of the occurrence of workplace violence on physical and mental health

Impact on physical and mental health from violence	Verbal abuse (n=309)	Physical violences (n=62)
Injured as a result of the a violent incident		
Yes	0	11 (17.7)
No	309 (100)	51 (82.3)
Required treatment for the injuries		
Yes	0	2 (8.2)
No	309 (100)	9 (81.8)
Absenteeism as a result of the a violent incident		
Yes	16 (5.2)	1 (1.6)
No	293 (94.8)	61 (98.4)
Duration of absence		
Average (mean)	3.3 days	2 days
Repeated, disturbing memories, thoughts, or images of the attack		
Yes	261 (84.5)	41 (66.1)
No	48 (15.5)	21 (33.9)
Avoiding thinking or talking about the attack or avoiding having feelings related to it		
Yes	259 (83.8)	40 (64.5)
No	50 (16.2)	22 (35.5)
Being "super-alert" or watchful and on guard		
Yes	265 (85.8)	56 (90.3)
No	44 (14.2)	6 (9.7)
Feeling like everything you did was an effort		
Yes	257 (83.2)	45 (72.6)
No	52 (16.8)	17 (27.4)

medical treatment and 2% were absent from their work for an average of 2 days. The participants who experienced verbal abuse were absent from work for an average of 4 days. However, in most cases victims were not absent from their work.

As to the impact on mental health, half of the victims who experienced physical violence (66.1%) and verbal abuse (84.5%) had mild to moderate disturbing thoughts and memories. More than half avoided thinking or talking about the attack. In addition, up to 86%-90% of the victims had anxiety and felt insecure after the incident (Table 6).

Discussion

This is the first report on workplace violence that determined the magnitude of that violence in all wards of a large medical school in Thailand. We also assessed physical and psychological impacts of the occurrence of workplace violence. The prevalence of workplace violence against nurses of 39% in this study is consistent with previous studies by Chalermrat and others (16,17). However, the prevalence was lower than that reported by others, e.g., Thaddao (85.5% in a secondary care hospital), Wanpen (84.7% in a tertiary care hospital), Napatsawan (62% in a secondary care and tertiary care hospital), and Kasara (52% all hospital levels) (11-14). The differences may be due to variations in in job settings, workload, and organization systems to protect against violence in different hospitals. Our finding of verbal abuse being the most common form (38%) followed by physical violence (8%) is consistent with other studies (6,11-13,17,18)

The finding of differences in workplace violence among job settings with the highest prevalence in the emergency unit is in line with several other studies (2,10-14). Factors which put nurses at high risk of imminent violence could include the urgency of care required combined with the high level of anxiety and stress felt by patients and relatives, crowding and lengthy waiting times (16,18-23). The high prevalence of workplace violence in the ICU could be related to patients' condition and/or work tension, which could easily trigger conflict and violence (17). In addition, conflicts may arise due to poor communication, e.g., relatives of a patient with a severe condition might be dissatisfied if they feel they did not receive enough information.

The finding that younger nurses (age 20-29 years) have a higher risk of violence compared to nurses over 40 years (OR 2.73, 95%CI = 1.23, 6.04) is consistent with previous studies (16,18,23,24). Younger nurses might lack work experience and have might have not yet developed adequate communication skills and the ability to cope with conflict situations. In contrast, senior nurses have more experience and generally have better skills to cope with conflict. Previous reports have also shown that other personal risk factors, e.g., gender and education, are associated with workplace violence (16,18,21,25). However, this study did not find gender to be a significant determinant, probably due to the predominance of females in the nursing profession in Thailand. Nevertheless, for education, we found that nurses who had a higher education were more likely to experience workplace violence. This is in line with a study by Zeng in large psychiatric hospitals in 2013 which reported that some nurses with higher education might be dissatisfied with their high workload and low pay which triggered conflict. Notably, our study also revealed that understaffing correlates with the occurrence of violence as well. Tension occurs among patients with long waiting times, leading to patient dissatisfaction with service and triggering conflict which can easily lead to verbal abuse. This finding is in accordance with the results of other studies (16,20).

Our study participants reported that communication gaps are one of the crucial factors that can provoke aggression and verbal abuse. A study by Kamchuchart similarly found that inadequate communication was associated with workplace violence (16). In addition, nurses who have direct contact with patients with a mental illness or drug/substance abuse are more likely to encounter aggression and physical violence, as the patient's mental condition can induce behavioral agitation and aggressiveness (16,19).

The nature of the violence varied depending on the category of perpetrator. Patients and their relatives were the main perpetrators of physical violence, a pattern similar to that reported in many other studies (12,16,18,20,24,26). This association is related to the fact that in their daily work nurses frequently interact with patients and their relatives who have feelings of dissatisfaction, unmet expectations of care, or who have experienced long waiting times. Verbal abuse perpetrated by colleagues, on the other hand, could be attributable to the work environment, e.g., understaffing, increased workloads, and impaired team cooperation or job stress, which ultimately affect the quality of care. Our results that most incidents occurred during the morning shift, and on weekdays. This could be due to the high number of patient visits during those time periods. This finding is consistent with studies by Fujita and Seun-Fadipe (17,24), but it is inconsistent with studies by Napatsawan and Wanpen (11,13), both of which reported more frequent incidents during the afternoon shift. Those difference might also be due to differences in job description.

In response to physical violence, study participants reported they usually told the person to stop, which is in accordance with the findings of other studies (11,13,26). Despite concerns about workplace violence, our study showed that most participants did not report incidents, citing as the main reason that it was not critical to do so and/or that they were afraid of negative repercussions, results which are in line with several other studies (11,13,16,27). Some victims felt that the reporting system did not actually help prevent future incidents, particularly in cases of an unintentional attacker such as a psychotic patient. In cases of frequent verbal abuse by their supervisor, the victims seldom reported the incident in the system. Each of these factors result in an increase in the underreporting of incidents.

