ANALYSIS OF RESILIENCE LEVEL OF NURSES AND ITS IMPACT ON PATIENTS

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ABSTRACT: Nowadays, the aggressive nature of the clinical practitioners towards the patients while treatment has been increasing. The level of resilience is needed to be controlled for improving the medical practices and obtaining effective patient outcomes. To meet this objective of the research a questionnaire methodology is used and the statements were recorded from the participants located in Bangladesh, most of them were medical practitioners. In this research, it is found that health care providers who categorise their hospital's protection as good/very good are less vulnerable to violence and exhibit less aggressive conduct towards patients after abuse. It has been concluded that one in 5 emergency services does not take any action or intervention to defend its employees from hostile committers, & to this end, it is recommended that a protection strategy be implemented along with safety personnel requirements. By enhancing protective practises and interventions in hospitals, it is important to decrease both the vulnerability of health care personnel to violence and the detrimental impact of hostility on patient behaviour. Although this study did not inquire about depression, the limited-resilience participants (n=7) reported jaded feeling (n=4) and alert feeling (n=2).

KEYWORDS: Health-care sectors, Medical practitioners, Resilience, Violence.

INTRODUCTION

The term violence is described in various forms by the members of WHO: the deliberate utilisation violent force or control, threatening or real, against itself, another individual, but against a group or society, that either resulted in death, injury, psychological damage, lack of development or oppression, or has a high probability of resulted in it. Violence can be seen as emotional, sexual & physical forms. Abuse in healthcare facilities & organisations occurs in the form of aggressive behaviour, physical attack, & sexual abuse/harassment by staff, patient family, or some other person that they may be. Research also showed that 26-89 percent of the workers of the medical services have been subjected to mental, sexual &physical harassment or violence during the last year [1]. Several researches performed there so far have indicated variations among, the level of violence &, on the other hand, the states, occupations & working environment or workers organisation, with the working environment being a state hospital or a teaching & research institution. Aggressions are most commonly identified as families of patients, accompanied by clinicians in the 2nd position along with families of patients, & patients individually in 3rd position. The major public health concern nowadays is Aggression, like all other industries, has in recent years disrupted social stability in health care institutions and clinics, & this has increasingly become a very significant problem for both healthcare professionals & families of patients. While there are several reports on violence to injured or elderly people, the literature includes just a few reports on aggression to medical-care professionals [2]. Despite all the steps taken & all the recommendations made in conjunction with this, the hostility & violence against health care providers has been rising steadily through the years & the health care providers are operating under pressure in terms of hostility. The major concern regarding the nurses working in the hospitals nowadays is lateral violence. Also recognised as horizontal violence or bullying at the working location, it is troublesome & unacceptable actions shown in the work environment by one worker to the next who is in an equal or inferior position anymore [3]. This intentional conduct can be exhibited openly; but, as is repeated, it is more often veiled &discreet, frequently escalating with time. Whilst also individual acts may seem innocuous, the combined impact of these custom attacks & aggressive behaviours intensifies the damage more than a single violent act can. The main profession at risk for lateral aggression was found to be nursing. Research suggests that 46% to 86% of nurses are the ones who had to face lateral abuse; up to 89% of nurses report being
perpetrators of lateral violence in the working environment. Regrettably, most frequently then not the seasoned nurse is the attacker, whereas the inexperienced nurse is the probable survivor. Researchers find that learners & highly trained nurses observe lateral abuse on a daily basis and encounter severe intimidation in their clinical environments. Some research suggests that this behaviour is considered 'natural' because of its occurrence & recognised within the community of nursing; thus, it is frequently ignored & unnoticed.

The injured healer’s image is initially observed in Greek mythology, & has been utilized for more than 3000 years now. The injured healer's archetype implies healing strength is the product of a healer’s own trauma, or wound [4]. A centaur recognized for his goodness, unintentionally received an incurable & debilitating wound from the arrow of Heracles, he fled to his cellar to live alone, as per the researchers. They did not die because of the poison which was the reason for his wound, since that was invincible. Researchers were going beyond his own suffering & they joined Hades to cure others. This self-sacrificing act indicated his potential for shaping, transcending & eventually reducing his pain. An injured healer, they appeared. Even of the past injuries, they exhibited spiritual characteristics that are vital for understanding how the process of healing will affect others. The Injured Healer principle can be used today in the areas of behavioural therapy, psychiatry, & theology. It's been utilized for a long time to characterize interactions between physicians & patients, with the doctor utilizing themselves as an intermediary to help the patient restore health. The philosophical work of a psychologist extended the wounded healer’s idea. One of the fundamental assumptions made by researchers was that each person endured some form of trauma in life. Both unconscious & conscious influences that are generated from private interactions influence human actions & accept all humans. They must be understood as co-existing rather than perceiving these variables as dichotomous. The concept of being able to recognise this duality & perceive all pieces as a whole is termed as transcendence. It generates a self-extension beyond the boundaries of common interactions. When society attempts transcendence, it tries to pursue experiences, links, associations & integrations with the universe surrounding us in order to achieve wholeness, to make any sense of, to describe the essence of, & to discover the intent of all of it.

