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“I hope this shift goes alright”: Workplace violence among generalist nurses in a small rural hospital — a descriptive phenomenological study

Christine Trotman

chris@christrotman.com.au

Federation University

Joanne Porter

Federation University

Michael OLASOJI

Federation University

Anita Raymond

Latrobe Regional Hospital

Bindu Joseph

Federation University

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Abstract

Background

Workplace violence (WPV) in rural hospitals remains a major concern, yet general ward nurses lived experiences are largely unexamined. This study explores nurses' lived experiences of WPV in one rural hospital, the second site in a three-hospital qualitative project, addressing the research gap in qualitative studies on rural nurses' experiences and support needs, and highlighting their voices to inform context-specific prevention, reporting and support strategies.

Methods

A descriptive phenomenological design, informed by Giorgi's modified Husserlian method, was used. Semi-structured interviews were conducted with registered nurses working in general wards in a single rural hospital located more than 100 kilometres from a metropolitan area (n = 10). Data were analysed using Giorgi's five-step whole–part–whole method to derive an essential structure.

Results

Three constituents emerged: (1) perceiving an erosion of quality patient care causing moral distress, (2) expecting but not accepting WPV while maintaining compassion for cognitively impaired patients and (3) living with an interwoven personal and professional aftermath in a small rural community. The essential general structure was frequent and frightening violence in a rural hospital, eroding nurses' ability to provide care that aligned with their professional values, and compounding the personal and professional aftermath in a small rural community.

Conclusion

Findings highlighted patterned lived experiences of WPV among rural generalist nurses. Participants experienced being known in their small community as amplifying fear and vulnerability, indicating a need for locally tailored safety planning and post-incident support that extends beyond the workplace. Resourcing was also a key issue, with nurses often managing WPV incidents without security or a consistent local police presence.

Implications for nursing management

For nurse managers, the results highlight the importance of strengthening WPV prevention and management to include preparation for internationally trained recruits, on-call behavioural emergency support teams and coordinated support pathways for affected staff that are tailored to the small rural community.

Introduction

Workplace violence (WPV) towards nurses in general inpatient wards is a longstanding problem and now represents a critical occupational health and safety issue for healthcare organisations. Patients and visitors are the primary sources of WPV, [1, 2] which includes physical assault, verbal abuse, threats, racism and sexually inappropriate behaviour directed at nurses during the course of their work. Exposure to WPV is associated with psychological and physical harm, reduced job satisfaction and increased turnover intention [2, 3], making it a key contributor to ongoing nursing workforce instability. From a management perspective, WPV also has implications for patient safety and quality of care, including associations with adverse events and reduced service capacity in already stretched systems [1, 4].

Rural hospitals face distinct WPV challenges that intensify these risks for nurse leaders and executives, yet there is a paucity of studies on how WPV is experienced in everyday practice by frontline nursing staff [5]. Recruitment and retention of nurses in rural hospitals is more challenging than their metropolitan counterparts due to perceptions of limited facilities, social and opportunities for non-clinical employment for nurses' families [6]. Nurses living and working in small rural hospitals are more likely to know, and be known by, patients and families outside work, and some authors suggest this familiarity may discourage reporting when staff fear repercussions in their personal lives and limited alternative employment options [7, 8]. Difficulties maintaining privacy and anonymity in rural towns may also shape how nurses participate in local social events, as they seek to reduce their visibility and manage potential risks from disgruntled community members [8]. In addition, limited on-site resources, reduced security presence and variable access to police further constrain organisational responses to violent incidents, intersecting with the long-standing difficulties recruiting and retaining nurses in rural areas and amplifying the strategic importance of effective WPV prevention and post-incident support [5].

Current literature largely focuses on high-acuity clinical areas including emergency departments and mental health or aged care units, particularly in urban or metropolitan settings [1]. The lack of in-depth studies of rural nurses' experiences, is a significant research gap [9], which this study begins to address. Using a Giorgian descriptive phenomenological approach in one rural hospital, the second site in a three-hospital multi-site study, we explored nurses' lived experiences of WPV and, from these descriptions, identified practical, context-specific strategies for prevention and response to inform nurse leaders and health service managers.

