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The impact of workplace violence on health professionals in tertiary hospitals in Delta State, Nigeria.

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Abstract

Background: Workplace violence (WPV) is 'the act or threat of violence, ranging from verbal abuse to physical assaults directed toward people at work or on duty'. It is common worldwide. Health Professionals are at risk and vulnerable to WPV when compared to other professions. Forms of WPV are Physical, Verbal abuse, Sexual violence, Intimidation and damage to physical Property. Global prevalence is 61.9% and is a serious cause of Public Health concern. It is underreported and recent information revealed that the current knowledge is just the tip of the iceberg. Di Martino model, (takes into cognizance the several variables related to WPV from the perpetrator, the victim and the environment) was adopted as the framework. Objective: To determine the impact and consequences of WPV among Health Professionals in Tertiary health institutions in Delta State. Method: It was a descriptive cross-sectional study carried out among 301 Health Professionals obtained by multistage sampling technique in Delta State University Teaching Hospital, Oghara and Federal Medical Centre, Asaba with analysis done using SPSS version 2.6. Result: The mean age of respondents was 38.60 ± 8.43. Of the respondents, 152 Health Professionals have experienced WPV, representing a prevalence of 50.5%. There was under-reporting of incidents of WPV. Out of the 152 respondents who had experienced WPV, 120 (78.9%) had Post-Traumatic Stress Disorder. The identified associated risk factors included age, sex, marital status, qualification and years of experience. Conclusion: The prevalence is high, and it was under reported. There was an impact on the psychological wellbeing of Health Professionals. It was recommended that policies against WPV by management, the provision of training programmes for Health Professionals and periodic psychological evaluation of staff who have been victims of WPV.

***Keywords**: Workplace Violence, Health Professionals, Post-traumatic Disorder.*

Introduction

Workplace violence (WPV) is a common phenomenon occurring across all work settings, crossing borders, cultures, occupational groups in both developed and developing countries. (Jia et al. 2020) The definition of workplace violence is a spectra as varied considerations are being generated, ranging from offensive language, brutality to fatality (Azodo et al. 2011). A comprehensive definition is that of the World Health Organization (WHO); World report on violence and health (WRVH) defines it as, "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal development, or deprivation". (Krug E, 2002).

There is a general perception that workplace violence as a physical assault however there are several forms which include threatening behavior, Written or verbal threats, Verbal abuse, Physical attacks, Sexual abuse and harassments, Racial abuse (Rodwell & Demir, 2012). While four categories of workplace violence have been noted: Type I or "external" violence, (where the perpetrator is neither an employee nor a client and the aim of attack is cash or some other valuable commodity). Type II or "client-initiated" violence (which involve some form of assault by a person who is either the recipient or the object of a service provided by the affected workplace or the victim). Type III or "internal" violence, (where an assault is perpetrated by a fellow worker). Type IV or "Personal Relationship" (here the

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perpetrator usually has a personal relationship with an employee) Most incidents or cases of workplace violence experienced and reported in health care settings fall under the type II classification. (Phillips, 2016; Stene et al. 2015).

A model adapted and modified for used in this study was that of Chappell and Di Martino, which takes into cognizance the several variables related to workplace violence from the perpetrator, the victim and the environment. This model recognizes the risk of WPV are multifactorial and emphasizes the fact that the resultant consequences affect the worker and the workplace (Chappell & Di Martino. 2006)

Workplace Violence has become a scourge worldwide and a cause of Public Health concern. (Hossain et al. 2020) and unfortunately what is known in recent information is just the tip of the iceberg. Global prevalence is estimated to be at 61.9%, with Africa having values ranging from as low as 9% and as high as 62.3% (Ekpor et al. 2024). In Nigeria, the incidence of violence against health care workers ranges from 10% to 60%. Surprisingly, a study in Northern Nigeria revealed that all Health Workers sampled had experienced workplace violence at one point in their practice (Abdullahi et al. 2018). Considerations for this wide variation at the national and sub-National level are differences in socio-economic and cultural status. (Njaka et al. 2020). However, despite these alarming occurrences, majority of health workers who are victims of violence do not report these incidents to their superiors, law enforcement agents. (Abaate et al. 2022).