The presence of abuse at the working environment but also induce signs of post-traumatic disorder of stress & diminished productivity. Not every nurse witnessing abuse in the workplace will suffer detrimental consequences however. The consequences of trauma can be modulated by human resilience. Resilience is the capacity of a person to recover health & vitality during conditions of distress. Several studies have demonstrated that the introduction of coping training to nurses helps improve stress control. The aim of this research is to explain the interactions of nurses with workplace harassment, and how they affect their clinical treatment depending upon the level of resilience.

Research Questions:
1) What causes the aggression to the nurses towards the patients in their working environment?
2) How does the violanceness behaviour of the health-care providers can be reduced while performing the medical activities in the healthcare sector?

LITERATURE REVIEW

Researchers investigate the effect of work-place social & relational control on a nurse's experience of job stress & satisfaction of work. Previous study has shown the personal, organisational, & financial consequences of job pressure ranging from absenteeism to worker benefits & workplace harassment [5]. Structural equality includes a working atmosphere with access to knowledge, services, encouragement, and learning opportunities. Psychological wellbeing is decided when the workers react with a sense of control, confidence & self-efficacy to this situation. Attempts made to provide health-care providers with a sense of autonomy over decision-making dramatically lower their level of burden on work. Efforts to increase institutional & relational resilience will
potentially contribute to increased morale & engagement of staff, and also enhanced results & satisfaction for patients. Studies also found the negative impact of lack of support for the workplace & abuse on nurses' personal & professional health. Despite this, only a handful have studied specifically the impact of these problems on work satisfaction for nurses. Study regarding the satisfaction of the employees towards the job for nurses remains focused on economic aspects in large measure. Researchers sought to examine the effect of occupational abuse, non-economic influences and appreciation over nurses' job satisfaction rate [6]. The research employed a cross-sectional analysis of the questionnaire. 600 trained nurses serving in public hospitals were interested in this. Findings from this study found that nurses were, generally, neither pleased nor unhappy with their work. More than half of the subjects had been physically assaulted, & during the 15 months prior to the survey, few had been sexually exploited. Even so, most nurses felt they had been valued in the job. More number of regression analyses have shown that physical harassment & perceived value are statistically important predictors of work satisfaction among nurses. Nurses that had physical harassment & a poor degree of appreciation were more likely to show low ratings of work satisfaction. It is hypothesized that non-financial interventions like healthy workplace environments can increase the level of job satisfaction for nurses. For safety of nurses & medical-care practitioners in general, a principle of zero tolerance for abuse & low tolerance for contempt should be implemented.

Harmful personal & social conduct at work has been researched from the victim point of view. By comparison, victimisation hypotheses say other causes may also decide whether certain people are affected more often than others. There can be external variables that have a significant contribution in an environment which fails to stimulate serious harm. Such occupational accident cases may be affected knowingly or inadvertently by the patients themselves. The previous analytical research expands previous research into adverse work-place behaviour by analysing whether self-perceived victimisation is expected by the behavioural component of condition of the working environment of the nurses and the dispositional features of aggressive behaviour & anxiety symptoms [7]. Researchers speculated that the work status of an employee will be strongly linked to alleged victimisation, based on studies in criminal victimisation. Study on abuse victims was the reason for the expected consequences of negative affectivity & aggressiveness. Data were generated by a randomly chosen group of city council workers who conducted a survey as part of an organisational appraisal. Researchers conducted confirmatory factor analysis studies on the reactions of employees to develop effective victimisation interventions. The analyses showed that perceived victimisation took elements either direct or indirect. Hierarchical analysis has been used to evaluate theories about the research. Results showed that perceived victimisation was not significantly influenced by employment status. Workers who have aggressive behaviour, however, reported higher levels of victimisation than those low in those characteristics. It discusses the implications for organisations & offers future implications for research.