Methods

Aim

This study aimed to explore the lived experiences of rural hospital generalist nurses exposed to workplace violence from patients and visitors in the smallest of three rural hospitals with differing socio-economic profiles.

Study Design

This descriptive phenomenological study, informed by Giorgi's modified Husserlian method [10], explores rural general ward nurses' experiences of WPV. It is the second phase of a larger multi-site study conducted in three rural hospitals and was informed by a previously published scoping review on rural nurses' experiences of WPV [11]. The study methods and reporting were guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [12].

Population and location

The study was conducted in a small rural hospital located over 100 kilometres from an Australian metropolitan area, serving a catchment population of approximately 52,500. At the time of data collection, the hospital employed around 132 full-time equivalent nurses, working across a range of clinical areas. Purposive sampling was used to recruit registered nurses working in general acute medical and surgical wards who had lived experience of WPV. Compared with other staff, registered nurses are more likely to be responsible for shift and incident management, hence the sample population was limited to this cohort.

Data Collection

The recruitment and interview processes for data collection mirrored those used in our earlier study in the first of the three rural hospitals. Participants were recruited via advertising flyers, ward briefings and direct face-to-face approaches. All participants received a hard copy of the plain language information statement and verbal information about the study. Written informed consent was obtained from all participants prior to interview, including consent to audio-recording, anonymised transcription and the use of de-identified quotations in publications. Participation was voluntary, and nurses were reminded that they could decline to answer any question or withdraw from the study at any time without consequence.

Two enrolled nurses expressed interest but were ineligible because they did not meet the study population criteria. Data were collected from June to August 2025 through semi-structured, in-person interviews developed exclusively for this study. Interviews were held in a separate office within the hospital, with only the interviewer and participant present. Interviews lasted approximately 25–55 minutes, and were recorded digitally, transcribed verbatim in Microsoft Word, and then checked against the audio recordings to ensure accuracy. All interviews were conducted by the primary author (CT), a female PhD candidate and retired registered nurse who had no relationship with the interviewees. Participants understood that the researcher was investigating WPV in rural nursing as part of her PhD, with no personal agenda beyond academic publication and improving rural nurse safety. Before beginning data collection, the primary author consulted with support services and completed qualitative interview training including a focus on trauma-informed practice, to minimise participant distress and ensure she could refer individuals, if required, to an appropriate service that had been briefed about the study.

Consistent with descriptive phenomenological methodology, whereby data collection is shaped by the phenomenon rather than a pre-determined design [13], the semi-structured interview guide was kept flexible. It invited participants to describe their nursing career journeys and current roles, explain their understanding of workplace violence (e.g. 'When I use the term workplace violence, what comes to mind?'), and describe specific WPV incidents in which they were involved, including any personal impact. Participants first provided initial naïve descriptions, after which clarifying questions were used to elicit deeper, richer and more vivid descriptions of their lived experiences. Interviews concluded with a solution-focussed question asking what, in a 'perfect world', would need to happen to address WPV on general inpatient wards, prompting participants' own ideas for improvement.

Data Analysis

Data were analysed using Giorgi's five-step whole–part–whole descriptive phenomenological method. First, the researchers adopted a phenomenological–psychological attitude, with epoché and psychological reduction maintained throughout the analysis. In step 2, each transcript was read in full to gain a sense of the whole; in step 3, the text was delineated into meaning units; and in step 4, these units were transformed through imaginative variation and synthesised into an essential structure of the phenomenon. In step 5, this essential structure was then used to guide and deepen interpretation of the raw data, consistent with Giorgi's view that; "the key test of a structure is to see if the structure collapses if a key constituent is removed" (Giorgi, 2012 p. 166). Excel spreadsheets were used to store, manage and organise the de-identified data. Quotations are attributed using participant identifiers (eg P101), where 'P' denotes participant and the number is a unique study ID assigned for this project.

Sample size

Sample size was guided by Giorgi's methodology, which prioritises the information needed to develop a general structure from rich descriptions rather than conventional saturation rules [14]. While Giorgi suggests a minimum of three participants, and Creswell proposes between five and 25 for phenomenological studies, these are indicative rather than prescriptive [10, 15]. In this study, the first author used the information power model [16] to appraise the study aim, sample specificity, use of established theory, quality of dialogue and analysis strategy, and, after 10 interviews, the research team agreed that adequate information power had been achieved.