Whereas a lot of work has been done on the prevalence and forms of WPV, there are large gaps and paucity of research on the impact of these incidents on health care professionals in Delta State. There has been a surge in desire of health care professionals to migrate and seek for Jobs in other climes. It is imperative to ascertain if the reasons are for better remuneration alone or could other factors such as workplace violence. There is empirical research that explored the consequences of violence against health-care workers. Majority of campaigns against workplace violence are based on research exploring the consequences of violence for crime victims in other sectors. Again, there appears to be a lopsided focus on physical injuries with little attention on the psychological impact of violence against health-care workers. This research assessed the psychological impact of using standardized and validated tools.

Maintaining a healthy and violent free work environment is important for the health sector to thrive and blossom. Interestingly it appears to be in line with vital aspects of the Sustainable Developmental Goals (SDGs) especially as it concerns SDG 3(Good Health and Well-being), 8(Decent Work and Economic Growth) and 16(Peace, Justice and Strong Institutions). This study showed the magnitude of WPV thus bringing facts to the hospital management, thereby influencing development of appropriate policies and strategies.

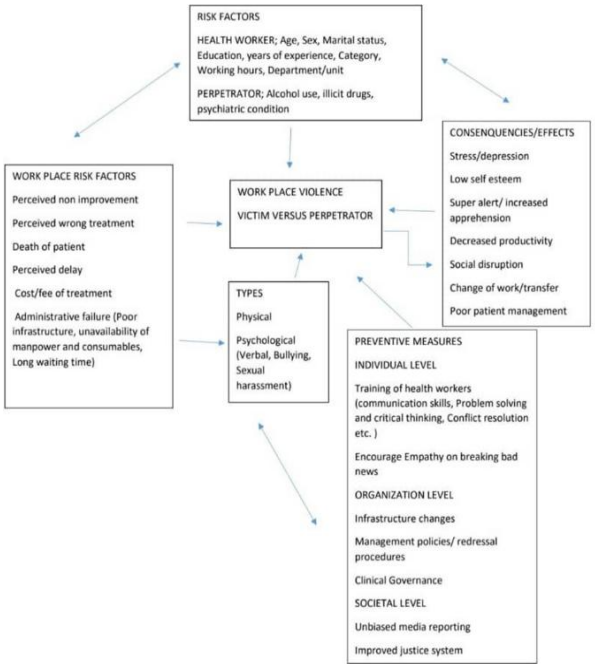
This study was aimed at determining the prevalence, the pattern of reporting and impact of workplace violence on health professionals in tertiary institutions in Delta State. It is often noticed that violent episodes against doctors and other health workers are rarely reported. A study suggested that out of the total cases, employees report only 50% cases of verbal abuse and less than 40% cases of physical assault (Kynoch, Wu & Chang, 2011). Some doctors and other health care workers might consider only episodes causing physical injury as violence while some assume that reporting cases of violence will not lead to any positive change. (Morken, Johansen & Alsaker, 2015).

The effects of WPV are not just limited to physical and psychological well-being but translates to other issues such as increased burnout, reduced job satisfaction and performance, which may ultimately hinder the quality of patient care. (Kumari et al. 2020). A Palestinian study on WPV revealed significant effects on the well-being of employees, care of patient and well-being of employees in hospitals emergency; in fact, more than three and a half times likely to even quit their jobs (Hamdan & Hamra, 2015). In a cross-sectional study including 270 health care workers in 12 family medicine centers in Saudi Arabia, the consequences of WPV were decrease in job productivity (31.1%), feeling embarrassed (4.9%), feeling worried (2.5%), and other concerns (5%). Also from the study, the majority of Health Care Workers who experienced violence were either unsatisfied (45.9%) or very unsatisfied (25.4%) with the way the violent event was managed. (Al-Turki, Afify & AlAteeq, 2016).

A meta-analysis on the effect of workplace violence and discrimination showed a negative impact on the attitude

to work and on the physical and mental health of the affected persons. (Triana, et al. 2018). The impact of violence to health care professionals can directly result in post-traumatic stress disorder (PTSD) as shown by Wizner et al. 2022 and Dia et al. 2024.

