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ORIGINALES

Violence in the workplace from the perception of nursing professionals in a pediatric emergency service

Violencia en el lugar de trabajo desde la percepción de profesionales de enfermería en un servicio de emergencia pediátrica

Katherine Lisbeth Almeida Cisneros[1]
Elsa Jaqueline Arellano Verdezoto[2]
Venus Medina-Maldonado[3]

[1] Pontificia Universidad Católica del Ecuador. Faculty of Nursing Master's Program in Care Management with mention in Emergency Units and Intensive Care Units. Gender Violence Prevention Research Group (E-previous). Ecuador.
[2] Latin American Health Research Center (CISeAL) Faculty of Administrative and Accounting Sciences. Ecuador.
[3] Latin American Health Research Center (CISeAL) Faculty of Nursing, Nursing career. Gender Violence Prevention Research Group (E-previous). Ecuador. vemedinam@puce.edu.ec

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ABSTRACT:

Introduction: Healthcare professional face a higher risk of experiencing physical, sexual, or psychological injuries due to violence in the workplace fulfilling their role in providing health care to a pediatric patient in emergency cases. Incidents where professionals are abused, threatened, or assaulted in circumstances related to their work pose an explicit or implicit challenge to their safety, well-being, or health.
Objective: To explore the perception of nursing professionals regarding workplace violence in the performance and execution of healthcare activities in Pediatric Emergency Nursing.
Method: Qualitative research with a phenomenological design. The study was conducted among nursing professionals in the Pediatric Emergency Service, with a sample size of 32 participants divided into 4 focus groups. A semi-structured questions were designed to gather perceptions about various aspects of their work, that were collected through voice recordings and field notes. The results were analyzed to identify the sources of violence in the workplace.
Results: Through the data collected from the participants, the lead researcher analyzed the manifestation of workplace violence as perceived by nursing professionals. This analysis determined the existing risks and provided recommendations for designing an action plan to prevent violence.
Keywords: Psychological exhaustion aggression, anxiety, occupational stress, motivation, workplace violence.

RESUMEN:

Introducción: Los profesionales de la salud tienen un mayor riesgo de sufrir lesiones físicas, sexuales o psicológicas debido a la violencia en el lugar de trabajo ocupando su rol al brindar cuidados de salud hacia el paciente pediátrico en casos de Emergencia. Los incidentes en los que el profesional es

abusado, amenazado o agredido en las circunstancias relacionadas con su trabajo implican un desafío explícito o implícito a su seguridad, bienestar o salud.
Objetivo: Explorar la percepción de profesionales de enfermería sobre la violencia laboral en el desempeño y ejecución de actividades orientadas al cuidado de salud de Enfermería en la Emergencia Pediátrica.
Método: Investigación cualitativa de diseño fenomenológico, el estudio se realizó en profesionales de Enfermería del servicio de Emergencia Pediátrica con una muestra de 32 participantes, distribuidas en 4 grupos focales. Se diseñó una guía de preguntas semiestructuradas sobre los aspectos percibidos en el ámbito del trabajo del profesional que fueron recopiladas mediante archivos de voz y notas de campo, los resultados fueron analizados identificando las fuentes de la violencia en el lugar de trabajo.
Resultados: Con la recopilación de datos de los participantes, la investigadora principal analizará la forma en que se presenta la violencia laboral desde la percepción de profesionales de Enfermería determinando los riesgos presentes para brindar recomendaciones y diseñar un plan de acción que ayuda a prevenir la violencia.

Palabras clave: agotamiento psicológico, agresión, ansiedad, estrés laboral, motivación, violencia laboral.

INTRODUCTION

Violence in the workplace within the healthcare sector is considered a public health problem, which has generated much concern due to its high prevalence worldwide [1] . In fact, nursing and medical professionals are at greater risk of being attacked by patients and their family members compared to the rest of the healthcare team [2,3]. According to scientific evidence, professionals consecutively face verbal and physical violence while performing their functions in the workplace [4], which can lead to subsequent consequences for all involved in healthcare in a facility.

The professional members of the healthcare team have the ability to solve health-related problems and respond to the needs of a patient, his/her family, and/or community. Within the team, nursing plays the fundamental role of collaboration to contribute to all parties involved in the maintenance or recovery of health, this of course also includes the patient, family and community [5]. In this context, nursing professionals are exposed to violence not only from the population but also from other healthcare workers in the same facility.