Trustworthiness and Rigor

To ensure quality, the study drew on Lincoln and Guba's trustworthiness framework, addressing credibility, transferability, dependability, confirmability and authenticity [17]. Consistent with Giorgi's descriptive phenomenological method, member checking was not undertaken, as participants in the natural attitude are not tasked with validating phenomenological reductions or eidetic structures, which remain the responsibility of the phenomenological researcher (Giorgi, 2012). Credibility was supported through purposive sampling of nurses with direct experience of WPV, meticulous checking of interview

recordings against transcripts and disciplined use of phenomenological psychological reduction during analysis. Quotations were lightly edited for readability (for example, removal of fillers and obvious repetitions) while preserving participants' original meanings and tone. The primary researcher maintained a reflexive journal, field notes, process notes and analysis documentation to provide an audit trail, enhancing dependability, confirmability and overall trustworthiness. Recognising that different descriptive phenomenological researchers may generate different meaning units with different participants (Giorgi, 2012), transferability was fostered through rich descriptions of the setting, participants and incidents, allowing readers to judge the applicability of the findings to other contexts.

Results

A total of 10 participants constituted the final data set, comprising 8 female and 2 male registered nurses. The majority were aged between 30 and 39 years of age and had over 6 years' post-graduate nursing experience as shown in Table 1.

Using Giorgi's descriptive phenomenological approach, three authors independently coded the raw accounts from the 10 participants. The data were initially segmented into meaning units corresponding to changes in psychological meaning, tone, or intention. These units were subsequently transformed into broader, psychologically sensitive formulations through imaginative variation, whereby essential features were identified by envisioning alternative situations. A process sample of the two-column method [10, 13] is shown below in Table 2.

Table 2
Excerpt of the Giorgi-style two-column method.

Column 1 – **Naïve description from participants(P)**	**Column 2 –** **Transformed Meaning Unit**
P203 We will be stressed going in there, and it will really reduce the quality of care we are giving. We will not be talking to them in the best possible way, and it may decrease the quality of care…we just finish the work and then come out	P experiences anticipatory stress when entering the patient's room after WPV, feels unable to provide care in the way they believe they should, and responds by limiting interaction to essential tasks and leaving the room as quickly as possible, which they experience as a reduction in the quality of care
P201 No nursing home would take her because of the behaviours she was having and that was a turning point: where are these people meant to go if they can't even go to a dementia ward or a high acuity or locked dementia ward? We don't have security	P feels a turning-point frustration when a patient with cognitive impairment is refused by multiple nursing homes because of her behaviours, and is left asking where such patients are meant to go, while working on a ward without security or suitable resources to care for them
P202 This person was living locally, and that impacted my life and peace of mind. If I keep seeing this person in the supermarket or school drop off, it will not be comfortable.	P feels that their peace of mind and everyday life are affected by the offender living locally, and anticipates ongoing discomfort at the possibility of unexpectedly encountering them in community places such as the supermarket or school drop-off

The transformed meaning units were then synthesised into constituents of the general structure, as shown in Table 3, which are elaborated with participant quotes in keeping with the authenticity principle [18].

Table 3
Constituents linked to clusters of transformed meaning units.

Constituents of the general structure	Clusters of transformed meaning units
Perceiving an erosion of quality patient care giving rise to moral distress	Becoming a lot more common Reduced care for other patients Unprepared for racism and workplace violence Insufficient resources to provide desired care Reaching breaking point
Expecting but not accepting workplace violence while maintaining compassion for cognitively impaired patients	Part of the job Compassion through an illness lens Protecting self and others
Living with an interwoven personal and professional aftermath in a small rural community	Uncertain response pathways Lack of anonymity in small rural town

Constituent 1

Perceiving an erosion of quality patient care, giving rise to moral distress

The first constituent captures participants' experiences of the prevalence of violence and the direct impact on patient care due to the additional time and emotional resources spent on managing incidents. A state of cognitive-emotional dissonance, commonly experienced as moral distress, can result when nurses are constrained from providing the standard of patient care expected both professionally and personally [19]. Some nurses expressed a perceived increasing frequency of WPV incidents, using terms such as "*it's happening every shift …it's becoming a lot more common*" (P201). One nurse described a link between violence and substance abuse, stating that:

