Acta Scientific MEDICAL SCIENCES (ISSN: 2582-0931)

Volume 9 Issue 10 October 2025

Research Article

Worker's Perception of Changes in Workplace and Factors Associated with Work Place Violence in ESUT Teaching Hospital Parklane, Enugu

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DOI: 10.31080/ASMS.2025.09.2154

Received: July 21, 2025

Published: September 10, 2025

Abstract

Background: Globally, there is growing concern about workplace violence in healthcare settings. The likelihood and perception of violence in these settings may be influenced by a number of demographic and occupational factors. Developing successful strategies to reduce violence and enhance working conditions requires an understanding of the experiences, and perceptions of healthcare professionals.

Aim/Objectives: This study looked at healthcare workers' perceptions of changes in workplace and factors associated with workplace violence.

Methods: A questionnaire-based cross-sectional descriptive study.

Results: A sizable percentage of respondents withheld information about their years of experience and employment status. The majority of respondents (44.8%) were full-time employees, 74% did not work shifts, and 62.1% of those who did work shifts worked day shift. More than half of the respondents (54.4%) said they had no interaction with patients, and no direct physical contact with patients (52.6%). 22.7% of respondents said that staff conditions had gotten worse, reflecting a generally negative perception of recent workplace changes. Increasing staff (49.5%), improving security (48.5%), offering training (41.0%), and screening patients (20.9%) were among the measures suggested to lessen workplace violence. There were significant correlations between age, gender, job role and workplace violence. The highest prevalence was amongst males and those aged 30-34 years. Years of experience showed no significant correlation.

Conclusion: The study highlights that younger and male staff are more at risk of experiencing workplace violence, and despite a variety of changes in working conditions, staff shortages, poor security, and a lack of training were still perceived as contributing causes of workplace violence. Therefore, there is a need for focused interventions, such as increased security, better staffing, and conflict management training, to establish a safer and more encouraging healthcare environment.

Introduction

There are significant transformations in workplace dynamics in Nigeria, essentially due to shifts in the economy, advancements in technology, and the evolution of organizational structures. These shifts, although fostering growth and innovations, can also present some challenges and drawbacks, such as workplace violence, particularly in the healthcare sector. Many factors, such as organizational culture, management practices, and individual experiences, influence workers' perception of workplace changes [1].

Workplace violence, which refers to any act of physical assault, threatening behaviour, or verbal abuse occurring in a work setting, is prevalent, particularly in the healthcare sector, manifesting in various ways like physical violence, verbal abuse, psychological abuse, and sexual harassment. The effects of workplace violence can be damaging, including affecting physical and psychological state, reducing job performance, and thus affecting the productivity of the sector [2].

The understanding of workers' perceptions of changes in the workplace and the factors associated with workplace violence is important for the development of effective strategies to ensure a safe and very conducive working environment.

Therefore, this study aims to understand workers' perceptions of changes in the workplace and factors associated with workplace violence in ESUT Hospital Parklane, Enugu.

Materials and Methods

Study design

The study was a 3-month questionnaire-based cross-sectional descriptive study at Enugu State University Teaching Hospital (ESUTH), Parklane, Enugu, Southeast Nigeria. ESUTH, being a tertiary health facility in the heart of Enugu city, serves the healthcare needs of both the entire state and neighbouring states. Enugu State, being one of the 36 states in Nigeria, is bordered to the north by Kogi and Benue states, Ebonyi state to the east, Anambra state to the west and Abia state to the south, with 17 Local Government Areas (LGA) and estimated total population of approximately 4,411,119 (National Bureau of Statistics, 2020).

Study population

Respondents in this study were essentially hospital employees working not less than one year in this hospital. This group includes clinical staff like medical doctors, pharmacists, nurses, medical laboratory scientists, laboratory technicians, radiographers, physiotherapists and non-clinic staff like medical record officers, accounting officers, cashiers, orderlies, porters, cleaners, security personnel.

Ethical clearance

Before the study started, approval from the ESUTH Health Research and Ethics council was acquired. Every participant signed a written informed consent form after being instructed on the study's goals and given assurances regarding the questionnaire's anonymity, confidentiality, and voluntary nature.

Sample size, data collection and analysis

Sample size was determined using $n = z^2pq/ d^2$ where n is the sample size [3]. The prevalence rate (p) of 64.4 percent from a Nigerian tertiary hospital study was used [4]. Sample size of 388 was calculated adding 10% attrition in ESUT Teaching Hospital Parklane, Enugu.

The total number of responders per department was chosen by proportionate allocation using a list of all the medical staff, patients, and patient relations from different departments and specialties. Using the balloting approach, simple random sampling was used to choose the respondents who satisfied the inclusion requirements. The International Labor Organization, International Council of Nurses, World Health Organization, and Public Services International (ILO/WHO/PSI) developed a semi-structured self-administered questionnaire on "workplace violence in the health sector," which was used [5].

The Statistical Package for Social Science (SPSS) version 26.0 (from Chicago IBM Co., Armonk, NY) was used to import the data after it had been manually sorted, entered into the computer system, cleaned, coded, and examined. The data were displayed as frequency tables, with a significance level of $p < 0.05$.