In Rwanda, a study conducted from 2007 to 2008 and published in 2011 on WPV among healthcare workers in Districts hospitals showed the consequences of WPV as serious as workers' withdrawal from the nursing career after violence, absenteeism and lower productivity (Musengamana, et al. 2022). A Nigerian study revealed psychological problems like low self-esteem, staff burn out as common consequences WPV (Chinawa, et al. 2020). These findings were like a national cross-sectional study done in India among 617 doctors where more than half of the participants reported "loss of self-esteem", "feeling of shame" and "stress, depression, anxiety or ideas of persecution" following the incident of WPV. (Kaur, et. al. 2020). Workplace violence has a significant effect on the psycho-social well-being of health care workers, as well as an impact on patient management; these effects are capable of escalating discontent and distrust among the public, this in turn increases the incidents of workplace violence. Thus leading to a so-called self-propagating vicious cycle. (Toska et al. 2023).



Adapted Chappell & Di Martino model on Workplace Violence

Materials and Methods

Study Area

The study was carried out at Delta State University Teaching Hospital, Oghara and Federal Medical Centre, Asaba both in Delta Sate, South-South geo-political zone Nigeria.

Study Design

The research was a descriptive cross-sectional design.

Study Population

Health care workers in Delta State University Teaching Hospital, Oghara and Federal Medical Centre, Asaba. Health workers belonging to the professional category of Doctors, Nurses, Pharmacists Medical Laboratory scientists and other allied professionals that were willing to participate were included in the study while excluding health workers with less than 12 Months working experience, those who participated in pretest survey and those on leave.

Study Duration

This research was carried out in four (4) months; from October 2023 to January 2024

Sampling Technique

Multistage sampling was used in this study. The first stage was by cluster technique was to group tertiary health institutions into 4 cluster (Federal Medical Centre, Asaba; Delta State University Teaching Hospital, Oghara; Asaba Specialist Hospital, Asaba; Lily Hospital, Warri) from which 2 were randomly selected by balloting (Delta State University Teaching Hospital, Oghara and Federal Medical Centre, Asaba.

In the second stage, department/units in the selected institution were grouped into a cluster of 24 units and 10 units were selected randomly by balloting. The third stage was by systematic random with an interval of 3 from each of these clusters

Sample Size Determination

The minimum sample was calculated using the Cochran formula. (John Wiley & Sons; 1977). A prevalence of 78% from previous study. (Abaate, et al. 2022).

A minimum sample size of 264 was calculated and adding 10% attrition rounded off to 290, however 301 was collected.

Research Instruments

A Semi-structured Questionnaire pretested 27 item questionnaires with three (3) sections was used. The first section was on socio-demographic information and work-related details while second section was on information about details of workplace violence (experiences, pattern of reporting, consequences). The third section was on policies, measures and satisfaction with existing policies and recommendations for preventing workplace violence. A standard Trauma Screening Questionnaire with a total score of 10 was also used to assess Post-Traumatic Stress Disorder (PTSD). Those with scores greater than or equal to 6 had PTSD.

Data Collection

The chosen participants were provided with the directives, requested to sign a consent form permitting them to participate in the survey with semi-structured self-administered questionnaire and Trauma Screening Questionnaire in English version was distributed to respondents. A pre-test was done to ascertain the possible challenges with the questionnaire use.

Data Analysis

Data was analyzed by using Statistical Package for the Social Sciences (SPSS) version 26.

Inferential statistic such as Chi-square test was used to assess relationship between factors and WPV.

Ethical Consideration

Ethical clearance was obtained from the health research and ethics committee of the Delta State University Teaching Hospital, Oghara. (Approval Number: HREC/PAN/2023/045/0593) Institutional approval was obtained. A consent form was filled in by each participant. The ethical principles were taken into cognizance.

Table 1**: Socio-demographic variable of respondents (n = 301)**

Variable	Frequency	Percentage
Age (in years)		
20 – 24	7	2.3
25 – 29	40	13.3
30 – 34	65	21.6
35 – 39	88	29.2
40 – 44	18	6.0
45 – 49	49	16.3
50 – 54	16	5.3
55 – 59	15	5.0
60 and above	3	1.0
Mean age 38.60 ± 8.43		
Sex		
Male	138	45.8
Female	163	54.2
Marital Status		
Married	176	58.5
Single	87	28.9
Separated/Divorced	17	5.6
Widow	21	7.0
Years of experience		
1 – 5	88	29.2
6 – 10	73	24.3
11 – 15	66	21.9
16 – 20	56	18.6
Over 20	18	6.0
Mean years of experience 10.64 ± 6.43		
Professional group		
Physician	95	31.6
Pharmacist	47	15.6
Nurse	84	27.9
Laboratory scientist	34	11.3
Professions allied to medicine (e.g Physiotherapist, radiographer, optometrist)	31	10.3
Midwife	7	2.3
***Others (nutritionist, technician)**	3	1.0
Department/unit		
Outpatient Clinics (GOPD, MOP& SOP)	118	39.2
Specialized unit	53	17.6
Accident and Emergency	32	10.6
Technical services	31	10.4
Operating room	21	7.0
Intensive care	16	5.3
Community medicine/ Health visiting	13	4.3
Psychiatric	7	2.3
****Others**	10	3.3
Number of staff per duty		
1 – 5	26	8.6
6 – 10	185	61.5
11 – 15	86	28.6
Over 15	4	1.3
Mean number of staff	8.80 ± 2.75	

**Others: Nutritionist -1; Technician -2; **Others: Dialysis – 5; Optometrist – 2; Physiotherapy – 1

Professional allied medicine – Physiotherapist, radiographer, optometrist, opticians
Specialized unit – Paediatric, Orthopaedic, Radiology, ENT, Ophthalmology

Table 1 shows the socio-demographic characteristics of respondents. 29.2% between the ages of 35 – 39 years, 21.6% between the ages of 30 – 34 years, while 16.3% between the age 45 – 49 years. However, above 60 years age group had the least respondents of 1.0% of the respondents. The mean age of respondents was 38.60 ± 8.43.

One hundred and thirty-eight (45.8%) of the respondents were males, 163 (54.2%) were females. With regards to marital status, 176 (58.5%) of respondents were married, 87 (28.9%) were unmarried, 17 (5.6%). The mean years of experience was 10.64 ± 6.43 years, with 88 (29.2%) having 1 – 5 years of experience, 73 (24.3%) having 6 – 10 years, 66 (21.9%) with 11 – 15 years of experience, 56 (18.6%) with 16 – 20 years of experience and 18 (6.0%) with over 20 years of experience.

With regards to professional group, 95 (31.6%) were physicians, 47 (15.6%) were pharmacists, 84 (27.9%) were nurses, 34 (11.3%) were laboratory scientist, 31 (10.3%) were professional allied medicine, 7 (2.3%) were midwifes, and 3 (1.0%) others. With regards to unit, 118 (39.2%) were in general medicine/surgery, 53 (17.6%) were in specialized unit, 32 (10.6%) in emergency wards, 31 (10.4%) were in technical services, 21 (7.0%) were in operating room, 16 (5.3%) in intensive care, 13 (4.3%) community/district, 7 (2.3%) psychiatric, and10 (3.3 %) were others. With regards to number of staff, 26 (8.6%) had 1 – 5 staffs with them in their unit, 185 (61.5%) 6 – 10 staffs, 86 (28.6%) 11 – 15 staffs, 4 (1.3%) over 15 staffs, with the mean number of staff being 8.80 ± 2.75.

Table 2: Prevalence of WPV

Variable	Frequency	Percentage
Ever experienced any form of WPV		
Yes	152	50.5
No	149	49.5

Table 2 shows the prevalence of workplace violence among HCW's. A total of 152 (50.5%) of HCW's reported that they've experienced WPV, while 149 (49.5%) reported that they've not experienced any form of WPV.

Table 3: Reporting of WPV incidents and level of help received (n = 152)

Variable	Frequency	Percentage
Report the incidents of WPV to any competent authority/Personnel		
Yes	70	46.1
No	82	53.9
***The authority/personnel reported to: Seniors/Head**	115	75.7
Administrators	65	42.8
Police	4	2.6
Association	1	0.7
Colleagues	4	2.6
Received help		
Not applicable	82	53.9
No	45	64.3
To some extent	20	28.6
Satisfactorily	5	7.1
Reasons for not reporting the case		
Felt is part of the job	47	57.3
Nothing will be done	35	42.7

Table 3 shows Reporting of WPV incidents and level of help received. A total of 70 (46.1%) reported the incident to authority/personnel while 82 (53.9%) did not report. Out of those that reported, 115 (75.7%) reported to their senior/head, 65 (42.8%) administrators, 4 (2.6%) reported to police, 1 (0.7%) to their professional association/union, and 4 (2.6%) to colleagues. From those who reported the incident, 45 (64.3%) received no help, 20 (28.6%) received help to some extent, while 5 (7.1%) were satisfied with help received. With regards to reasons for not reporting the case, 47 (57.3%) reported that they felt it is part of the job, 35 (42.7%) felt that nothing will be done (i.e the case will not be addressed).

Table 4a: Consequences of WPV on the performance of clinical duties (n = 152)

Clinical duties	Increased	Decreased	Same as before	No response
Prescribing/ dispensing drugs	64 (42.1)	13 (8.6)	71 (46.7)	4 (2.6)
Surgical/ medical interventions	27 (17.8)	31 (20.4)	91 (59.9)	3 (1.9)
Request of investigations	39 (25.7)	20 (13.2)	90 (59.2)	3 (1.9)
Handling Emergency/ critical /Complicated cases	81 (53.3)	11 (7.2)	59 (38.8)	1 (0.7)
Handling non-complicated cases	5 (3.3)	13 (8.6)	133 (87.5)	1 (0.7)
Referral/ consultation with other specialists	80 (53.9)	4 (2.6)	64 (42.1)	4 (2.6)

Table 4a above shows the consequences of violence on clinical duties of HCW's. With regards to prescribing/dispensing drugs, 64 (42.1%) and 13 (8.6%) reported there was an increase and decrease respectively, while 71 (46.7%) reported that it was same as before. In surgical/medical interventions, 27 (17.8%), 31 (20.4%) reported that there was an increase and decrease respectively, while 91 (59.9%) reported that it was same as before. Thirty-nine (25.7%), 20 (13.2%) and 90 (59.2%) reported an increase, decrease and no changes respectively in suggesting investigations. Eighty-one (53.3%), 11 (7.2%) and 59 (38.8%) reported an increase, decrease and no changes respectively in emergency/critical/complicated cases. Five (3.3%), 13 (8.6%) and 133 (87.5%) reported an increase, decrease and no changes respectively in handling of non-complicated cases. Eighty (53.9%), 4 (2.6%) and 64 (42.1%) reported an increase, decrease, and no changes respectively in referral/consultation with other specialists.

Table 4b: Psychological Impact of WPV on HCWs

Variable	Frequency	Percentage
Psychosocial Problems Self-reported impact of WPV on Victims		
Sense of defeat	48	31.6
Loss of self-esteem and shame	66	43.4
Avoidance/Missing work and loss productivity & incompetence	12	7.9
Engaging in risky behaviour and substance use	2	1.3
Stress/depression/anxiety/prosecution ideas	119	78.3
Avoiding social gatherings/social disruption	3	1.9
Increased aggressiveness towards patient	19	12.5
Had to change place of work/shift to another place	3	1.9
Frightened	1	0.7
Trauma Screening (Psychosocial impact Assessment) Questionnaire	120	78.9
Total TSQ Score greater or equal 6	32	21.1
Total TSQ Score less than 6		

Table 4b shows the psychosocial impact of violence and trauma experienced. With regards to psychosocial impact of violence, 48 (31.6%) experienced some sense of defeat, 66 (43.4%) loss of self-esteem and shame, 12 (7.9%) avoidance/missing work and loss of productivity/incompetence, 2 (1.3%) engaged in risky behaviour and substance use, 119 (78.3%) stress/depression/anxiety/prosecution ideas, 3 (1.9%) avoiding social gatherings/social disruption, 19 (12.5%) increased aggressiveness towards patient, 3 (1.9%) had to change place of work/shift to other place, and 1 (0.7%) were frightened.

Overall, 120 (78.9%) had Post Traumatic Stress disorder present with a TSQ score greater than/equal 6 of the 10 items while 32 (21.1%) of respondents had scores less than 6 hence PTSD was absent.

Table 5: Association between socio-demographic characteristics and workplace violence

Variable	Experience WPV		X^2	p-value
	Yes	No		
Age (n = 300)				
20 – 24	1(14.3)	6 (85.7)	28.249	<0.001
25 – 29	14(35.0)	26 (65.0)		
30 – 34	23 (35.4)	42 (64.6)		
35 – 39	47 (53.4)	41 (46.6)		
40 – 44	11 (61.1)	7 (38.9)		
45 – 49	29 (59.2)	20 (40.8)		
50 – 54	14 (87.5)	2 (12.5)		
55 – 59	10 (71.4)	4 (28.6)		
60 and above	2(66.7)	1(33.3)		
Sex (n = 285)				
Male	75 (56.8)	57 (43.2)	3.896	0.048
Female	69 (45.1)	84 (54.9)		
Marital Status (n = 249)				
Married	88(57.9)	64(42.1)	Fisher's	0.002
Unmarried	26(32.9)	53 (67.1)	exact test	
Separated/ Divorced	6 (60.0)	4 (40.0)		
Widow	6 (75.0)	2 (25.0)		
Years of experience (n = 301)				
1 – 5	26(29.5)	62 (70.5)	31.635	<0.001
6 – 10	35(47.9)	38 (52.1)		
11 – 15	37(56.1)	29 (43.9)		
16 – 20	40(71.4)	16 (28.6)		
Over 20	14(77.8)	4 (22.2)		
Professional group (n = 148)				
Physician	77(55.0)	63 (45.0)	Fisher's	0.003
Pharmacist	19 (40.4)	28 (59.6)	exact test	
Nurse	26 66.7)	13 (33.3)		
Laboratory scientist	17 (50.0)	17 (50.0)		
Professions allied to medicine	9 (29.0)	22 (71.0)		
Midwife	0(0.0)	4(100.0)		
Department/Unit (n = 299)				
Out Patient Clinics (GOPD, MOP&SOP)	47 (39.8)	71 (60.2)	39.47 7	<0.001
Specialized unit	26(49.1)	27 (50.9)		
Emergency	31(96.9)	1 (14.3)		
Technical services	15(48.4)	16 (51.6)		
Operating room	10(47.6)	11 (52.4)		
Intensive care	5 (31.3)	11 (68.8)		
Community medicine/Health visiting	6 (46.2)	7 (53.8)		
Psychiatry	6 (85.7)	1 (14.3)		
Dialysis and Physiotherapy	5 (62.5)	3 (37.5)		
Number of staff present on duty per unit				
1 – 5	12(46.2)	14 (53.8)	13.682	0.003
6 – 10	81 (43.8)	104 (56.2)		
11 – 15	55(64.0)	31 (36.0)		
Over 15	4 (100.0)	0 (0.0)		

Table 5 above shows the association between socio-demographic variables and prevalence of workplace violence. Factors that were significantly associated with workplace violence includes: Age, sex, marital status, qualification, years of experience, professional group, unit and number of staff in the department.

Discussion

In this study, half of the respondents (50.5%) experienced WPV. This is like the findings of Heddar et al., (2022) and Al Anazi et al. (2020) where about half of the respondents were victims of WPV. The prevalence of WPV reported in this study is lower than the pooled prevalence ranging from 61.9% to 67.6% reported in two systematic reviews conducted by Liu et al. (2019) and Tian et al. (2022) as well as in Ethiopia and Gambia with prevalence of 58.2% and 62.1% respectively (Yenealem et al. 2019; Sisawo et al., 2017). This higher prevalence of WPV noted may be attributed to the fact that the authors sampled healthcare workers mainly from the emergency departments. Civil unrest and hostility also occurred in the Eastern African region at the time of the research.

There are various reasons given by HCW's for not reporting cases of WPV. Slightly less than three-fifth of those who had experienced WPV in this study did not report the case because 'they felt that it is part of the job.' This is not surprising as Singh et al. (2019) stated that doctors are often told to consider these episodes of violence as "part of the job" and are even encouraged to tolerate abuse, while two-fifth didn't report the case because they felt nothing will be done about the case of WPV. In the same vein, it has been posited that healthcare workers may appraise that reporting cases of violence will not lead to any change (Morken et al., 2015). This is also supported by findings from this study where only less than one-tenth of those who reported cases of WPV received help to a satisfactory level. This observation is therefore suggestive of the need to put

effective control measures in place to forestall the occurrence of WPV in the Healthcare sector. More than three-quarters reported that the incident wasn't shared on social media. Of those whose incidents were shared on social media, most of the cases were shared on their departmental forum. Other reasons why healthcare workers do not report cases of WPV include: feeling of shame, concern for the health status of patient (Morken et al., 2015).

This study also assessed the consequences of WPV on performance of clinical duties. Notably was the increase in handling cases of emergency/critical, referral, prescription of medications etc. These could eventually lead to burning out with resultant absenteeism, reduced job satisfaction and decrease in productivity; thus, may ultimately hinder the quality of patient care. This was corroborated by other studies (Lanctôt & Guay, 2014; Al-Turki et al., 2016; Duma et al., 2016; Kumar et al., 2020; Musengamana, et al. 2022; Chinawa, et al. 2020).

Furthermore, from this study, 78.9% (that is more than three-quarter) suffered from post-traumatic stress disorder and this is higher than Wizner et al. 2022 and Dai et al. 2024 that recorded 48.9% and 28.5% respectively, this difference, may be accounted for geographical location and provision mental evaluation in United State of America and China. Also, more than two-third of the WPV victims in this study reported stress/depression/anxiety/prosecution ideas due to the impact of WPV, and two-fifth and about one-third reported loss of self-esteem and shame and sense of defeat respectively. This is line with findings of previous studies where WPV was reported to have negative impact on psychological and mental health, such as low self-esteem, feeling of shame/embarrassment, depression, stress, anxiety, suicidal ideation, fear/worry, trauma, demoralization (Chinawa et al. 2020; Kaur et al. 2020; Triana et al. 2018; Ferri et al. 2016; Al-Turki et al. 2016; Duma et al. 2016). It also results to financial loss incurred because of absenteeism from work (Lanctôt & Guay, 2014).

Conclusion and Recommendation

The prevalence of WPV was high and there was under-reporting of WPV. The study also noted that WPV had several consequences on clinical duties including increasing the handling of critical patients and referral to other specialists. There was also impact (consequences) of WPV on health care workers themselves as it had a significant impact on the mental and psychological wellbeing of Health Professionals. In fact, post-traumatic stress disorder was noted in majority of health workers that experienced WPV. This shows the importance and need for concerted efforts and commitment from the Government, health-care administrators and entire populace in preventing violence in the workplace in areas of policy on work safety and security. In fact, clear statements on 'zero-tolerance' against workplace violence should be made. Victims must be encouraged to report any incident of WPV by providing proper medium for reporting and an effective redresser system.

It is also important for management to ensure the provision of regular training and education programmes for managers, supervisors, employees and security officials. It is imperative that there should be provision of comprehensive, periodic psychological and mental assessment as well as well-coordinated and continuous care for staff, most especially victims of WPV to mitigate against Post traumatic stress disorder and other psychosocial problems.

Study Limitation

Also, this study used a retrospective self-reporting approach in data gathering, by recalling events in the last twelve months prior to study which might be froth with possible biases.

Future Research

After critically appraising and noting the findings of this study, there may be need to have a similar study using qualitative design such that health workers and administrative staff will be interviewed on WPV as it affects the Hospital setting.

Also, there is a need to do a study on the patients/clients as it will give balanced insights into the aspects of the perpetrators of WPV, the reason why they engage in violence and their perceived solutions.

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