"It [WPV] *is getting more and more and there is a lot of substance abuse involved as well and the more… drug issues, the more violence there is." (P202)*

Many participants described feeling stressed, afraid and in turmoil when they were unable to provide the standard of care they believed was ethically required for all their patients because of the additional emotional and physical workload created by violent incidents. Nurses highlighted examples of non-violent patients being worried, unable to sleep and *"threatening to self-discharge "*(P207) when they heard the commotion of WPV incidents. One nurse described:

"I missed so many of my morning drugs to other patients because she was yelling and I missed my other patient care" (P204)

Participants who had gained their nursing qualifications either in Australia or internationally reflected that neither their nursing education, nor the hospital orientation had prepared them for the extent of WPV they experienced in practice. Several participants also highlighted that the hospital orientation program did not alert them to the potential for racial abuse from patients and families. Recollections from Australian undergraduate education included:

"[The University] *touched on it lightly but it's not something that's really covered"* (P205) and *"you don't really talk about it in your degree"* (P201).

An internationally qualified participant recounted:

"They didn't tell me anything about this; they just told us all the colourful things, and I thought every person in Australia is going to be so polite, so gentle and so good" (P203)

Many participants expressed frustration at not having sufficient resources to support them in providing appropriate care, when aggressive patients were on the ward. Male maintenance staff were sometimes called to assist with patients during physical attacks, in lieu of security, but they were not available after hours. Nurses described feeling vulnerable, particularly on night shift when staffing was expressed as '*bare bones'* and '*skeleton staff'*. Participants recounted the need to call police, paramedics or an external security company for additional support. Most participants highlighted the absence of on-site security in a town where the local police station was only intermittently staffed during business hours and remained closed after hours and on weekends. Several participants described waiting several hours for police to arrive and on occasion, the offender had left the hospital. A participant noted:

"*Police were required urgently and it took them two hours to get here because they were dealing with something else… it was very scary"* (P206).

The cumulative strain of being unable to transfer complex patients to specialist clinical facilities due to lack of available beds, was described by many participants. Participants described feeling worried that they were unable to provide adequate support for patients with behaviours of concern or severe mental

health conditions including suicidal ideation, explaining that *"getting a bed is extremely hard" (P202)*. One nurse expressed:

"No nursing home would take her because of her behaviours… where are these people meant to go?" (P201)

Nurses also described feeling that they were reaching breaking point, with no one to turn to in very difficult situations. One participant recounted a death threat that left her manager too scared to work on the ward while a particular inpatient remained. Several reported fearing interactions with patients, uncontrolled shivering and crying, hiding on the ward, swapping shifts, and avoiding staff social events to conceal the emotional impact:

"I*t makes you angry and upset and not want to come back"* (P205).

Others described being at the end of their tether and considering leaving the hospital, the profession or the country. One participant described racist WPV incidents that led her to hide in the shower room to cry, while her family urged her to return to her country of origin, but she felt unable to do so because they had sacrificed "*a lot of money"* to enable her to work here (P203).

Breaking point incidents recalled by participants involved prolonged, uncontrolled aggression that left them feeling unsafe, including a patient with dementia barricading herself in a kitchenette with a knife for almost six hours (P201), or a patient who grabbed a nurse by the throat and lifted him up against a wall before releasing him when a visitor screamed (P202). One participant described reaching breaking point when a patient was;

"Running and chasing staff down the corridors and staff members had to barricade themselves in other patients rooms" (P206)

Considered together, these descriptions show that participants' lived experiences of WPV at a rural hospital were deeply traumatic and significant, with some incidents culminating in a feeling that they could no longer cope and questioning whether they could continue in their roles.

Constituent 2

Resignation to expect but not accept WPV alongside compassion for cognitively impaired aggressors.