Results

The findings of this research work are presented on tables 1 to 4. The study captured a range of work-related characteristics among healthcare workers. A significant proportion of the respondents (33.0%) did not provide a response regarding their years of experience in the health sector. Among those who responded, 16.2% had less than one year of experience, while 15.7% had

between 6 and 10 years of experience. Additionally, 12.1% had between 1 and 5 years, and 11.6% had between 11 and 15 years of experience.

In terms of employment status, 44.8% of the respondents were employed full-time, 12.9% were employed part-time, and 5.2% were in temporary or casual employment. A notable portion (37.1%) did not indicate their employment status. Most of the respondents (74.0%) reported that they do not work in shifts, while 26.0% indicated that they do engage in shift work.

Regarding the timing of their work, 62.1% of the respondents reported working between 8:00 a.m. and 5:00 p.m., whereas only 4.6% reported working night hours, specifically between 6:00 p.m. and 7:00 a.m. However, 33.2% did not provide information about their work hours. More than half of the respondents (54.4%) stated that they do not interact with patients during their work, whereas 45.6% confirmed that they do. Slightly over half of the respondents (52.6%) indicated that they do not have routine direct physical contact with patients. On the other hand, 47.4% acknowledged that their job involves routine direct physical contact with patients.

A substantial proportion of respondents (22.7%) perceived that the work situation for staff had worsened following workplace changes. On the other hand, only 8.5% believed that the work situation for staff had improved, suggesting a generally negative perception of recent changes. Regarding the impact on patients, 15.5% of the respondents felt that the situation for patients had worsened, whereas 10.6% believed that it had improved. A small proportion of respondents (4.4%) indicated that they did not know how the changes had affected either staff or patients.

Healthcare workers identified several key strategies that they believe would help reduce violence in their work environment. The most frequently mentioned measure was to increase the number of staff, reported by 49.5% of respondents. This suggests that staff shortages may be contributing to tension and conflict in the workplace. Security measures were also highly prioritized, with 48.5% of respondents identifying this as an important way to curb workplace violence. This highlight concerns about physical safety and the need for protective interventions. Training was cited by 41.0% of respondents as a vital measure, reflecting the perceived importance of equipping staff with skills in conflict resolution, communication, and managing aggression. Patient screening, aimed at identifying individuals who may pose a risk, was suggested by 20.9% of respondents.

Socio-demographic characteristics were associated with the experience of workplace violence among respondents, using Chi-square statistical tests.

There is a significant association between age and workplace violence (χ^2 = 32.409, p = 0.000). The highest prevalence of workplace violence was reported among individuals aged 30–34 years (27.4%), followed by those aged 35–39 years (21.2%) and 40–44 years (16.4%). The prevalence was notably lower among the youngest group (19 and below: 4.1%) and those aged 60 and above (2.1%).

Gender also showed a statistically significant association with workplace violence (χ^2 = 6.396, p = 0.011). A higher proportion of those who experienced violence were male (76.7%) compared to female respondents (23.3%).

There was a significant association between a respondent's current status in the hospital and their experience of workplace violence (χ^2 = 35.776, p = 0.000). The majority of those who reported experiencing violence were hospital staff (68.5%), followed by other staff members (21.2%) and patients (10.3%).

The association between years of experience and workplace violence was not statistically significant (χ^2 = 6.755, p = 0.239). Although workplace violence was most reported by those with under 1 year (23.6%), 11–15 years (22.8%), and 6–10 years (18.9%) of experience.

Variables	Frequency	Percentage
Years of work experience in health sector		
Under 1	63	16.2
1-5	47	12.1
6-10	61	15.7
11-15	45	11.6
16-20	20	5.2
0ver 20	24	6.2
No response	128	33.0

Employment status		
Full time	174	44.8
Part time	50	12.9
Temporary/Casual	20	5.2
No response	144	37.1
Working in shift		
No	287	74.0
Yes	101	26.0
Time of work		
Between 6 pm and 7 am	18	4.6
Between 8 am and 5 pm	241	62.1
No response	129	33.2
Interact with patient while working		
No	211	54.4
Yes	177	45.6
Routine direct physical contact with patients		
No	204	52.6
Yes	184	47.4

Table 1: Work related Characteristics.

Perceived Changes	Frequency	Percentage
Work situation for staff worsened	88	22.7
Work situation for staff improved	33	8.5
Situation for patients worsened	60	15.5
Situation for patients improved	41	10.6
Don't know	17	4.4

Table 2: Workers' perception of impact of work changes.

Impacts	Frequency	Percentage
Increase staff number	192	49.5
Security measures	188	48.5
Improve surroundings	43	11.1
Patient screening	81	20.9
Training	159	41.0

Table 3: Most important measures that would reduce violence in work space/setting.

Variables	Violence experienced (%)	Chi-square	P-values
Age (Years)			
19 and below	6(4.1)	32.409	0.000*
20-24	8(5.5)		
25-29	14(9.6)		
30-34	40(27.4)		
35-39	31(21.2)		
40-44	24(16.4)		
45-49	12(8.2)		
50-54	4(2.7)		
55-59	4(2.7)		
60 plus	3(2.1)		

Gender Female Male	 34(23.3) 112(76.7)	6.396	0.011*
Current status in the hospital Hospital staff Staff Patients	 100(68.5) 31(21.2) 15(10.3)	35.776	0.000*
Years of experience Under 1 1-5 6-10 11-15 16-20 0ver 20	 30(23.6) 23(18.1) 24(18.9) 29(22.8) 9(7.1) 12(9.4)	6.755	0.239

Table 4: Socio-demographic Characteristics in association with prevalence work place violence.

Discussion

The results of this study provide important insights into the current dynamics of workplace changes and their link to workplace violence (WPV) in a Nigerian tertiary healthcare setting. The findings are particularly relevant in dealing with socio-economic pressures, structural reorganization, and the global push toward improved occupational safety in healthcare.

It was observed that more than half of the respondents interacted directly with patients (45.6%) and had routine physical contact with them (47.4%). These activities naturally increase the risk of exposure to violence, particularly when dealing with agitated, mentally unstable, or dissatisfied patients and their relatives. Studies have shown that patient dissatisfaction due to long wait times, perceived medical negligence, or poor communication is a common trigger of violence [2,6]. Working shifts (26%) and night-time duties also contribute to vulnerability. Research has repeatedly highlighted night shifts as riskier due to reduced security, staffing shortages, and heightened emotional distress among patients [7,8].

Interestingly, over one-third of respondents did not disclose their employment status, and this may reflect a lack of confidence or fear of repercussions—an indirect indication of the psychologically unsafe environment in some Nigerian public hospitals. Employment insecurity is itself a psychological stressor that may influence how workers respond to or report workplace aggression [9].

The perception of staff on the impact of workplace changes in the hospital revealed that 22.7% believed that their work situation had worsened, and 15.5% opined that the condition for patients had also deteriorated. This perception might be attributed to increased workload, understaffing, lack of resources, and administrative constraints—a scenario commonly reported in Nigerian public hospitals [7].

Research has validated the correlation between workplace reorganization and negative employee perception. According to earlier research, organizational changes without corresponding support networks result in higher levels of job dissatisfaction and burnout [10,11]. Poor communication, job insecurity, and underpayment are common negative consequences of public sector restructuring and economic adjustments in Nigeria, which can negatively impact employees' perceptions and morale [12].

The study revealed that violence was significantly associated with age ($p = 0.000$), gender ($p = 0.011$), and current status in the hospital ($p = 0.000$), but not significantly related to years of experience ($p = 0.239$). This aligns with research from Nigeria and other low- and middle-income countries showing that younger and more frontline staff—such as nurses and medical officers—are more vulnerable to verbal and physical assaults [1,4,13].

The most affected age group was 30–34 years (27.4%), followed by 35–39 years (21.2%) and 40–44 years (16.4%). These age groups represent the core of the active workforce who are most likely to be in frontline clinical positions, engaging directly with patients. The statistically significant association (p = 0.000) suggests that mid-career professionals are most at risk, potentially due to their roles requiring direct patient contact and decision-making responsibilities.

The gender disparity in violence exposure found in this study, with males significantly more affected (76.7%), contrasts with global trends where females, especially nurses, are often reported as the most targeted group [14]. However, in the Nigerian hospital environment, security roles and direct confrontational situations (e.g., emergency services, psychiatric care) are often handled by male staff, possibly explaining this outcome.

Hospital role or current status in the hospital also significantly influenced exposure to violence. Full-time hospital staff accounted for 68.5% of the reported cases, while patients and patient relatives made up 10.3% and 21.2% respectively (p = 0.000). These figures demonstrate that those deeply embedded within the hospital system, particularly full-time staff, face greater exposure to workplace violence. This could be attributed to increased working hours, higher patient interaction rates, and extended responsibility.

The implications of the findings of this research are broad. First, they underscore the urgent need for Nigerian healthcare institutions to implement structured workplace violence prevention programs. As noted by Al-Turki., *et al*. the absence of such frameworks not only endangers health workers but also compromises patient care quality [6].

Secondly, the role of management and organizational culture cannot be overemphasized. Perceived fairness, support, and participatory decision-making significantly improve staff satisfaction and reduce conflict. Workers who feel respected and valued are more likely to respond constructively to workplace changes, rather than with resistance or fear [15,16].

Moreover, addressing workplace violence has been shown to improve job performance, reduce absenteeism, and promote retention of skilled personnel—a critical need in Nigeria's struggling health sector [1,15]. Healthcare staff turnover is costly and disruptive, and workplace violence is a major contributor.

Conclusion

This study has provided valuable data on how healthcare workers at ESUTH perceive workplace changes and the factors associated with violence in their environment. While changes in workplace structure are inevitable due to technological and economic shifts, it is imperative that these changes are managed inclusively and proactively to prevent adverse outcomes like workplace violence. The data strongly advocate for systemic reforms, increased staffing, capacity-building, and improved working conditions to foster a safe, responsive, and productive healthcare environment.

Conflicts of Interest

None.

Funding

None.

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