Negative consequences of workplace violence can also result in psychological damage to the victim. The victim might have disturbing thoughts and memories, avoid thinking or talking about the attack, feel like everything made an effort, and feel insecure after the incident. None of those consequences are currently included in the reporting system. In cases of physical violence, few of the victims received any significant injuries as a result. Most incidents did not require any medical treatment, indicating that the physical damage was not serious. The incidence of absence from work resulting from for verbal or physical violence was 2-5%, lower than that in a previous study in Thailand by Wanpen (2010) which reported that 10% of nurses' absences from work were the result of violence occurring on the job. Additionally, some participants reported that after an incident they felt discouraged, considered leaving their job, felt they lacked moral support, and felt they had lost confidence in themselves and the hospital system, all of which indicates that violence affects not only the individual but also the organization as a whole. Additional consequences could include higher costs for medical care and a negative impact on the quality of that care.

This study had some limitations. First, this was a cross-sectional study, so it could not demonstrate direct causal relationships. Second, information on workplace violence and other covariates were self-reported for the previous 12 months and thus were subject to recall bias. Thirdly, about 17% of the questionnaires were excluded for being incomplete which might have slightly decreased the precision of the study. However, the characteristics of the respondents with incomplete data were generally similar to those with complete data, so are unlikely to have substantially affected the findings. Finally, this study reflects the problem of workplace violence in a single medical school. It may not be representative of other types of hospitals with different occupational and environmental situations. However, this study does provide useful information for planning and implementation of programs to prevent workplace violence in other hospitals.

Conclusions

This study demonstrates that workplace violence is a common occupational hazard in at least one medical school hospital and that it adversely

affects nurses' physical and mental well-being individually and the hospital organization as a whole. However, the problem has often gone unrecognized and underreported. Nurses at high risk for workplace violence are generally younger, have a higher education, work in an emergency unit or ward with an insufficient number of staff. Poor communication is one factor that may trigger workplace violence. Preventive measures to reduce workplace violence include strengthening the zero-tolerance policy, allocating an adequate number of nurses, providing coping skills training, strengthening the reporting system (including privacy and confidentiality) as well as working to strengthen safety in the work environment.

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Conflict of interests

The authors do not have any conflict of interest to declare.

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ความชุก ปัจจัยเสี่ยง และผลกระทบของความรุนแรงในสถานที่ทำงานของพยาบาลในโรงเรียนแพทย์แห่งหนึ่งในประเทศไทย

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วัตถุประสงค์ เพื่อศึกษาความชุก ปัจจัยเสี่ยง และผลกระทบของความรุนแรงในสถานที่ทำงานของพยาบาลในโรงเรียนแพทย์ในประเทศไทย

วิธีการ การศึกษาแบบภาคตัดขวางได้ดำเนินการในโรงเรียนแพทย์แห่งหนึ่งในประเทศไทยในปี พ.ศ. 2563 โดยผู้เข้าร่วมแต่ละคนได้ตอบแบบสอบถามออนไลน์ที่รายงานด้วยตนเอง มีการวิเคราะห์ถดถอยโลจิสติกส์แบบพหุคูณ เพื่อหาปัจจัยเสี่ยงของความรุนแรงทางกายและทางวาจาในสถานที่ทำงาน

ผลการศึกษา มีจำนวนพยาบาลทั้งหมด 816 คน เข้าร่วมการศึกษานี้ โดยความชุกของความรุนแรงในสถานที่ทำงานของพยาบาลในช่วง 12 เดือนที่ผ่านมา คิดเป็นร้อยละ 39 (มีการล่วงละเมิดทางวาจาร้อยละ 38 และการทำร้ายร่างกายร้อยละ 8) ผู้ก่อเหตุความรุนแรงทางวาจาที่พบบ่อย ได้แก่ เพื่อนร่วมงาน (ร้อยละ 32) และผู้ป่วย (ร้อยละ 29) ส่วนผู้ก่อเหตุความรุนแรงทางกายได้แก่ ผู้ป่วย (ร้อยละ 84) ปัจจัยเสี่ยงต่อการเกิดเหตุความรุนแรงในสถานที่ทำงาน คือ อายุน้อย (อายุระหว่าง 20-39 ปี) ระดับการศึกษาสูง (ระดับปริญญาโทและเอก) มีจำนวนบุคลากรไม่เพียงพอ และทำงานในแผนกห้องฉุกเฉิน ($p < 0.05$) โดยร้อยละ 5 ของผู้ถูกกระทำขาดงานจากการล่วงละเมิดทางวาจา ในกลุ่มผู้ที่ถูกทำร้ายร่างกายพบว่าร้อยละ 18 ได้รับบาดเจ็บและร้อยละ 8 ต้องได้รับการรักษาพยาบาล

สรุป ความรุนแรงในสถานที่ทำงานของพยาบาลเป็นอันตรายจากการทำงานที่พบบ่อย ซึ่งส่งผลต่อความเป็นอยู่ที่ดีทั้งทางร่างกายและจิตใจ ดังนั้นมาตรการดำเนินการต่าง ๆ เช่น การฝึกอบรมทักษะการจัดการความรุนแรงสำหรับพยาบาลที่อายุน้อย การเสริมสร้างระบบการรายงาน ตลอดจนการดูแลสภาพแวดล้อมการทำงานให้ปลอดภัยจึงควรทำให้เข้มแข็งขึ้น **เชียงใหม่เวชสาร 2564;60(4):437-47. doi: 10.12982/CMUMEDJ.2021.39**

คำสำคัญ: ความรุนแรงในสถานที่ทำงาน พยาบาล โรงเรียนแพทย์