Consistent throughout the interviews was a sense that participants have come to anticipate WPV as a routine and enduring feature of their work, which led to hypervigilance and avoidance of at-risk patients. Yet episodes still occurred abruptly on the ward, and participants expressed safety concerns for themselves and for other patients, including aggressors with cognitive impairment. Many participants lamented that WPV had become normalised, noting that it should not be accepted as part of the nurses' role.

"The sad thing is you think [WPV] *is part of the job… which is not the right way" (P207)*

A more experienced nurse related their lived experience:

"[WPV is] *a bit confronting, it's not something that I think nurses should just accept, however I feel like the longer you're in the profession, you do harden a little bit and you don't want to say that we get used to it, but we do" (P206)*

Understanding and empathy for those aggressors with cognitive impairment were highlighted by most participants using comments such as "*we understand"* (P202), and *"it would be frightening"* (P207). One participant stated:

"They don't understand what's happening… they're unwell now and they probably would never have done this at all previously." (P206)

The compassion described by nurses extended to a perceived need to protect patients.

"I wasn't expecting him to do that… I was just making sure he was safe and he wasn't going into other patients' rooms, then he turned on me " (P207)

Taken together, these accounts revealed an essential constituent of the structure: nurses anticipate a constant background of WPV as part of their work, with each new incident erupting acutely against this chronic strain and compounding their stress, even as they strive to maintain compassion and protection for cognitively impaired aggressors and other patients.

Constituent 3

Living with an interwoven personal and professional aftermath in a rural community.

Given the complexity of violent incidents, the often-non-linear trajectory towards resolution, and limited after-hours backup in a rural community, response pathways were experienced as complex and uncertain. Several participants explained that they needed clarity, strengthened policies, and clear guidelines on where to seek help and how to respond once an escalation occurs. Participants described the current ad hoc process of calling male maintenance staff, paramedics or police to assist them, essentially reaching out to anyone they perceived could offer physical support. Participants reflected on feelings of helplessness about where to turn for support, *"What can we do… where do we go" (*P207), *"Who do we have to turn to besides us"* (P205).

Post-incident support was also described as sub-optimal, with participants usually relying on their colleagues or family members for support after an incident. No participants used the phone-based Employee Assistance Program (EAP), perceiving that an anonymous counsellor would not understand the situation as well as ward peers. One participant described their need for post-incident debrief:

"Maybe our manager can give us like 5 minutes, and she can only listen and not judge." (P208)

Post-incident ramifications were described particularly in the context of a small rural town, where nurses were more likely to encounter aggressors outside of work.. The lack of anonymity in a rural community caused concern for some participants, with recognition that incidental meetings "*can't be avoided*" (P206). One participant reflected that:

"I was actually worried ... mainly because of the kids... walking in the streets with my kids was always a bit of a worry." (P202)

Other participants described avoiding social events for fear of encountering an aggressive patient outside the work environment and cancelling social engagements when they felt uncomfortable about mingling with the patient or their family members.

One participant described:

"Because of the mental trauma I could not go to the party, I was afraid that the people would know what happened (P204)

Considered as a whole, the transformed meaning units examined through imaginative variation, revealed an essential, invariant constituent of the general structure: nurses live with an interwoven personal and professional aftermath of WPV in a small rural community, in which the effects of violence extend beyond the hospital into their everyday lives.

Viewed together, the three constituents illuminate how rural nurses experience WPV as an ongoing, multi-layered burden. First, they perceive an erosion of quality patient care that gives rise to moral distress. Second, they live with a chronic expectation of violence that periodically erupts into acute episodes against a backdrop of ongoing strain, even as they strive to maintain compassion and protection for cognitively impaired aggressors and other patients. Third, they endure an interwoven personal and professional aftermath in their small rural community, where the effects of WPV extend beyond the hospital into everyday life and relationships.

General structural description

The lived experience of WPV for nurses in this rural hospital is one in which violence is both expected and deeply unsettling. In a working environment characterised by chronic exposure to violence, overlaid with recurring acute incidents and limited after-hours support, nurses perceive an erosion of the quality of care they can provide to all their patients. The resulting moral distress is compounded by nurses' struggle to meet their professional and personal standards of nursing care, particularly towards cognitively impaired aggressors. This experience overflows into nurses' personal lives, as living and working in a small town interweaves personal and professional identities and can blur the boundaries between them. Considered together, this constitutes the essential structure of rural nurses' lived experience of WPV in this hospital.

