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Workplace Violence Against Healthcare Workers: A Literature Review

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Abstract

Introduction: Violence against healthcare workers in the workplace is a complex issue affecting various healthcare professionals. Workplace violence (WPV) poses significant occupational hazards to healthcare employees.

Objectives: To identify the causes, types, and perpetrators of WPV and explore the effects of violence on healthcare workers' well-being.

Methods: This literature review analyzes 15 selected research papers published between 2015 and 2020, focusing on WPV against healthcare workers, and gathers insights from healthcare professionals with prior experience of WPV. Through an analysis of the selected research papers, this study provides a comprehensive overview with WPV in the healthcare setting. The respondents in the included studies were healthcare professionals who had encountered WPV in their work.

Results: While nurses remain particularly vulnerable to violence due to their constant patient interaction, this study reveals that verbal violence is the most prevalent type, significantly impacting the well-being of healthcare workers as a whole. The identified causes of WPV include long waiting times, understaffing, miscommunication, inadequate security measures, high patient expectations, and overcrowding. Respondents emphasized the importance of education, security enhancements, and administrative support to address or prevent WPV.

Conclusion: The findings strongly highlight the crucial role of administrative support in reducing the incidence of WPV. It is crucial to implement broader measures to ensure the safety and well-being of all healthcare workers.

Keywords

workplace violence, healthcare violence, healthcare workers, patient violence

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Introduction/Background

Violence against healthcare workers is widespread all over the world, but not well-recorded. Despite the framework guidelines established by the International Labour Office (ILO) and World Health Organization (WHO) (2002), it remains a threat to healthcare workers' safety and well-being. Workplace violence (WPV) has been defined as "incidents where staff is abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health" (International Labour Office (ILO) & World Health Organization (WHO) 2002). Workplace violence must be addressed, as it has serious ramifications for employers, employees, and customers. It is considered one of the leading causes of death among workers (WHO, 2022).

In the United States, the Bureau of Labor Statistics has reported that the healthcare and social service industries exhibit the highest rates of injuries resulting from WPV and are five times more likely to experience such incidents (BLS, 2020). It is important to note that WPV can occur

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not only from patients but also from other sources within the healthcare environment. Research has revealed that instances of violence often arise during periods of heightened activity and increased interaction with patients (NIOSH, 2018).

Healthcare workers are the second-most vulnerable group to WPV (Ahmad et al., 2015). It has been found that between 8% and 38% of health workers suffer physical violence at some point in their careers, and the most common forms of WPV are physical and nonphysical violence that has a negative impact on healthcare workers (WHO, 2022).

Workplace violence may occur most frequently in psychiatric wards, emergency rooms, waiting rooms, geriatric units, and areas that need to work directly with volatile people, especially when they are under the influence of drugs or alcohol, have a history of violence or have certain psychotic diagnoses, are working in crowded and understaffed units, have long waits for service, have inadequate security, have unrestricted movement of the public, and are poorly designed environments (NIOSH, 2018).

There is underreported WPV against healthcare workers because of the complex process of reporting and the fear that the manager will not support the victim (Al-Qadi, 2021). It has been found that while 70% of emergency physicians have reported acts of violence against them, only 3% have pressed charges (The Joint Commission, 2018). Moreover, the magnitude of WPV underreporting among healthcare workers is difficult to quantify, as studies have found a high prevalence of underreporting of violence (Arnetz et al., 2015).

Almost one-third of healthcare workers reported physical assault by patients, and half experienced emotional abuse (Stevenson et al., 2015). Three-fourths of the nurses have ever been exposed to WPV, especially in the emergency department, and verbal abuse was the most common form due to intense workload, high patient expectations, and substance abuse (Mishra et al., 2018).

Workplace violence has many consequences in terms of lives, productivity, and customer service, which result from a lack of trust in management, a loss of team cohesiveness, and a perception that the work environment is hostile and dangerous (Magnavita et al., 2020; NIOSH, 2018). Moreover, it may increase job stress, absenteeism, family turmoil, and worker turnover (NIOSH, 2018). Healthcare workers who were exposed to WPV had an increased risk of developing psychological disorders (Hsu et al., 2022). In addition, nurses who frequently observe WPV during work will be negatively influenced by their attitudes and self-efficacy toward the nursing profession (Ayasreh & Khalaf, 2020).

Aim

The augmented magnitude of WPV stirred the attention of researchers to explore further and understand the occurrence of WPV and how it can mitigate or prevent violence against healthcare workers. The purpose of the study is to know the causes and types of violence against healthcare workers and to discover who the perpetrators are. Also, this will explore the effect of violence on the well-being of healthcare workers, both physically and psychologically.