Several of the major fields associated with the risks is the emergency room, where abuse against workers working in the medical sector is a widespread & severe concern. Abuse has detrimental impacts on staff & hence upon the level of treatment rendered in the field of emergency services. Researchers sought to classify the prevalence, forms, causes & aspects associated with risks of violence documented by staff in the department of emergency care [8]. A cross-sectional analysis was performed using a WHO-developed model questionnaire. This research had contained 89 survey questions. The most documented verbal abuse was in contrast with physical abuse. Waiting time was the much-recorded cause for abuse & that patient & family needs were not fulfilled. It was confirmed to hospital authorities by just 30 percent of staff who witnessed verbal abuse and 25 percent of those who encountered physical violence. Around 80 per cent of staff claimed that abuse in the workplace should be avoided, & about 70 per cent said the hospital authority has not taken any action against the assailant. Emergency service brutality against employees is a serious
problem & could not be triggered and overlooked. There are many explanations for doing so. The main point in solving the issue is coping with its particular triggers.

Researchers focused on investigating the extent of health care providers’ vulnerability to occupational conflict & abuse, & the influential factors thereon, as well as the impact of violence over the practitioners in medical-care [9]. Materials & procedures. This cross-sectional style analysis was carried out in the Hospital of Training and Science and the State Hospital in Iran. The researchers’ list of questions was conducted by face-to-face discussions with a total of 200 health care professionals who decided to participate in the report. The resulting results were analysed and measured by a kit system. 70 percent of participants indicated exposure to violence & harassment during the last year, the most prevalent form of abuse being physical. 91% of health care workers subject to occupational violence reported that the new statute would not shield employees from abuse, & 89% claimed that their company did not help them as a result of violence. There was a statistically important variation in the level of exposure to aggression among seniority, age, in the working environment, location of exposure to violence, & occupation of health-care workers (p<0.06). Nearly half of the healthcare professionals believe that violence has adversely affected their behaviour toward more patients. These negative behavioural changes are even higher in women assistants, & staff who believe safety at work in their organisation is at risk (p<0.06). Approximately 60 percent of healthcare professionals noted being exposed to violent acts at least once in the last year, & half of all those exposure to trauma confirmed that their behaviour towards patients had been adversely affected by it.

Researchers aimed at examining the effects of sensitivity to work-related violence & centred in specific on abuse as a mediating variable. The sample includes American public house license holders—individuals who run public houses & possess a licence to sell alcoholic beverages on site. List of questions were sent to 450 licensees, resulting in a response rate of 49 per cent [10]. Each questionnaire measured vulnerability to a variety of violent assaults, fear of violence, particular well-being, work satisfaction & commitment to organisation. Depending upon a final survey of 200 pub license holders, regression analyses found that as the magnitude of the abuse that licensees were subjected to grew, so did anxiety of becoming a victim & symptoms of diminished well-being, while work satisfaction and organisational engagement decreased. Hierarchical analyses found that perception of violence entirely mediated on both of these other variables the negative effect of exposure. It is proposed that the administration of appraisals of terror should be implemented into organisational approaches to aggression in the workplace.

Researchers sought to investigate the impact of abuse against child care workers by service consumers in America & Europe. Proposals resulting from the review of study results for better procedures and processes in institutions are discussed, with special reference to England [11]. Furthermore, consequences and effects of a limited number of interviews with Finnish social workers are discussed. The study found that, based on the precise combination of variables present in each given situation, there are a variety of distinct impacts arising from abuse on child protection social workers. They include questions about the impact of consumer abuse on social workers' abilities to protect children; the value of managers concentrating on workers' protection, particularly as risks are not necessarily visible to others; employee intervention strategies; reactions to aggressive service users; & how to use workers' perspectives to enhance risk identification & risk management. This previous study shows that social workers' perceptions of and insights from abuse cases need to be more consistently integrated into policy formulation & analysis. Furthermore, attitudes & processes must be in place to encourage social staff to report their issues & also have them handled in an effective manner.