Recent literature describes the experiences of nursing professionals who have undergone workplace harassment, also known as mobbing. Manifestation of mobbing is related to training aspects and historical and cultural contexts. It was previously concluded that the organizational environment plays a relevant role in the mobbing phenomenon since the culture of the institutions and the styles of labor relations can create a cycle that perpetuates harassment [6] . In another Latin American study, it was confirmed that aspects of the organizational context, such as climate and leadership styles, can be associated with the appearance of violent behaviors and different forms of harassment [7] .

Violence in the workplace triggers mental health-related consequences for healthcare sector workers, and some studies have established “lack of experience and despotism” as causes for such violence [8] . In relation to the effects of violence on a personal level, low motivation, lower performance in executing their functions, lack of concentration, irritability, variation in memory changes, depression, anxiety, physical complications, such as heart disease, digestive disorders, and others, skeletal muscle

problems, emotional exhaustion, and personal and family problems have been reported [8].

Ecuador has not escaped these problems. A recent study with a mixed design in which 387 nursing professionals participated in the quantitative phase and 47 participants in four focus group discussions from three specialty hospitals in the city of Quito reported that 37.73% of the professionals iin these hospitals reported verbal abuse over the last 12 months. This finding was corroborated by the qualitative data that reported hostile phrases and derogatory qualifiers were used towards nursing professionals [9]. It should be noted that the aforementioned research was carried out in specialty hospitals and adult services.

One of the motivations for conducting this study was that a search of the major databases did not retrieve current national studies that address workplace violence in healthcare services targeting pediatric patients. Therefore, it is necessary to address this gap in the current knowledge using a qualitative approach for its analysis.

From our own experience, stress on the part of pediatric patients and their families when they enter the emergency service and undergo diagnostic and therapeutic procedures has been demonstrated. Likewise, a great amount of stress among nursing colleagues and the rest of the healthcare team when handling different procedures with pediatric patients exists. This burden leads to people reacting in a non-assertive way and committing certain behaviors that translate into hostilities, mistreatment, abuse, and/or violence.

From a conceptual point of view, we refer to Leininger's theory of holistic cultural care[10,11] in which the existence of four subcultures within the health system that could explain violence in the workplace within emergency services exist: (1) nursing professionals who work in the service, (2) institutional management departments that may be made up of intermediate and high management levels, (3) patients and/or family members with violent behavior and (4) patients or family members without violent behavior [11].

This analysis as do studies on violence will contribute to visualizing the violence problems in the nursing profession and will expose a reality that should facilitate the search for solutions that ultimately result in the biopsychosocial well-being of the patients and family members who attend the nursing service. According to the above, our study seeks to answer the following question: “What is the perception of nursing professionals about the situation of violence in the workplace during the performance of activities aimed at nursing care in the Pediatric Emergency Department?”

AIM

To explore the perception of nursing professionals concerning workplace violence in the performance and execution of activities aimed at nursing healthcare in the Pediatric Emergency Department.

METHODS

The study was qualitative research with a phenomenological design focused on obtaining information and recalling and describing actual experiences. The study addressed personal experiences and/or perceptions of the participants who were nursing professionals about violence in the workplace. I worked through the focus groups in a Pediatric Emergency Service. It involved an analysis of the data obtained and a thorough description of the reality of violence in the workplace [4] .

Study subjects

The study population consisted of 40 nursing professionals of both sexes, who work in the Pediatric Emergency Service. However, given the nature of the research that maintained a qualitative approach, the sampling method was intentional non-probabilistic and the participation of n= 32 people with an age range of 28 to 55 years was reached, a total of 29 women and 3 men. all performed direct patient care functions in the selected service. The number of focus groups and participants was determined based on voluntary participation and information saturation. The latter consists of the variety of opinions with abundant information in addition to obtaining of new and different ideas by the participants [12] . The right to refuse participation in the study was taken into account at all times regardless of study stage. The inclusion criteria included several parameters: (1) nursing professionals of both sexes, (2) work in the emergency service in its contracting, definitive appointment or provisional appointment modalities, (3) at least three months of experience in the Emergency Service, (4) direct care or head nurse in the Pediatric Emergency Service at the selected hospital, and (5) signed the informed consent.