Discussion

The findings in this article are drawn from the second of three studies conducted in rural hospitals, forming part of a larger qualitative investigation into the lived experiences of WPV among rural generalist nurses. To our knowledge, this work is among the first descriptive phenomenological studies to focus on WPV in rural general ward settings and adds qualitative depth to a predominantly quantitative body of literature that has historically centred on high-risk clinical departments. The study addresses this significant research gap by giving rural nurses a voice to describe their lived experiences of WPV.

A key finding in this study, supported by extensive earlier research, is the negative impact of WPV on nurses' mental health and wellbeing [3, 4]. Other findings consistent with the literature include: (1) the association between WPV and the ability to provide high quality patient care [1]; (2) quiet quitting characterised by reduced interaction with patients [20]; and (3) diminished job satisfaction [3], which may increase intention to leave. Additionally, the finding that many nurses felt underprepared and ill-equipped to manage WPV on the ward is also supported by earlier studies [21]

This study specifically identified that internationally qualified nurses felt unprepared for the extent of WPV and racial abuse, as these issues were not mentioned during recruitment or at hospital orientation. Although previous studies have inferred a lack of preparedness for racism, [22], this appears to be the first study to explicitly report this issue, though other evidence may exist. Given that orientation programs are an important component of a successful transition for nurses relocating to a foreign health service [23], this represents an opportunity to provide WPV awareness and de-escalation education before internationally trained nurses commence work on the wards. Furthermore, the non-emergency patient admission process could be modified to include information for patients and families emphasising the vital contribution of internationally qualified nurses, stating that racism and discrimination are unacceptable, and offering respectful communication strategies to support mutual understanding. Policies could also be strengthened to include behaviour contracts and unwelcome letters where appropriate, supporting other WPV strategies. Public-facing information could be more specific than the slogan-based 'zero-tolerance' or 'don't cross the line' approaches, instead highlighting the negative consequences of WPV on nurse retention and the quality of patient care.

The risk associated with the absence of security staff and overreliance on local police who are inconsistently available, particularly during night shifts when small numbers of nurses are the only staff on site, was identified in this study and is consistent with previous research [5]. While the demand for after-hours on-site security services is highly variable and may exceed the budgetary capacity of small rural hospitals, permanent security positions are unlikely to be feasible. An on-call behavioural emergency support team, referred to by various names including Code Grey team [24], that can be rapidly deployed to ward incidents when required may be an efficient model for rural hospitals. This model would provide after-hours nurses with clear response pathways and may alleviate some feelings of fear and vulnerability. Literature shows some association between the presence of such teams and reduction of WPV and related injuries in various clinical settings [25]; however, no evidence could be found

regarding their effectiveness specifically in rural hospitals. This gap in the literature highlights the contribution of the current study to this little-studied context.

Participant reflections of the normalisation of WPV and its cumulative toll on nurses were supported by previous research on violence normalisation and psychological distress among nurses [26]. Perceptions of suboptimal post-incident support [27] and the lack of anonymity in rural communities [28] were similarly consistent with earlier studies. Notably, participants in this study did not view the EAP as a helpful resource in this context. Post-incident support strategies including Code Lavender and Schwartz Rounds [29] have shown promising early results in pilot work to support staff wellbeing after distressing events and are worthy of further investigation to determine their effectiveness in rural hospital settings. Consistent, timely, structured debrief and follow-up by management was desired by participants to help them process incidents and feel supported, suggesting that rural hospitals may benefit from strengthening clear post-incident support protocols for nursing staff.

The key findings identified in this study both echo and extend those previously reported, suggesting that many features of nurses' experiences of WPV may be shared across rural generalist settings while also being shaped by local context. Together, these findings underscore the need for nursing management in rural hospitals to address WPV not only as an individual clinical issue, but as a system-level priority encompassing prevention, preparedness, and post-incident support.

Limitations

This study used purposive sampling within a single rural hospital, which means the findings should be transferred to other contexts with caution. The descriptive phenomenological approach generated a general structure of the lived experience that may not fully align with work conducted in different settings, time periods or participant groups. Participants' accounts of WPV may also have been influenced by recency and negativity bias in their recall of particular incidents. Even so, these limitations do not detract from the value of nurses' first-hand narratives of their lived experiences of WPV.