The most frequently identified form of aggression by nursing staff in any setting was verbal abuse. In Japan (95 percent), China (92 percent) and America (over 91 percent), high occurrences of verbal abuse by patients or their relatives have been evident. Nurses reported the rate increases of physical harassment ranged from 95 per cent to 18 per cent experienced by nurses. The rate of
verbal abuse compared with physical assault was generally around 4:1. Common forms of verbal abuse toward nurses involve yelling, cursing, intimidating, & sexual language & innuendo harassment. In the case of aggressive behaviour like bullying & verbal abuse, professionalism issues with doctors made derogatory responses on Nursing Education. Violent & physical assaults have been recognised as more widespread in mental health services, gerontology, long-term care, & care homes than in general hospital areas in a study across countries in Europe (n=40000) [12]. Literature suggests emergency department (ED) nurses experiencing relatively high levels of physical assault in the workplace, where it might possibly be directly linked to the acuity, psychological condition and/or level of awareness of the patients presenting to the ED. In contrast, planning to work under time constraints, getting burned up out in the role of caring & being youthful all increased the potential for violent attacks. The occurrence of violent abuse in a cohort of Palestinian nurses ranged from as low as 21 percent to as high as 55 percent experienced in Portuguese nurses and 83 percent of ED nurses in the America. Obvious genetic acts of violence committed by patients toward nursing staff involve spat on, getting hit, being pushed / tossed, scratched and decided to kick, and are usually inflicted by patients who were treated. It also suggested extreme abuse was associated with the use / intoxication of alcohol by patients and because of misunderstanding.

Within a week of require rigorous (both physical or verbal) the returned proof revealed a high degree of non-reporting by nursing staff. Non-reporting remains a company funds & barriers exist have been identified as making a contribution to the lack of coverage by nurses experiencing workplace aggressive behaviour[13]. These hurdles to monitoring would include – a lack of (or uncertain) policy / method for incident reporting; poor or lacking assistance for individuals who are vulnerable-incident management; nurses with previous experience of non-reporting;Activity post the event and opt to disregard the event;And worry of person's perception repercussions, including being interpreted as not dealing with healthcare professionals and not being able to participate with them well. Alarming, up to 82 percent of non-reporting occurred in some cases and evidence of non-action from post-aggression managerial events incident to patients' nurses or their care givers was also present. Interestingly, when only half would take the opportunity to discuss the incident with the management. Impoverished monitoring was seen in cases of stereotype threat, and also some study recognised no activity or shortage of manpower in managing aggressive behaviour.

In addition, perpetrators have been seen as mis-sensitive, or misconstruing the behaviour and intentions of a colleague that were not designed to be individual. Thus, the offenders of these misconstrued actions were deemed not to be cowards[14]. Furthermore, harassment was common toward student nurses and in this case a student may felt helpless or jeopardised to opt for no monitoring. Managing aggressive behaviour as stereotype threat has often been poor without appropriate support systems in place and in certain cases continues to remain more of a worry over the possibility for aggressive behaviour from many other references. Not remarkably, in the dark background of the evidence provided here, support was sought primarily from other staff members not via the organization's structure. Using staff as support makes it appear to be a source of information that institutions remain unexplored in the planning of aggressive behaviour towards nurses. Organizations did tend to select employee aggressive behaviour professional development, with teaching reviews being successful in reducing the likelihood of being a perpetrator of working behaviours.

It's been well recorded that nursing professionals with clinical supervision are at significant risk of being exposed to violence. For instance, a nationwide study trusted source observed that the proportion of employee compensation claims linked to terrorism had been the second largest of all professions for nursing staff aid workers, and the sixth highest for nurses. In the nursing practice, many quantifiable reviews could be found that stated how violent behaviour is prevalent, and there are distinctions between groups in clinical settings. What's really missing is a quantifiable
review which pre-set of rates of violent behaviour broken by form of harm (physical, – anti-
physical, harassment, and sexual misconduct), establishment (e.g., clinic, hospital ward, and mental
health facility), citation of violence (physician, family, and/or buddies, and employees such as other
nursing staff), and travel abroad. This report outlines such a financial success, combining results
from 170 samples from 137 reports of research. There are many forms of violence reported in this
study. Perhaps the violent abuse that can lead to physical damage is of most pressing issue[15].Non-
tangible violence which ranges from insulting & gross remarks to severe physical harassment is
far more common.