Study setting

The research was carried out in the meeting room of the Emergency Service Third Level Pediatric Public Hospital of the city of Quito, Ecuador with the possibility of freely, confidentially, and privately discussing topics that on some occasions, could be considered taboo within cultural work establishments [13] . The procedures related to the start of the project until the data collection took place between May and October 2023.

Data collection technique

The focus group technique, which consists of the discussion of the topic proposed by the researcher in which the opinions of an individual and the interaction of the others were presented, was applied with consideration of changes in the reflections needed to reach a collective agreement [14,15]. The total number of participants were distributed into four focus groups whose discussion times ranged from 20 to 45 minutes. The main author/moderator of the study was present during the focus group discussion, and two co-researchers with extensive experience in the study of violence participated as observers.

During the implementation of the focus group, a digital recorder was used to collect information. The data were transcribed and stored in Microsoft Word documents. All testimonies were “anonymized, the measures for the protection and confidentiality of

the information were also complied with” [16,17] . Regarding the design of the group interview, semi-structured questions without predetermined answers following the method of main question and follow-up questions [18] about the perceived and sensitive aspects involved in the field of work of the nursing professional were used.

Procedures

Requests for the letter of interest to the study institution, requests for approval of the protocol by the ethics and research committee on human beings, familiarizing the participants in the emergency service with the data collection plan, notification of service supervisors, agreements with nursing professionals to conduct the schedule of focus group discussions, explanantion of the objectives, importance, risks, benefits, use of information, and freedom to participate in the research, delivery of informed consent for signature if an interest in participating was expressed were undertaken. Once the informed consent was signed, the focus groups were conducted. It is worth noting a co-researcher with a clinical psychologist degree was present for support in case management and development of a contingency plan in case any professional participating in the study presented an uncontrolled, emotional response.

Interview guide

Semi-structured questions for the group interviews were developed taking into consideration the conceptual framework of the International Council of Nurses (ICN) as described by several groups [19] . The question guide was part of the central theme of the study in addition to the assignment of the deductive categories that correspond to the first level of analysis and the subsequent inductive analysis. This order was based on the qualitative content analysis method [20] and empirical evidence on violence in the workplace [4.21] . Table 1 shows the topic and category tree.

Table 1. Topic box and categories with default assignment

Topic: Violence in the workplace		
Assignment of deductive categories	**Definition**	**Anchor expressions**
C1: Meanings of Violence in the workplace	It is a behavior by which the person is attacked by another adversary at work.	¨She/he feels very terrified. "The family member yelled at me"
C2: Health consequences	They are events that affects the individual emotionally, physically, and mentally.	I feel stressed “I'm going to change service”
C3: Regulations for the prevention of violence.	They are rules created to adjust the behavior of the individual.	¨The professional mentions. “It would be very helpful to apply prevention rules.” we are grateful

Source: Main author

Data analysis

The voice files were transcribed into Word documents (text material) with the help of the free software QCAmap v.1.2.0 [22] . Text material from group discussions and observation notes were analyzed. The qualitative content analysis consisted of a procedure strictly guided by rules that contains qualitative steps (assignment of categories to passages of text) and identification of inductive categories and quantitative steps (analysis of category frequencies) to establish density processes and theoretical and structuring of knowledge.

Ethical aspects

This protocol received approval by a Human Research Ethics Committee with code EO-91-2023.

RESULTS

To systematize and organize the information from the focus groups and identify the origin of ideas, each participant was identified by the letter “E” , which indicates a participant.The letter was accompanied by a number to differentiate each of the participants. Additionally, each focus group was assigned the acronym GF with the respective number; this coding shows the quote linked to each verbal expression of the participants. To identify the sex of the participants, the acronym M for man and F for woman was placed at the end of the appointment. According to the observations, GF1 and GF3 had less participants in the discussions, GF2 and GF4 included more participants who expressed more open opinions when expressing their ideas and discussing the topic related to violence in the workplace.