Methods

Design

A literature review study was performed. This design was used to reconceive the presented problem's perspective and facilitate an effective answer. The methodology follows Whittemore and Knafl's (2005) recommendations for researching and analyzing the literature, in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) checklist developed by Tricco et al. (2018).

To ensure a comprehensive and robust analysis, the research methodology employed various strategies, including constant comparison, prolonged engagement, member check, and triangulation. The research team consisted of experts in health policy and management (NE), WPV (AA), and qualitative and quantitative research methodologies (AA and AK), along with specialists in health services management (AA and AK).

Constant comparison was used to validate and refine the findings, employing a recursive method to generate new insights and ideas throughout the analysis process. In order to ensure alignment with real-world experiences, two participants were provided with the research concepts for their input, and consensus was reached through a member check.

Triangulation was carried out by including both quantitative and qualitative studies to collect data. This involved examining data from multiple sources and employing different research methods to ensure a comprehensive understanding of the topic. The collected data were then analyzed by the three researchers, further enhancing the validity and reliability of the findings.

Inclusion/Exclusion Criteria

The studies that were chosen were limited to studies published in English full-text articles from 2015 to 2020. The studies included must have had healthcare workers as respondents who had previous experience with WPV. Also, studies should examine the causes of violence, the types or forms of violence, whether they are physical or nonphysical, and whether the perpetrators of violence should be patients or relatives. Moreover, there should be strategies or solutions that can be used as a basis for the results of this study.

The exclusion criteria were studies that had only doctors as respondents. The decision was made to focus on healthcare workers as a whole. While doctors are an integral part of the healthcare system, the aim of this study was to

explore the experiences of a broader range of healthcare workers. Therefore, studies that exclusively focused on doctors were excluded to ensure a more comprehensive understanding of WPV among various healthcare professionals. Also, horizontal violence is excluded because the offenders were colleagues and supervisors in the workplace, which is not the focus of this study.

Search Methods

CINAHL, PubMed, Mosby's Nursing Consult, Springer Link, SAGE publications, Wiley Online Library, and Google Scholar were used to search. Single and/or combined keywords were used in the searches, including *WPV, healthcare violence, violence in the workplace, registered nurse experience of patients' violence,* and *violence against healthcare workers.*

Quality Appraisal

This literature review followed Cabello-López (2015), who employed the CASPe (Critical Assessment Skills Programme Spanish) critical appraisal tool to evaluate the methodological quality of the publications, in line with the PRISMA guidelines for systematic reviews (Moran et al., 2014). Different versions of CASPe exist for evaluating reviews, clinical trials, and qualitative investigations. The tool's questionnaires consist of 10 (for reviews and qualitative studies) or 11 (for clinical trials) questions, the first two (for reviews and qualitative studies) or three (for clinical trials) of which are eliminatory, that is, if the answer to any of these questions is "no," the study is excluded. The subsequent questions permit a deeper analysis of the study.

In the case of reviews and clinical trials, the first eight questions require "yes," "no," or "I don't know" responses. The response "yes" scores 1 point, and "no" or "I don't know" scores 0 points. In both situations, the scoring range is from 0 to 8, as the last two questions pertain to the overall conclusion of the study and encourage the reviewer to express his or her judgment. In the case of qualitative investigations, the scoring range is 0–9 because only the final question solicits the reviewer's judgment.

Only publications scoring seven or more points were included in this examination of the methodological quality of the articles. To evaluate the methodological quality of cross-sectional studies, Berra et al. (2008) developed a framework. It consists of 27 questions with four possible responses: "excellent," "good," "average," and "poor." A study's methodological quality may be deemed strong if the majority of respondents selected "very good" or "good." (see Table 1).

Abstraction of Data

To collect information pertinent to this review's objectives, the 15 selected articles that met the inclusion criteria and were included in the review were carefully examined (Figure 1). All disputes were handled through consensus among all authors. The gathered data included authors, publication year, study design, WPV-related barriers and facilitators, and screening tool characteristics.

Synthesis of Data

Once the data had been extracted, the results were categorized and organized so they could be analyzed and compared to meet the objectives of the review (Whittemore & Knafl, 2005). The authors chose to classify WPV's barriers and facilitators. The information obtained on screening tools (structure and characteristics, psychometric properties, and availability of validation studies) was collated throughout this time.

Results

Studies Overview

In Figure 1, you can see the PRISMA flowchart illustrating the study identification process. Initially, a keyword search was conducted, resulting in a total of 1420 articles. After eliminating duplicates, there were 923 unique articles left, which underwent preliminary screening based on their titles and abstracts. Out of these, 779 articles were considered irrelevant and subsequently excluded from the review. The remaining 144 articles were then subjected to the study selection criteria, leading to the exclusion of 129 studies for various reasons. These reasons included only doctors as respondents. Also, horizontal violence is excluded because the offenders were colleagues and supervisors in the workplace, had an inability to access full-text articles, and were limited to conference abstracts only. In the end, 11 quantitative, three qualitative, and one mixed-method studies met the inclusion criteria and were included in the review. The CDC website (NIOSH) and WHO definition of WPV were used (Table 2).

The articles included in the study were explored to understand the common causes of violence, identify the dominant forms of violence, determine the common perpetrator (patient or relative), discern the effect of violence on the healthcare worker's well-being physically and psychologically, and seek suggestions to mitigate or prevent violence against healthcare workers.

The 11 quantitative, three qualitative, and one mixed-method studies listed in Table 1 were conducted in twelve countries, including facilities and departments. Regardless of the different methodologies, the cross-sectional studies were the most popular. The data in these studies have been collected using self-reported questionnaires.

Table 1. The Results of Quality Appraisal of the Review of Studies.

Author/s (Year)	Study design	Sample size	Method	Data analysis	Relevance to research question	Quality rating
Stevenson et al. (2015)	Qualitative	12 registered nurses	Clearly described	Thematic analysis	Highly relevant	High
Hamdan & Hamra (2015)	A cross-sectional	596 personnel	Clearly described	Bivariate & Multivariate analysis	Highly relevant	High
Ataman & Gökhan (2016)	Retrospective-descriptive	136 health workers	Adequate described	Bivariate analysis	Low relevant	Low
Sisawo et al. (2017)	Mixed methods design	219 nurses	Clearly described	Bivariate & Multivariate analysis and Transcribe software	Highly relevant	High
Mishra et al. (2018)	An Observational cross sectional	141 staff nurses	Detailed described	Bivariate analysis	Moderate relevant	Moderate
Olashore et al. (2018)	Cross-sectional retrospective	201 mental health staff	Detailed described	Bivariate analysis	Moderate relevant	Moderate
Hamzaoglu & Türk, (2019)	A cross-sectional	447 health care workers	Detailed described	Bivariate analysis	Moderate relevant	Moderate
Berlanda et al. (2019)	A cross-sectional	149 nurses	Clearly described	Bivariate & Multivariate analysis	Highly relevant	High
Tian et al. (2020)	A cross-sectional	3684 respondents	Detailed described	Bivariate analysis	Moderate relevant	Moderate
Davey et al. (2020)	Qualitative	63 participants	Detailed described	A hybrid thematic analysis approach	Highly relevant	High
Boafo, (2016)	Qualitative	24 participants	Detailed described	Thematic analysis	Highly relevant	High
Alkorashy & Al Moalad (2016)	A cross-sectional	370 nursing personnel	Detailed described	Bivariate analysis	Moderate relevant	Moderate
Cheung & Yip (2017)	A cross-sectional	850 nurses	Clearly described	Bivariate & Multivariate analysis	Highly relevant	High
Lin et al. (2015)	A cross-sectional	1626 health workers	Clearly described	Bivariate & Multivariate analysis	Highly relevant	High
Alsaleem et al. (2018)	A cross-sectional	738 healthcare workers	Clearly described	Bivariate & Multivariate analysis	Highly relevant	High

Sociodemographic Characteristics of Healthcare Workers who Experienced WPV

In Table 3, the sociodemographic characteristics of healthcare workers who experienced violence are presented. Six out of the 15 studies had nurses as their respondents (Alkorashy & Al Moalad, 2016; Boafo, 2016; Cheung & Yip, 2017; Mishra et al., 2018; Sisawo et al., 2017; Stevenson et al., 2015). Yet, nine of the other studies included a mixture of nurses, doctors, and other healthcare workers as respondents (Alsaleem et al., 2016; Ataman & Gökhan, 2016; Berlanda et al., 2019; Davey et al., 2020; Hamdan & Hamra, 2015; Hamzaoglu & Türk, 2019; Lin et al., 2015; Olashore et al., 2018; Tian et al., 2020). The other healthcare workers included are paramedics, medical technologists, and other allied health professionals working in the different hospital areas or units such as emergency rooms, psychiatric inpatients, OB-GYNE, community, and others. The study with the least sample size was conducted in an inpatient psychiatric hospital in Canada with 12 respondents, while the highest was in China with 3684 respondents (Stevenson et al., 2015; Tian et al., 2020).

Two studies didn't mention the gender of the respondents, but women dominated the number of participants in these studies (Ataman & Gökhan, 2016; Davey et al., 2020). Studies consistently highlight that nurses, being at the forefront of patient care, are the most vulnerable group to WPV.

Types, Perpetrators, and Causes of Violence

Verbal and physical abuse were the most common types of violence that healthcare workers experienced. Table 4 displays the types of WPV that healthcare workers experience. Verbal abuse was the most common type, and physical abuse was the second (Alkorashy & Al Moalad, 2016; Alsaleem et al., 2018; Ataman & Gökhan, 2016; Berlanda et al., 2019; Boafo, 2016; Cheung & Yip, 2017; Davey

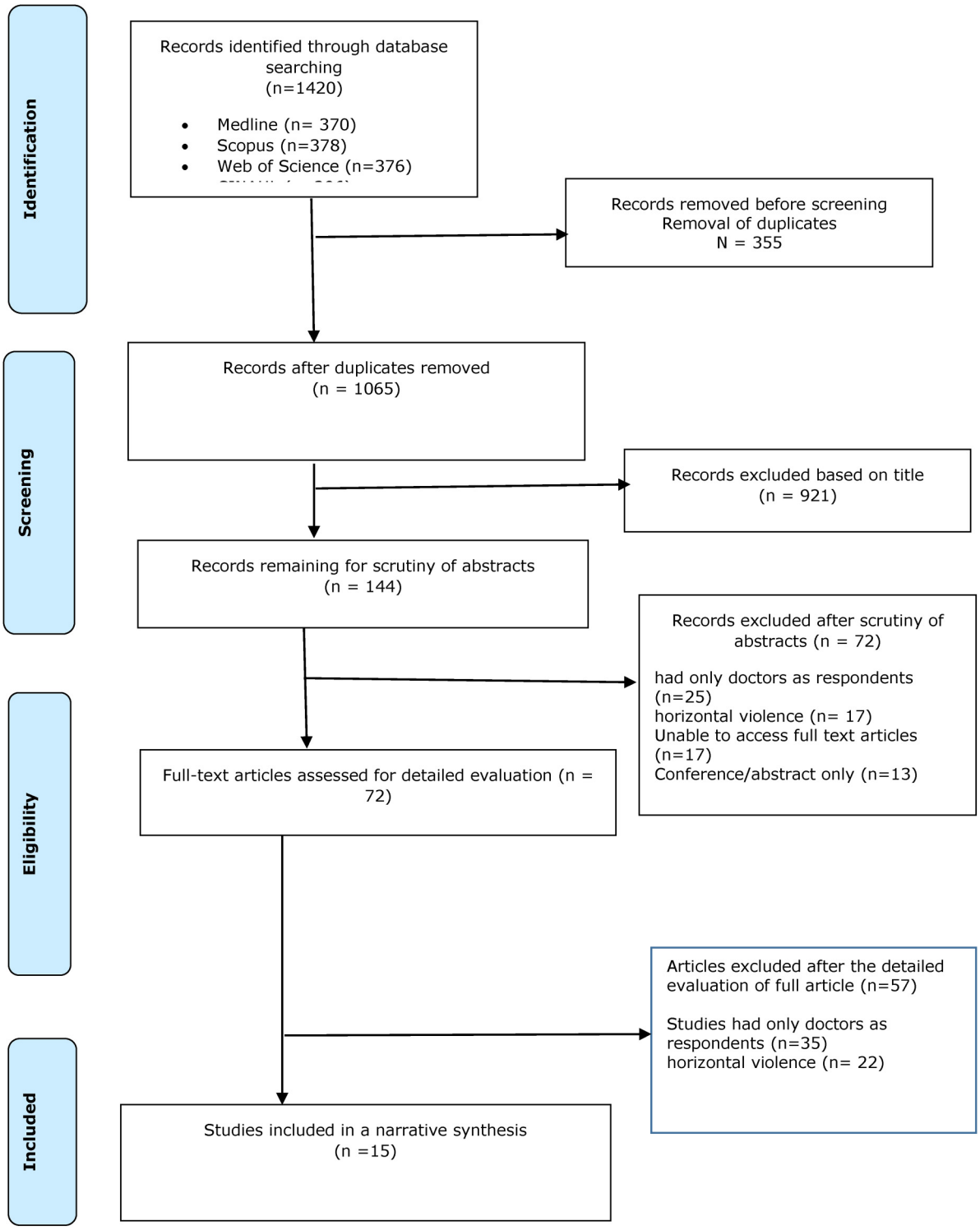

Figure 1. The PRISMA flowchart of included studies.