Bullying is an aggressive mode of physical and/or extreme abuse over time which can be directed
towards one or more people. It can often be analysed in terms of lateral or horizontal atrocities
inflicted on their nursing staff co-worker by nursing assistants. Finally, both colleague and clinician
sexual assault is a problem that has obtained significantly less interest than different violent
behaviour. Aggression visibility rates have been shown to vary by trying to set, with some
researches supplying equivalences across healthcare organisations, and others displaying broader
equivalences across different clinical settings. Studies have been carried out in specific places, such
as hospitals, care facilities, or mental hospitals where violent behaviour is of particular concern[15].
The origin of the attack, most particularly sufferers, patient friends and relatives, and senior staff,
including doctors and other nursing staff, is another problem that has attracted significant
attention. Although most sexual harassment happens to come from patients & their family /
friends, other members of staff are responsible for a significant proportion of violence that is in
different forms. Even though much will be recognised about the exposed of nurses to workplace
violence, most of the literary works is blurred, and quantifiable review is needed to incorporate the
findings. Such a review may provide forecasts of exposure rates according to types of abuse and
in different contexts. The percentage of each form of harm may also be indicated by different
sources. Finally, although there are studies from several countries in the English-language literary
works (the evaluation here includes surveys published in 40 nations), there is little assimilation or
synthesis which would allow one to make judgements about distinctions in visibility rates as well
as reason of violent acts.

METHODOLOGY

Design:
The questionnaire methodology is adapted for this research & the Brief Resilience Scale (BRS)
tool is utilised for assessment, a 5-point measure measuring one's willingness to resolve traumatic
interactions [16]. The BRS includes 3 positively formulated & 3 negatively formulated products,
each of which is scored on a 5-point Likert scale from completely disagreeing to completely
agreeing. The scale makers characterized low resilience ratings to be 1–2.88, regular resilience
ratings to be 3 - 4.29, & high resilience ratings to be 4.32–5. The internal accuracy of the BRS
varies from a 0.70 to 0.89 Cronbach alpha with 0.70 test-retest validity. The BRS exhibits strong
associations with the indicators of resilience, motivation & life intent. The participants selected in
this research had answered several questions regarding their experience in the working
environment, their uncontrollable violence & behaviour with the patients.

Sample and Data Collection:
The participants were selected with the help of online social networking websites like Twitter,
Facebook, etc. Some participants were also gathered with the help of nursing colleagues by
contacting them through Gmail. Most of the participants were registered health-care professionals.
The information was gathered within several weeks in between March-2019 to April-2019. The
survey approval was granted from the Govt. medical institution of Bangladesh.

Data Analysis:
Qualitative results are analysed with the help of inductive interpretation of data. The collected
information is arranged by transparent coding, in which each researcher reads & writes headings
from the surveys. The topics were translated then, creating divisions. The groups were then clustered together to classify the category to which the data belong. The data were then abstracted to create a group description. When the evaluation was finished the evidence, they met to review findings & validate them. Microsoft Excel ® programme measured the BRS scores & informative figures.

**RESULTS**

From 60 people who replied to the survey, 4 respondents declined to answer the queries. Furthermore, only 3 from 4 factors on the BRS were answered by a single respondent (Table 1). The data analysis did not include all 5 answers, & the final sample consists mainly of 50 replies. Qualitative responses were split into 2 major narratives: Aggression forms & violence effects. It defined 3 forms of violence: physical, mental, & horizontal. The norms for the results of violence were: no influence, caution, part of the work, vigilant but carefully individualised, development, & jaded. 40 participants (76 %) recorded instances of physical abuse with forms of aggression, such as being hit, kicked, and seriously assaulted. Meanwhile 16 participants (25%) reported sexual violence experiences involving physical harassment & violent abuse. Lastly, 12 respondents (18%) recorded horizontal aggression encounters with events like: physical harassment & psychological bullying by experienced staff who taught them along with other focused colleagues, being moved by an RN while assisting a patient, & being threatened & overtly insulted by peers.

Statistics for impact of violence on health care reported 17 respondents (27%) who claimed their workplace violence experience did not impact their patient care (Table 2). Respondents indicated that the hostility was attributed to compartmental factors, 15 participants (25%) reported being vigilant while addressing patients after witnessing abuse, but becoming more careful, and they appeared to anticipate an attack in order to be alert & vigilant for all patients. The recognition of aggression as part of the work was another group found by 10 respondents (15 %). Nurses understand its part of the career they've chosen and know it's a challenge to deal with the media & the essence of where they're employed. Unlike these answers, there were 10 (15 %) respondents who understood how their experience acted as a development opportunity suggesting that they could turn this negative experience into better treatment for the patients. Before they became aggressive, they learned more knowledge & became more able to recognise problems.