In the central theme “Workplace Violence in the Pediatric Emergency Service”, three deductive categories and eight inductive subcategories were assigned and obtained from the transcribed texts from each focus group. According to the experiences described by the study subjects, the response presented most frequently indicated that the most common aggressors toward the nursing team were a pediaric patient’s family members with tendencies to manifest verbal aggression. Very few attacks by pediatric patients, who generally react to pain or fear due to the stressful situation, ocurred, and those that did occur were perpetrated by psychiatric patients or those with autism. Comments were also made on possible verbal offenses coming from colleagues and the rest of the members of the health team that works in the service.

Workplace violence in a pediatric emergency service

The central theme of this research showed the results obtained on the perception of nursing professionals about the meaning of the problem, the impact of violence on health, and the guidelines for its prevention.

C1: Meanings of Violence in the workplace

In this first category, participants addressed the meaning of violence and its various forms of manifestation in the work environment according to their perceptions. The expressions that stood out are shown below:

> “Violence is an aggression, whether physical or verbal” (GF-1EF).
> “Negative factor that can affect or cause harm to the other person” (GF2 -2EF).
> "It can be some type of aggression that can occur, not only physically, but also psychologically, verbally and emotionally" (GF3-E10F).
> ¨The word violence for me encompasses not only physical violence, but also psychological one. Therefore, if there is violence, it is not only verbal, it is also psychological and occurs in the work environment indirectly” (GF4-E11F).

According to the expressions and experiences indicated, workplace violence can take various forms. Based on the results from the focus groups, we identified expressions in which verbal violence was the most common form that was identified during work activities. However, exposure to psychological and physical violence was also evident. The experiences were described according to the perception of the professionals. These manifestations are detailed below:

> “The gestures”(GF3–E10F).
> “Lack of respect” (GF3–E12F).
> “Inappropriate words” (GF3–E13F).
> “Raising your voice” (GF3E–14F).
> “Verbal reactions by family members who address you” (GF4–E15M). “Direct threats” (GF3–E17M).
> “More verbally” (GF4–E15M).
> “Threats” (GF4–E19F).
> “Between colleagues talking behind each other saying that you don't do things well, putting you down or taking away your authority” (GF3–E17M).
> “The patients are sending us a big hand” (GF3–E17F).

The inductive subcategory sources of violence gives us information about the origin of the violence in detail, that is, the origins of the violent behavior. In this study, it was observed that some episodes of violence in the workplace are most frequently perpetrated by family members, members of the healthcare team, and colleagues. In this regard, the participants reported several observations:

> “Family members who come looking for a type of care ” (GF2–3EF).
> “Offenses issued by parents when they come to receive patient care specifically in the triage area ” (GF3–E11F).
> “Here the patients themselves are children, here comes serious violence by parents toward health personnel or companions” (GF4–E16F).

From GF1–GF2, testimonies mentioned by several people at the same time were recorded in which they expressed the phrase: “Families generally.”

Below are the opinions in which behaviors originating from the healthcare team and colleagues were identified as the source of violence:

> “Toward the nursing staff in the way doctors ask us to do anything” (GF2–4EF).
> “The same companions” (GF3–E17M).

> “Doctors sometimes take it in a bad way when they do something wrong, and it is corrected. There are few people who accept mistakes and say, well, thank you, but others take it the wrong way” (GF4–E11F).
> “Among colleagues they have professional envy” (GF3–E17M).
> “It could be the same colleagues having problems with each other, there is an offense between them, sometimes, other times the staff who work with us are doctors, auxiliary therapists. Sometimes there is a confrontation between the parties and the parties may be” (GF4–E15M).

It was observed that the majority of participants have an understanding of the concept of workplace violence and its different manifestations, including the use of inappropriate words and raising the tone of voice. In the source of violence subcategory, it was concluded that much of the violence comes from family members and companions of patients who come to the hospital due to their anxiety and concern about a patient’s condition. On the other hand, it was noted that, although there are certain disagreements between colleagues and other professionals, these are not very frequent.

As a second subcategory, the causes that trigger violence were revealed. This inductive subcategory refers to situations that generate sources of stress and conflict. The GF2 participants indicated, according to their experiences, that the main causes are the concern and anxiety that family members feel about the health situation faced by pediatric patients who attend the service. This type of situation leads them to interact with nursing professionals in a negative way. Several most notable expressions were reported:

> ¨Perhaps they fall into the fatigue and anxiety of seeing their family member who is unwell and they tend to react that way without knowing that it causes a type of mistreatment towards the health personnel who are about to care for their family member” […] Oneself approaches, notify the doctor, the daddy is a little upset, he presents a little anxiety and irritability when saying that nothing has been done to him here, in that way, communication, I think, is lacking a little so that the father can be a little more calm about the evolution of your child” (GF2–E3F).

This opinion denotes aspects that can be improved in the assistance services in emergency services, which are related to the use of the approach that optimizes family-centered care, which can be executed by nursing professionals with training in nursing skills, communication, and conflict management in emergency services.

The third inductive subcategory refers to the normalization of violence, revealing the testimony of some participants who perceive violence as something natural without reflecting on the emotional impact that words or gestures can have on others. It is important to recognize that even seemingly small actions can have a negative effect on the affected person.

> “It can be hurting the type of susceptibility of the other person because sometimes it cannot be considered, my way of saying or expressing things, to how the other person receives it, I think that has to intervene in order to receive a message well. in work terms, but the other person does not receive it that way and perceives it as a form of abuse, so there is also poor communication with the reception of the message” (GF–3EF).

> “We are talking about users who are not yet mature enough to face the health situation in which they are and the position we are in, which is not to cause them harm, but to help them, because the channeling of a of one way or giving them oxygen, putting a nasal cannula is not to harm them but to help their health, but due to their state of immaturity, they still do not understand it that way” (GF3–E17F).

The fourth inductive subcategory, called dismissal of professional autonomy, emerged from experiences in which professionals experience restrictions on their freedom, independence, and discretion in making decisions. It is important to recognize that this limitation may affect the family member in terms of obtaining information.

> “We know about the patient, but we are not there, we do not have the authority to speak with the family members” (GF2, E3F).
> “The daddies usually come and complain to the nursing staff. What they are told is dad, calm down, go talk to the doctor who is in charge of him, he will explain it to you” (GF2, E3F).

Another subcategory that emerged from the inductive analysis was the abuse of power, which reflects the experiences by nursing professionals and denote the management of influence by family members in order to threaten professionals who provide the service. On many occasions, family members react negatively due to the desperation they feel about the pediatric patient’s emergency situation. This type of reaction can occur even when the care needed is only first level, family members are not familiar with the triage system , prioritizing the situation as an emergency without knowing the established protocols.

> “In triage, for example, there are people who come with the use of power, like I work somewhere else or I am a relative of a person who works here and therefore they have to attend to me and they have to attend, to the voice of now as who says, because of the abuse of power sometimes people act aggressively” (GF2 7EF).
> In the triage área, I had a problem with a mother, but I mean, from the moment they step into the emergency they want it to happen to them. They want me to attend to them immediately. The mother came in and said that the children had already had a respiratory condition for about a week, but the vital signs of the two children were stable, but since we are in charge of triage , the mother was assessed and informed that a assessment, third level care. For them to stay here, a mother and father reported this. He uttered grotesque vocabulary. The lady is very bad, words I say, not even in my house do they treat me like that And they come and treat me in a despotic way” (GF3–E23F).

C2 Health consequences

In the second deductive category, the health consequences were identified. It could be observed that the impact is psychological and emotional. Likewise, responses included stress, frustration, feelings of offence, desire to quit, depression, and contemplation of changing services due to conflicts with both family members and colleagues in the emergency service. These factors have a significant impact on the mental health and emotional well-being of the professional. Several responses aer shown below:

> “Stress, there are certain situations that do cause stress” (GF2-4EF).