Conclusion

This descriptive phenomenological study provides an in-depth account of rural generalist nurses' lived experiences of WPV in the second rural hospital in a multi-site study. It highlights the cumulative toll of violence on nurses' mental health, sense of safety, and capacity to provide high-quality patient care. The findings also show that WPV in rural general wards is both common and increasingly normalised, contributing to emotional exhaustion, quiet quitting behaviours, and diminished job satisfaction. Internationally qualified nurses reported feeling particularly unprepared for the extent of WPV and racism, underscoring the importance of context-specific preparation and support when transitioning to rural practice. Overall, the findings indicate that WPV in this rural hospital is a significant occupational hazard for individual nurses and a risk to nurse retention and patient care quality for the health service.

Implications for nursing practice

For nursing managers and leaders in rural hospitals, the findings emphasise that WPV is a chronic occupational hazard with acute episodes that can erode nurses' capacity to provide safe, ethical care. Aligning staffing, skill mix and access to on-site security or on-call rapid-response behavioural support teams may help support nurses, thereby decreasing feelings of fear and vulnerability and contributing to a safer, more supportive organisational culture. Revision of response pathway policies including when to escalate action to involve such a team or in their absence, security, police or paramedics, along with clarity on how to document and report incidents, may also be beneficial in strengthening both nurse safety and the quality of patient care.

Strengthening orientation and ongoing education to include realistic discussion of WPV, racism, and de-escalation strategies with credible simulations—particularly for internationally qualified nurses—may enhance preparedness and reduce feelings of betrayal or shock when incidents occur. Revision of non-emergency admission processes and public-facing information to explicitly affirm the value of internationally qualified nurses, condemn racism and aggression, and promote respectful communication could help set clearer behavioural expectations for patients and families.

Consistent, timely, structured debrief and follow-up by management were desired by participants to help them process incidents and feel supported after WPV, suggesting that rural hospitals may benefit from strengthening clear post-incident support protocols for nursing staff. Nursing leaders are well-positioned to consider moving post-incident responses beyond generic phone-based EAP services, to include timely, structured debriefing, follow-up, and access to models such as Schwartz Rounds or Code Lavender where feasible. Timely, trauma-informed post-incident support—such as structured debriefing and accessible psychological services that staff view as credible—appears important in mitigating ongoing impacts. In addition, local protocols, education and support strategies that take account of the lack of anonymity and repeated contact with aggressors in small rural communities may assist nurse managers to promote both nurse safety and high-quality patient care.

Abbreviations

COREQ Consolidated Criteria for Reporting Qualitative Research

HREC Human Research Ethics Committee

WPV Workplace Violence

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the Latrobe Regional Health Human Research Ethics Committee (HREC) on 17 April 2025, (certificate no is 2024-66), with reciprocal ethical approval via the Federation University Australia Human Research Ethics Committee on 21 May 2025. All procedures were conducted in accordance with the Declaration of Helsinki and relevant national regulations. All participants received a hard copy of the plain language information statement and verbal information about the study. Written informed consent was obtained from all participating nurses prior to interview, including consent to audio-recording, anonymised transcription and the use of de-identified quotations in publications. Participation was voluntary, and nurses were reminded that they could decline to answer any question or withdraw from the study at any time without consequence to their employment.

Consent for publication

This manuscript does not include identifiable personal data. At the time of recruitment, participants were informed that anonymised quotations may be used in publications and provided written consent for this use. No additional consent for publication was required

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to the sensitive nature of the qualitative interview data and the conditions of the ethics approval. Additional de-identified data may be available from the corresponding author on reasonable request and subject to ethics approval.

Competing Interests

The authors declare they have no competing interests.

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CRediT Contribution Roles Taxonomy

CT – Conceptualisation, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Writing – original draft

JEP – Supervision (lead), Formal analysis, Validation, Writing – review and editing

AR – Supervision (supporting), Formal analysis, Validation, Writing – review and editing

BJ, MO – Supervision (supporting), Validation, Writing – review and editing

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Table 1

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