**Table 1 shows the demographic data obtained from the survey analysis. The collected information is arranged by transparent coding, in which each researcher reads & writes headings from the surveys.**

<table>
<thead>
<tr>
<th>Factors</th>
<th>The acquired data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time period</td>
<td>40 years</td>
</tr>
<tr>
<td>Residential State</td>
<td>Dhaka (n=40, 74%)</td>
</tr>
<tr>
<td></td>
<td>Banghaban (n=12, 8%)</td>
</tr>
<tr>
<td></td>
<td>Barisal (n=5, 6%)</td>
</tr>
<tr>
<td></td>
<td>Khalna (n=1, 1.1 %)</td>
</tr>
<tr>
<td>Average experience of medical practitioners</td>
<td>7 years</td>
</tr>
<tr>
<td>Occurrence of violence</td>
<td>76% - physical violence, 25% - sexual abuse, 18% - aggression encounters with physical harassments</td>
</tr>
</tbody>
</table>

Table 2 shows the level of resilience among the medical practitioners towards the patients while treatment. Wherein, statistical impact of violence was reported.
<table>
<thead>
<tr>
<th>BRS ratings</th>
<th>Classifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 (Highest)</td>
<td>Null impact (n=2), caring individual (n=2), vigilance (n=1)</td>
</tr>
<tr>
<td>5 (Neutral)</td>
<td>Null impact (n=10), development (n=10), jaded (n=3), work related aspect (n=2)</td>
</tr>
<tr>
<td>Less than 3 (Lowest)</td>
<td>Jaded (n=4), caring individual (n=3), vigilance (n=2)</td>
</tr>
</tbody>
</table>

DISCUSSIONS

76% of physicians reported physical harassment experiences from patients in this sample. The descriptions of these records are consistent with the most prevalent forms of physical attacks recorded by nurses including spitting on, punching, pushing / shoving, smashing, & kicking [12]. Obviously verbal abuse happens more often than physical violence. Yet nurses talked more of physical than verbal abuse incidents in this study. Nurses might be desensitised to physical abuse, that may have hindered their recounting of those experiences. Another explanation for lower violence reports denotes that nurses perceive it as part of the work, a trend identified in this survey by 15 percent of nurses. According to researchers, the concept of cynicism has been deduced from accounts of abuse being part of the work or from nurses' fears about stereotyping people, inferring that prejudice may be a contributing factor to abuse escalation. Becoming desensitised to violence not only impacts news, but can also contribute to lost chances for early action in the process of conflict, ultimately mitigating abuse.

Another conclusion from this research is that levels of tolerance have played a part in how nurses view interpersonal abuse experiences impacting their patient care. Many nurses with average or high levels of resilience experienced improvement, no impact, or continued the opportunity to provide individualised treatment. This may contribute to the key positive resilience influences: development, emotional control, social change, professional progress and successful coping. Prior study showed the sensitivity of Chinese nurses in people with no depressed disorders was slightly greater. Although this study did not inquire about depression, the limited-resilience participants (n=7) reported jaded feeling (n=4) and alert feeling (n=2). Teaching coping strategies to nurses may be a way to protect the welfare of nurses from the adverse consequences of abuse. A few studies have studied the benefits of endurance skills training nurses have. One research incorporated the Stress Control and Endurance Preparation curriculum into a new nurse routine, with participants developing increased resilience and reduced distress. Another research offered intensive care nurses 12 weeks of resilience preparation and reported reduced scores for stress as well as higher scores for resilience. These findings show the capacity for preparation to have a significant effect on the endurance levels of nurses, which will help nurses respond to abuse in a safe manner with minimal effects on patient care.

CONCLUSION

From the results, it was concluded that the resilience of the medical practitioners can be reduced in terms of level of violence towards the patient care. The BRS tool used in this research has proved to be beneficial in acquiring the findings of the research in an effective manner. The solution and the strategies to reduce the violent behaviour of the medical practitioners has been stated in this research. There is a need to conduct several training programs in every health-care sector in order to minimize the violent behaviour of the medical practitioners towards the patients in every hospital located in Bangladesh. As the sample selected for this present research is small, it offers a correlation between occupational abuse encounters & health care results when
considering measures of resilience. Another drawback is that the research came from seven states, restricting the resulting generalisation. Despite these restrictions, the study was voluntary & obtained by an online survey, providing an accurate response from nurses. There is a need to conduct research in the future suggesting the effects of the resilience level of medical practitioners towards the patients. In research covering all medical departments, & in tests performed exclusively in emergency facilities, the level of violence in emergency care is noted to be greater than any other hospital facility. Emergency departments, which are often the loci of ambulance procedures, are full of tension for both emergency personnel and patients and their families. For this cause, acts of violence are recorded more often in emergency care than in other departments. The position of the violence and the frequency / rate of exposure to violence coincided with the observations and outcomes of previous research in the sample.

REFERENCES: