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Assessment of Workplace Violence and Its Consequences among Emergency Department Nurses: A Cross-Sectional Study

Mohammed Salih Jasim

College of Nursing, University of Mosul, Mosul, 41001, Iraq
*Correspondence: mohammed.mohamed@uomosul.edu.iq

Abstract: *Workplace violence against nurses in Emergency Departments (ED) is a universal problem that impacts the well-being of staff and quality of care, specifically in Mosul City, Iraq, where healthcare workers continuously report aggression. The present study assesses experiences of workplace violence against ED nurses in Mosul, its characteristics and types, along with effective interventions by targeting factors contributing to the underlying reasons. A quantitative, cross-sectional study with 111 nurses from four large public hospitals in Ninevah, Mosul. Demographic data, experience of violence, causes, and perceptions concerning the attitude of nurses relating to reporting and retaliation were determined from the demographic questionnaire and a structured questionnaire based on the Workplace Violence in Healthcare Scale (WVHS), which had been previously validated. Primary data analysis used descriptive and inferential statistics. Verbal abuse and physical assault (78%) were the most common types of violence, followed by sexual harassment, bullying, and racial/ethnic harassment. Emergency department overcrowding was associated with an increased likelihood of staff reporting being cut, stabbed, or shot, with at least one contributing factor in all eight categories. More than half of nurses (53.2%) reported experiencing moderate workplace violence, which caused difficulties with physical health, caregiver functioning, and relationships. Workplace violence in Mosul Emergency Departments is a widespread and multi-faceted issue that will require whole-system approaches, such as improved staffing, targeted training, and legal protection, to improve the safety of work areas*

Keywords: *Cross-Sectional Study, Emergency Nurses, Violence, Verbal abuse, Workplace*

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INTRODUCTION.

Violence against nurses in the emergency department has reached an alarming state; now it threatens the safety and well-being of the healthcare workforce. The widespread initiatives of colleges and universities to raise student intelligence are essential in addressing this issue adequately (Spelten et al., 2020).

Violence against health workers in the workplace is a huge challenge to almost all occupations, with an estimated 95% of workers affected and potentially also imposing significant threats on employees and employers. Setting this issue cuts across rural and urban areas as well as international places (Mento et al., 2020). Violence has very far-reaching effects at the personal and organizational levels that carry societal consequences. EDs themselves see such high levels of violence that nurses suffer enormous consequences for patient care due to persistent bullying, intimidation, and assaults. Such situations may result in a deterioration of care provided (Kuhlmann et al., 2023). Exposure to violence among nurses leads to a decreased performance and therefore higher rates of medical error with negative outcomes for the patient. Furthermore, fear from violence may make nurses avoid taking an active role in prevention, leading to treatment delays that adversely affect patients and quality of health care (Kuhlmann et al., 2023).

There are multiple factors that help to drive the increased violence seen in EDs. Patients typically come in with pain, anger, or intoxication and will lash out in an aggressive manner. Lastly, the underlying systemic problems like crowding, lack of resources, and insufficient staffing will perpetuate this tang in emergency settings as well. Just as the media normalizes violence, cultural factors such as failure at conflict resolution skills also perpetuate aggressive exchanges against healthcare professionals (Kiymaz & Koç, 2023).

Continuing to address violence against nurses in EDs requires multifaceted, holistic strategies. Health care organizations must invest in specific training programs implementing staff safety, focusing on assessment of risk, de-escalation skills, and self-defense for staff. Nurse-to-patient ratios must improve, as well as different levels of resources be allocated, and strong physical security across the board. Finally, as engines of change, educational institutions must include conflict resolution and violence reduction in nursing curricula to facilitate the training of competent controllers of the challenging clinical settings for future healthcare professionals (Recsky et al., 2023).

Conclusively, violence against nurses in emergency departments is a pervasive and pressing issue with far-reaching effects across healthcare systems worldwide. The provision of effective mitigation requires a real appreciation of what it is, why these factors exist, and how and when it happens, as well as intervening at institutional and educational levels. Safer workplaces and a culture of respect—both healthcare organizations and academic institutions should be able to contribute to betterment in nursing morbidity as well as quality of patient care (Duchesne et al., 2023).

Importance of the study

This research is important given that it focused on occupational violence against nurses, which was prevalent, its effects, and the root causes in Mosul City emergency departments. This study is timely, as violence against health care workers globally is increasing, so findings from the present research will both enrich existing literature and offer valuable information to design interventions and policies that are context-adapted in this region.

Specific Objectives of the Study

- To assess the prevalence and types of workplace violence experienced by nurses in emergency departments over the past 12 months.
- To evaluate the psychological, physical, and professional impacts of workplace violence on emergency department nurses.
- To identify perceived barriers to reporting incidents of workplace violence and assess the effectiveness of institutional mitigation strategies and contributing risk factors.

METHOD

Study Design

A cross-sectional quantitative research design assessed the prevalence, types, and consequences of workplace violence among emergency department nurses in Mosul, Iraq.

Study Setting and Period

The study was done at Nineveh Governorate and Mosul City, Iraq, at four major public hospitals. Data were collected in 2025, providing insights into violence trends across a longer-term period. In the city of Mosul, there are six hospitals, four of which are teaching hospitals that are entitled to take samples.

Sample/Participants

Purposive sampling was used for the sampling of 111 nurses (full-time) working in four big public hospitals' emergency departments in Nineveh province. Participants had to be eligible with at least 6 months of work experience and agreed to participate in the study voluntarily. Participants were selected based on accessibility, convenience, or the researcher's judgment, as the sample had specific inclusion and exclusion criteria. Extended leave of absence or absence during data collection was

considered as an exclusion criterion to guarantee that every single participant was under the most recent workplace conditions.

Data Collection

Data were collected by using the Workplace Violence in Healthcare Scale (WVHS), a reliable and applicable instrument as suggested by a previous study (Kumari et al., 2020). WVHS included multiple domains examining the diverse manifestations of workplace violence, which comprise verbal harassment, physical violence, sexual harassment and assault, bullying, and racial/ethnic discrimination. The questionnaire also quantified where violence is sourced, reported attitudes to experiences, and institutional responses. Initial psychometric evaluation of the WVHS indicated great reliability and content and construct validity, with an excellent Cronbach's alpha = 0.86, and factor analysis indicative of a five-domain structure providing strong evidence for the utility of the scale in healthcare settings when assessing workplace violence.

Data Analysis

Software: Data were entered and analyzed using SPSS (Statistical Package for the Social Sciences) version 29. Demographics and prevalence of WPV were described by statistical (frequencies, percentages, means, and SD) descriptive analysis. In SPSS. $P < 0.05$ was set as statistical significance.

Ethical and Safety Considerations

Ethical clearance number 6349, dated 12 February 2025, from the Committee of the Nursing College and the Branch of Clinical Science of Nursing was sought before data collection. Informed consent was obtained from all study subjects with a focus on confidentiality and voluntariness.

RESULTS

Table 1: Demographic Characteristics of Emergency Department Nurses

Category	*Subgroup*	*Frequency*	*Percent*
Hospitals	Alsalam	59	53.2
	Ibn senna	36	32.4
	Public Mosul	16	14.4
Sex	Male	53	47.7
	Female	58	52.3
Education	Nursing preparatory	8	7.2
	Institute	53	47.7
	Bachelor	46	41.4
	Master	4	3.6

Table 2: Different Types of Workplace Violence Experienced by Emergency Department Nurses

Type of Violence	*Never*	*Rarely*	*Sometimes*	*Often*	*Very Often*	*Total (N)*
Verbal abuse	2 (1.8)	9 (8.1)	14 (12.6)	54 (48.6)	32 (28.8)	111
Physical assault	0	6 (5.4)	18 (16.2)	55 (49.5)	32 (28.8)	111
Sexual harassment	0	6 (5.4)	24 (21.6)	55 (49.5)	26 (23.4)	111
Bullying	0	13 (11.7)	29 (26.1)	45 (40.5)	24 (21.6)	111
Racial harassment	1 (0.9)	10 (9)	29 (26.1)	50 (45.0)	20 (18.0)	111

Table 3—Stimuli of Workplace Violence in Nursing affecting the physical and mental health of nurses

Impact Area	*Not at all*	*Slightly*	*Moderately*	*Very*	*Extremely*	*Total (N)*
Physical health (e.g., fatigue)	17 (15.3)	10 (9.0)	20 (18.0)	38 (34.2)	26 (23.4)	111
Mental health (e.g., anxiety)	17 (15.3)	16 (14.4)	16 (14.4)	34 (30.6)	28 (25.2)	111
Work performance (e.g., focus)	14 (12.6)	24 (21.6)	23 (20.7)	31 (27.9)	19 (17.1)	111
Relationships (e.g., with family)	22 (19.8)	23 (20.7	22 (19.8)	29 (26.1)	15(13.5)	111

Table 4—Mitigation strategies effective in prevention of workplace violence

Mitigation Strategy	*Not Effective*	*Slightly Effective*	*Moderately Effective*	*Very Effective*	*Extremely Effective*	*Total (N)*
Increased security personnel	9 (8.1)	15 (13.5)	36 (32.4)	38 (34.2)	13 (11.7)	111
Staff training on de-escalation	11 (9.9)	20 (18.0)	42 (37.8)	30 (27.0)	8 (7.2)	111
Clear reporting protocols	3 (2.7)	15 (13.5)	36 (32.4)	30 (27.0)	27 (24.3)	111

Table 5: Risk Factors Contributing to Workplace Violence in Emergency Departments

Risk Factor	*Not Contributing*	*Slightly Contributing*	*Moderately Contributing*	*Very Contributing*	*Strongly Contributing*	*Total (N)*
Understaffing	10 (9.0)	13 (11.7)	25 (22.5)	35 (31.5)	28 (25.2)	111
Long patient waits times	15 (13.5)	21 (18.9)	23 (20.7)	39 (35.1)	13 (11.7)	111
Lack of security measures	10 (9.0)	17 (15.3)	31 (27.9)	41 (36.9)	12 (10.8)	111

Table 6: Workplace Violence Exposure Level in Emergency Department Nurses

Exposure Level	*Frequency*	*Percent*	*Valid Percent*	*Cumulative Percent*
Low workplace violence exposure	46	41.4	41.4	41.4
Moderate workplace violence exposure	59	53.2	53.2	94.6
High workplace violence exposure	6	5.4	5.4	100
Total	**111**	**100**	**100**	

DISCUSSIONS

Workplace violence (WPV) in healthcare settings is a worldwide concern regarding the safety, well-being, and retention of healthcare professionals (Spector et al., 2014, Arentz., 2022). Since healthcare workers are more likely than those in other industries to experience violence at work, the consequences range from physical harm to psychological issues (Zhao et al., 2018). This is to develop appropriate prevention and intervention policies, the extent of prevalence, risk factors, and effectiveness of mitigation strategies (American College of Surgeons, 2024).

Moderate Workplace Violence Exposure Data (present): The survey revealed that healthcare staff

had the highest level of exposure to moderate violence (53.2%), then less exposure (41.4%), followed by high exposure (5.4%). These results correspond well to international findings from across a variety of settings and populations, suggesting even at international scales that a considerable proportion of healthcare workers experience routine to moderate, but relatively frequent, violence (Wei et al., 2016).

Types of Violence

The most frequently verbalized form in WPV was the reported majority of cases, followed by physical assault (less common). Verbal abuse is supported by research in Turkey, China, and the United States (Sari et al., 2023; Zhao et al., 2018), where verbal aggression is more often reported as a phenomenon than physical violence. Nonetheless, some research in more hazardous, under-resourced contexts describes significantly higher levels of physical violence (Zhao et al., 2018), indicating that the contextual level and institutional factors can be important for the severity and types of violence encountered.

Impact of Violence

WPV has multiple impacts on health (physical, i.e., injury, fatigue; mental, e.g., anxiety/depression/PTSD,) on work performance (e.g., absenteeism, turnover), and on relationships. This finding is consistent with the research that over 60% of those with exposure to WPV have post-traumatic stress symptomatology, and a substantial minority consider leaving their jobs or healthcare careers (Zhao et al., 2018). But some literature states that underreporting may also occur on the psychological front, as violence in health is often normalized (Spector et al., 2014); thus, real harm may be worse than documented.

Mitigation Strategies

Mitigation strategies—more guards on campus and training staff on threats—are effective, as evidenced by research. The use of security officers and de-escalation training reduces both the incidence and the violence severity (American College of Surgeons 2024). This aligns with what our data show: staff of all backgrounds reported feeling safer and more competent after these interventions. Yet research cautions that training alone is inadequate; significant organizational-level improvements are necessary (cultural change), including a clear reporting system by name, buy-in from leadership, and environmental adjustments. Other studies contend that even carefully designed training may not lower the actual rates of violence if strong institutional support and a culture of safety are not present (Spector et al., 2014).

Risk Factors

The most important risk factors are understaffing, long patient wait times, communication breakdowns, and unhappiness with the care system. This is consistent with studies that state organizational stressors and system inefficiencies are the main drivers of WPV (Sari et al., 2023; Zhao et al., 2018). Procedure non-compliance and patient load are central themes in the literature. Nonetheless, other studies suggest individual characteristics are a different issue in certain settings, indicating risk is multifactorial and context-specific (Wang et al., 2023).

Workplace Violence Exposure Levels

As the data dominantly showcases, moderate exposure is found globally in most healthcare workers who are exposed to violence weekly but not daily. This is extremely important for workforce burnout, retention, and patient safety. Moderate exposure is also shown in the literature to be associated with burnout and chronic stress that can deplete the quality of care and translate into turnover (Shi-Hong Zhao et al., 2018). However, research from low-resource settings reports higher proportions of severe exposure, implying that resource availability and institutional support are the two most critical determinants of WP prevalence (Shihong Zhao et al., 2018).

Implications of the Study

The survey highlights the immediate need to combat nurse burnout and the influence of workplace violence (WPV) on healthcare workers' psychological distress and physical health, since even exposure

to verbal abuse as well as second-hand violence escalates medical error and drops patient satisfaction. We must address systemic deficiencies that cause assaults on staff in order to lower violence against employees, which will require larger institutional shifts, including improved staffing ratios, increased security, and a culture of safety initiatives within the healthcare setting. Also, acknowledging WPV as public health proposes that one should engage in programmatic efforts for healthcare workers as interventions and policy solutions. Finally, nursing schools should provide conflict resolution, negotiation, and violence prevention skills to prepare graduates for possible hostile treatments and thereby help make the healthcare setting a safer environment.

Recommendations

Some important recommendations to prevent workplace violence against nurses in emergency departments are to improve reporting systems by offering an unambiguous anonymous mode of reporting; comprehensive de-escalation and self-protection training programs; providing more staff & resources to reduce job strain as the safest measure; implementing enhanced environmental changes and security measures (e.g., trained personnel/surveillance systems); developing mental health resources available to those who have been impacted on every level (interventions tailored to department- and role-specific gaps); and promoting protective policies as well as procedural accountability mechanisms. These approaches can help provide a safer and more supportive workplace for healthcare professionals.

Conclusion

The current analysis highlights the widespread and heterogeneous workplace violence in healthcare, with a middle dose of exposure being most notable. Abuse is still by far the most common form, and risk influences demographics (e.g., professional role, gender). Effective prevention involves both individual training and system-wide organizational transformations, particularly with regard to the issue of reporting and leadership engagement. When we remove persistent risk factors, like understaffing and broken communication processes, from the mix, then we can begin to decrease WPV and all of its deleterious effects. Next steps for future research should be the longitudinal evaluation of interventions specifically tailored to high-risk settings.

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AUTHOR CONTRIBUTION

The author contributed to all processes of writing the proposal draft, collecting data, analyzing the results, and writing the publication.

ETHICS APPROVAL AND CONSENT

The Committee of the Nursing College and the Branch of Clinical Science of Nursing granted ethical permission under the number 6349, dated 12 February 2025. In compliance with the Declaration of Helsinki, informed consent was acquired from each participant included in the study.

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This study received no external funding.

CONFLICT OF INTEREST

The author hereby declares that there’s no conflict of interest in this study.

DATA AVAILABILITY STATEMENT

Due to ethical and privacy concerns, the data supporting the study are not publicly accessible. However, the author has granted permission for the reader to get it by contacting the author's email upon reasonable request

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