"Bad mood all the time" (GF2-8EF).
"Frustration, insecurity, fear, discomfort" (GF2-3EF).
"You want to give up" (GF2-9EF).
"It can affect what is, not only the personal health relationship with the patients' mothers" (GF4-E11F).
" Stress " (GF4-E22F).
"Work stress" (GF4-E15M).
"Put yourself in a situation where you more or less despise work" (GF3-E11F).
"Mood changes" (GF3-E11F).
"Anger" (GF3-GF4).
"Normally anger towards the person who is offending" (FG4-E15M).
"Obviously it affects us, I try to avoid arguing with that person or with the patient or family member. If he is insulting me, I leave, I ask someone else for help because I'm not going to do it. I ask for help to channel a path" (GF3–E11F).
"Sometimes they pay for sinners, the other patients are also affected because we have changed our mood, no, we no longer treat them in the same way" (GF4-E22).
"The worker does not want to come to work, he becomes depressed, he isolates himself, he comes to work defensively" (GF3-E17M).
"You no longer feel like coming, you miss work, there is no longer any motivation to go to work, to work while watching your back" (GF3-E17M).
"You get depressed, you want to run away, you want to escape from the work environment" (GF3-E17M).

C3 Regulations for the prevention of violence

This deductive category considers existing workplace policies to create a safe environment. According to the opinions and experiences narrated, it is not an issue addressed by the hospital administration; when this type of situation occurs, professionals intuitively turn to security personnel or even to their own ability to escape from the situation. Some less frequent responses indicated an event notification channel, starting with the immediate boss.

Collective response GF1 and GF2 "The guard"
Collective response GF3 and GF4 "Nobody"
"You have to run with all your guard" (GF4–E21F).
"Report to our superior or the head of the Guard to the leader about what happened with a family member of a patient, report to our leader and make a report that there was a type of aggression from the family member towards the health personnel" (GF4–E20F).
"To the head of the Guard, he is the one who is here, constantly in the emergency he tries to solve that problem, he calls the police" (GF4–E20F).

Within this deductive category, subcategory strategies for managing violence in the workplace emerge, including how to gain coping skills that the nursing professional demonstrates during his interaction with users to mitigate violent events or prevent them from escalating when a conflict is evident.

"It would be one part to understand him, but not let him disrespect you, to remain calm because you are helping him and his child will be helped, but also the same level of respect, because if he starts with another type of aggression or raising my voice then it is also a form of violence towards us" (GF2–3EF).

"I think that there should be a law or an article where it says or is visible, where they can see the article or the penalty, more clearly, so that they do not come to disrespect us or treat us badly because we also have the right, but here practically In the hospital, there is no signage that says, if you treat me badly or disrespect the health personnel, you are subject to sanction. I think there must be, because if there is, when it is aggression" (GF4–E11F).

It was evident from the analysis of the experiences and reports that a coping strategy is to remain calm in a situation of aggression shown by a family member toward the nursing professionals, understand the situation of the family members, not allow oneself to be disrespected, and report the incidence to the superiors.

Finally, in the subcategory called improvement proposals, establishing effective communication between colleagues to prevent conflicts was described. The participants also proposed implementation of informative signs aimed at family members, which provide support and protection to the nursing professional in cases of violence.

"Good communication" (GF1,GF2).
"A safe, comfortable work environment where one feels good to be able to perform their duties" (GF2–E3F).
"Let the article that exists be disseminated, in the penal code if there is an article that defends, however, what they allow us to disseminate is that article, to make it known to the external user who comes here to seek attention, which for aobreason leaves out of our hands that it cannot be attended to. Signage" (GF3–E24F).
"Ethical talks and signals" (GF3–E25F).
"In conversations, many times the mothers say, instead of wasting time, answer son" (GF4–E11F).
"Better, informative, the article must be visible there, like a billboard of the Ministry of Health, it has to be visible so that every user who enters is aware" (GF3–E25F).
"Provide communication between colleagues to prevent these frictions" (GF3–E17M).
"Decrease this type of gossip that they generate" (FG3–E17M).

DISCUSSION

In accordance with the stated objective related to exploring the perception of nursing professionals about violence in the performance and execution of activities aimed at patient healthcare in a pediatric emergency service, research question was answered. It was observed that the form of violence manifested most frequently in this service is verbal violence according to the perception of professionals who pariticpated in the study mainly originates from family members who attend the pediatric emergency service with their children.

In the responses, the manifestation of violence was described through gestures, inappropriate words, raised tone of voice and insults. Among colleagues, direct threats and interpersonal problems were recorded. Likewise, some patients, such as infants, may raise their hand unconsciously due to their age and lack of maturity to understand the situation. In these three sources of workplace violence, the professional nursing

subcultures that work in the service, patients, and family members with violent behavior become evident [6–9].

