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Nurses' Resilience Levels and the Effects of Workplace Violence on Patient Care

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Title: Nurses' resilience levels and the effects of workplace violence on patient care

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Abstract: Nurses experience high rates of violence on the job, which is a significant stressor. Stress can alter nurses' care of patients, but stress can be mitigated by resilience. The purpose of this study was to examine the relationship between nurses' resilience levels and their reports of patient care following episodes of workplace violence. Six themes emerged from nurses' (n=57) responses to workplace violence: vigilance, cautious yet individualized with care, part of the job, growth, jaded, and no effect. Low resilience levels were found in nurses with themes of feeling jaded, cautious yet individualized with care, and vigilance. High resilience levels were found in nurses with themes of no effect, growth, cautious yet individualized with care, and vigilance. Nurses' resilience scores were related to their patient care descriptions after episodes of workplace violence. Raising nurses' resilience levels through training might help them to positively overcome the effects of workplace violence, limiting impacts to patient care.

Keywords: Workplace violence; resilience; patient care

Introduction/Background

The healthcare industry has the highest rate of nonfatal assaults occurring in the workplace (Emergency Nurses Association, 2019). The Joint Programme on Workplace Violence in the Healthcare Sector (2002) defines workplace violence as "incidents where staff 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, well-being or health." In addition to violence from patients, nurses may experience violence from other nurses, called horizontal violence (Purpora et al., 2015). In a survey of 175 hospital nurses, 139 (79.4%) experienced horizontal violence at work at least once in the preceding six months (Purpora et al., 2015). A negative relationship was found between horizontal violence and quality of care ($r=-.469$, $p<.01$), while errors and adverse events increased with horizontal violence ($r=.442$, $p<.01$) (Purpora et al., 2015).

The occurrence of workplace violence not only results in immediate injury, but can also cause post-traumatic stress disorder (PTSD) symptoms and decreased productivity (Gates et al., 2011). However, not every nurse who experiences workplace violence will experience negative effects. Individual resilience may modulate the effects of trauma (van der Werff et al., 2013). Resilience is an individual's ability to restore their health and wellbeing after distressing situations (Garcia-Dia et al., 2013). Studies have indicated that providing nurses with resilience skills helps to manage stress (Chesak et al., 2015; Mealer et al., 2014). The purpose of this project was to describe nurses' experiences with workplace violence and how these experiences affect their clinical care based on their resilience level.

Methods

Subjects were recruited via convenience and snowball sampling from posts on Facebook and emails to nursing colleagues and friends. Subjects had to be registered nurses (RNs) who had experienced workplace violence. Data was collected for seven weeks during December 2018 and January 2019 using Survey Monkey. Approval was obtained from the Institutional Review Board (IRB) at Fairfield University.

Subjects were asked to answer demographic questions and complete the Brief Resilience Scale (BRS), a six-item scale assessing one's capacity to overcome stressful experiences (Smith et al., 2008). The BRS contains

three positively worded and three negatively worded items, each of which is rated on a 5-point Likert scale from strongly disagree to strongly agree (Smith et al., 2008). The creators of the scale distinguished that low resilience scores are 1-2.99, normal resilience scores are 3-4.30, and high resilience scores are 4.31-5 (Smith et al., 2008). Internal consistency of the BRS ranges from a Cronbach alpha of .80 to .91 with test-retest reliability of .69 (Smith et al., 2008). The BRS displays positive correlations with the resilience measures, optimism, and purpose in life (Smith et al., 2008). Finally, subjects were asked to respond to two qualitative questions as follows: (1) Please describe your experience with workplace violence (2) Do you feel this experience has affected the care you have provided to subsequent patients in similar situations? If so, please describe how.

Qualitative data was analyzed using inductive content analysis. Data was organized through open coding, in which each author read through the surveys and wrote down headings (Elo & Kyngäs, 2007). The headings were then transcribed, and categories were generated. The categories were then grouped to identify which group the data belonged in. Then the data was abstracted to develop a description of the categories (Elo & Kyngäs, 2007). When the authors finished analyzing the data, they met to compare and confirm results. BRS scores and descriptive statistics were calculated using Microsoft Excel® software.

Results

Of the 62 individuals that responded to the survey, four subjects did not complete the qualitative questions. In addition, one subject answered only three out of the six items on the BRS. These five responses were not included in the data analysis and the final sample consisted of 57 responses.

Table I: Demographics

Demographic	**Information**
Mean Age (Years)	38.81 (SD 11.86)
State of Residence	CT (n=42; 73.68%), MA (n=10; 17.54%), NY (n=4; 7.02%), CA (n=3; 5.26%), ME (n=1; 1.75%), NJ (n=1; 1.75%)
Clinical Specialty	psychiatry (n=24; 42.11%), medical/surgical (n=13; 22.81%), geriatrics (n=1; 1.75%), emergency (n=9; 15.79%), operating room (n=1; 1.75%), critical care/intensive care (n=4; 7.02%), oncology (n=2; 3.51%), labor and delivery (n=1; 1.75%)
Mean Years Worked in Clinical Specialty	6.11 (SD 8.21)
Clinical Setting Where Violence	acute care (n=35; 61.40%), emergency (n=15; 26.32%), long-term care (n=1;

Occurred	1.75%), rehab (n=1; 1.75%), subacute (n=1; 1.75%), residential (n=1; 1.75%), dialysis (n=1; 1.75%), several settings (n=2; 3.51%)

Qualitative responses were divided into two main themes: types of violence and effects of violence. Three types of violence were identified: physical, verbal, and horizontal violence. For effects of violence themes were: no effect, vigilance, part of the job, cautious yet individualized with care, growth, and jaded.

For types of violence, 43 subjects (75.44%) reported experiences of physical violence including being "spit on, punched, kicked, bitten. . .," "hit in the face," "attacked and kicked in the abdomen." Meanwhile, 13 subjects (22.81%) reported experiences of verbal violence, including "nearly daily experience with verbal assault" and "verbal abuse regularly." Finally, 10 subjects (17.54%) reported experiences of horizontal violence with incidents such as: "verbal abuse and psychological abuse by the senior nurses who were training me and my other oriented coworkers," being "pushed by an RN when assisting a patient," and being "bullied and blatantly disrespected by peers."

Results for effects of violence on patient care identified 15 subjects (26.32%) that stated their experience with workplace violence has not influenced their patient care. Statements included: "no, because this aggression was due to frontal brain mets so I knew it wasn't their true fault" and "no, I compartmentalize well . . ." Meanwhile, 14 subjects (24.57%) reported being vigilant when approaching patients after experiencing violence, including being "more cautious, and I tend to expect an assault so that I can be prepared" and "I remain vigilant with all the patients." Another category identified by 8 subjects (14.04%) was acceptance of violence as part the job. Nurses stated, "I accept that it's part of the profession I chose and realize that it's a risk of dealing with the public" and "the nature of where I work." In contrast to these responses, there were 8 (14.04%) subjects that recognized how their experience served as an opportunity for growth indicating, "I was able to transform this bad experience into better care for my patients. I learned more skills and became better able to identify issues before they turned violent." Furthermore there were 5 subjects (8.77%) reporting a mixed response of being cautious yet individualized in their care: "I am probably more cautious around people who look like the people who were violent, but even when treating the same patient, I would treat them with respect and ensure that their needs were met." Finally, 5 (8.77%)

subjects reported how their experience resulted in feeling jaded: “less available, more avoidant,” “more fearful and less empathetic,” and “jaded towards certain patients.”

Table II: Resilience Scores

Brief Resilience Scale (BRS) Score Level	Qualitative Categories
High (BRS>4.30)	no effect (n=6), growth (n=1), cautious yet individualized with care (n=1), and vigilance (n=2)
Normal (BRS 3-4.30)	no effect (n=9), growth (n=9), vigilance (n=9), jaded (n=2), part of the job (n=2), and cautious yet individualized with care (n=4)
Low (BRS< 3)	jaded (n=3), cautious yet individualized with care (n=2), and vigilance (n=1)

Discussion

In this study, 75.44% of the nurses reported experiences with physical abuse from patients. Details in these reports are consistent with the most common types of physical assaults reported by nurses including being spat on, hit, pushed/shoved, scratched, and kicked (Edward et al., 2014). It is clear that verbal violence occurs more frequently than physical violence (Edward et al., 2014). However, in this survey nurses spoke more about episodes of physical than verbal violence. It may be that nurses are desensitized to verbal violence, which could have limited their recounting these experiences. Another reason for low reporting of violence may be due to nurses viewing it as ‘part of the job,’ a theme reported by 14.04% of the nurses in this study. In a study by Renker, Scribner, and Huff (2015), theme of “cycnicism” was deducted from reports on violence being a “part of the job” or from nurses concerns with “stereotyping” patients, inferring that cynicism could be a contributing factor to the escalation of violence. Becoming desensitized to violence not only affects reporting, but may also result in missed opportunities to intervene early in the cascade of aggression, possibly preventing violence.

Another finding of this study is that resilience levels played a role in how nurses described incidents of workplace violence affecting their patient care. The majority of nurses with normal or high resilience levels experienced growth, no effect, or maintained the ability to provide individualized care. This could be related to the core positive influences of resilience: integration, personal control, psychological adjustment, personal growth, and effective coping (Garcia-Dia et al. 2013). Prior research found Taiwanese nurses’ resilience was significantly higher in those without depressive states (Hsieh et al., 2016). While this study did not ask about depression, the

subjects with low resilience levels (n=6) identified feeling jaded (n=3) and vigilant (n=1). Teaching nurses skills in resilience may be a way to protect nurses' health from the harmful effects of violence. A few studies have examined the effects of training nurses in resilience skills. One study integrated the Stress Management and Resiliency Training (SMART) program into new nurse orientation, with participants developing improved resilience and decreased anxiety (Chesak et al., 2015). Another study gave 12-weeks of resilience training to nurses in intensive care and found decreased scores for depression and PTSD, as well as increased resilience scores (Mealer et al., 2014). These studies indicate there is potential for training to positively impact nurses' resilience levels, which may help nurses to respond to violence in healthy ways with limited impacts on patient care.

Although the sample size for this study is modest, it provides a link between experiences of workplace violence and effects on clinical care, while considering resilience levels. Another limitation is that the sample came from six states, limiting the generalizability of findings. Despite these limitations, the study was anonymous and collected via an online survey, allowing nurses to respond honestly.

In conclusion, results of this study indicate that resilience levels may help to determine how nurses' experiences with workplace violence lead to negative or positive changes in their care of patients. Because nurses are frequently faced with violence in the clinical setting, training them in resilience skills could enhance their ability to positively overcome the effects of violence. Future studies should examine the effects of resilience training on nurses' resilience levels and patient care.

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