The above also agrees with the findings of a qualitative study carried out in three public hospitals in the state of Veracruz, Mexico, in which it is mentioned that violence towards nursing professionals is due to factors, such as the increase in patient load. Psychological violence, expressed through shouting and insults, is the most reported type in interpersonal relationships between colleagues, family members of pediatric patients, and nurses [23] .

In relation to the consequences for the group under study, it can be highlighted that violence in the workplace significantly affects the nursing professional, generating both psychological and emotional repercussions. The consequences of violence manifest itself in various symptoms, such as stress, bad mood, frustration, insecurity, fear, discomfort, desire to give up, anger, depression, and lack of motivation. Meanwhile, in an integrative review study, it was found that the mental health of nursing professionals was most affected by violence at work. Symptoms, such as troubling memories, feelings of avoidance, anxiety, stress, and emotional exhaustion, were indicated, which ultimately led to the development of burnout syndrome [24] .

Finally, in relation to the regulations for the prevention of violence, the recommendations were oriented toward establishing closer communication channels between colleagues to prevent conflicts. This finding corresponds to a precedent in which it was established that communication should be the primary practice for the prevention of violence in care services [25] . Other recommendations included use of informative signs aimed at family members to educate them about the issue, reporting the incident to superiors, such as the head of security, and preparing a report on the event that occurred for follow-up investigations.

The findings related to the inductive categories show a reality that complemented the understanding of the violence phenomenon in the workplace; one of them was the dismissal of professional autonomy, which corresponds to a type of inequality in the work/cultural context in terms of the application and development of professional skills or competencies [26] in multidisciplinary collaboration within health institutions. Another response also mentions that within the forms of workplace violence and harassment toward nurses situations, such as withholding crucial information and disavowal, exists [7] . In reference to the present study, greater freedom of communication with family members would help reduce conflict situations in pediatric emergency services, and such communication would be a great contribution to the management of family-centered care regardless of the complexity existing in these services since it would favor communicating with family members and avoidig situations of misinformation for them.

The coping mechanisms described by the professionals in the focus groups in this study showed an actions guided by logic, intuition, and personal values rather than by the training provided institutionally are better for the management of a situation of violence that occurs in the assistance services [4,21,23] . One interpretation of these events is the normalization of violence since abuse towards health professionals is viewed as a non-existent problem and therefore is invisible.

Regarding the practical implications, opening up the focus groups to address the issue of violence in the workplace presented the possibility of dialogue and the free

expression of opinions. This type of study encourages interactions between participants and favors reflection on how to stop normalizing a situation that affects the culture of peace within hospital institutions. It is important to highlight that respectful and constructive communications between all the parties that make up the subcultures in health institutions contribute significantly to a positive and safe work environment, in which nursing professionals can work effectively and focus on providing the best possible patient care.

Although this study presents strengths due to the use of a method and its tool for qualitative analysis in addition to the subsequent categorization of the material with a rich and detailed perspective on the experiences of nursing professionals with perceived violence. The research design and the intentionality of sampling are methodological limitations since they do not allow generalization of these results. For future research, including the participation of nurses who fulfill institutional management functions to analyze the management of violence in the workplace and their role in promoting positive organizational climates is recommended.

CONCLUSIONS

A lack of instruction and advice to family members about patient care and triage protocols in the pediatric emergency service is a major deficiency in this service. It is crucial to recognize that this deficiency can lead to situations of tension and conflict between the nursing professional and the patients' families. Greater guidance will contribute to a more collaborative and empathetic environment in which family members feel supported and understood. This process will ultimately allow for optimal and safe care for pediatric patients.

Effective communication between colleagues is essential to prevent violence and promote a respectful and collaborative work environment. Avoiding professional degradation and refraining from spreading rumors about colleagues are key practices in this regard. By promoting empathy, respect, and transparency in communication, relationships between the team of professionals are strengthened and on a personal level, mental health problems can be avoided.

The creation of a regulatory framework that allows the implementation of prevention policies must be established. This process would include conducting campaigns, seminars, and courses aimed at managing personnel with the aim of raising awareness about the importance of managing the risks associated with violence in the professional field. In addition, such a framework should provide them with the necessary tools to identify, prevent, and adequately address situations of violence when they arise.

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