et al., 2020; Hamdan & Hamra, 2015; Hamzaoglu & Türk, 2019; Lin et al., 2015; Mishra et al., 2018; Sisawo et al., 2017; Stevenson et al., 2015). These types of abuse that perpetrators commit manifest themselves in different forms. Verbal violence includes emotional and psychological insults, which most healthcare workers tend to ignore, which leads to underreported incidence, but which are far more difficult to forget and have a bigger impact on their

Table 2. Review of Studies of Healthcare Workers Who Experienced Violence (Location, Design, Software Used, and Study Period).

Author/s (year)	Study location	Design	Software used	Study period in months
Stevenson et al. (2015)	Canada Psychiatric Department	Interpretative Descriptive	NVivo 10	Nine-month period
Hamdan and Hamra (2015)	Palestine Emergency Department	Cross-Sectional	SPSS version 9	Three-month period
Ataman and Gökhan (2016)	Turkey Health and Social Worker Union	Retrospective-Descriptive	SPSS version 19	Fourteen-month period
Sisawo et al. (2017)	Gambia Public Secondary Healthcare Facility	Quantitative and Qualitative	SPSS version 21	Three-month period
Mishra et al. (2018)	India Integral Institute of Medical Sciences & Research	Cross-Sectional	SPSS version 20	Seven-month period
Olashore et al. (2018)	Botswana Psychiatric Hospital	Cross-Sectional	SPSS version 19	Four-month period
Hamzaoglu and Türk, (2019)	Turkey Public and Private Institutions	Systematic Descriptive	SPSS version 18	Four-month period
Berlanda et al. (2019)	Northwest Italy Emergency Department	Cross-Sectional	SPSS package	Not mentioned
Tian et al. (2020)	China 12 Public Hospitals	Descriptive	SPSS version 21	Two-month period
Davey et al. (2020)	India Emergency Department	Qualitative	NVivo	Not mentioned
Boafo, (2016)	Ghana Public General Hospital	Qualitative	NVivo 10	Not mentioned
Alkorashy and Al Moalad (2016)	Saudi University Hospital	Cross-Sectional	SPSS package	Three-month period
Cheung and Yip (2017)	Hong Kong Healthcare Facility	Cross-Sectional	SPSS version 23	Two-month period
Lin et al. (2015)	China Community Healthcare Workers	Cross-Sectional	SPSS version 17	Five-month period
Alsaleem et al. (2018)	Abha Saudi Arabia Healthcare Setting	Cross-Sectional	SPSS version 23	Not mentioned

Table 3. Review of Sociodemographic Characteristics of Healthcare Workers Who Experienced Violence.

Author/s	Sample	Female	Male	Nurses	Doctors	Others
Stevenson et al. (2015)	12	8	4	12	†	†
Hamdan and Hamra (2015)	596	103	341	216	201	179
Ataman and Gökhan (2016)	101	‡	‡	39	45	17
Sisawo et al. (2017)	219	160	59	219	†	†
Mishra et al. (2018)	141	115	26	141	†	†
Olashore et al. (2018)	179	107	72	139	10	30
Hamzaoglu and Türk (2019)	447	305	142	274	167	6
Berlanda et al. (2019)	149	69	79	62	87	†
Tian et al. (2020)	3684	3128	556	2750	934	†
Davey et al. (2020)	63	‡	‡	10	47	5
Boafo, (2016)	24	15	9	24	†	†
Alkorashy and Al Moalad (2016)	404	376	28	404	†	†
Cheung and Yip (2017)	850	745	105	850	†	†
Lin et al. (2015)	1404	1029	375	565	568	271
Alsaleem et al. (2018)	424	274	150	215	122	87

‡Not mentioned.
†Not included in the study.

well-being. On the other hand, physical abuse involves chasing, being hit, being punched, being kicked, spitting, sexual harassment, and other types of violence that cause physical harm to healthcare workers.

Relatives or family members are the most common offenders (Ataman & Gökhan, 2016; Davey et al., 2020; Hamdan & Hamra, 2015; Mishra et al., 2018; Olashore et al., 2018; Sisawo et al., 2017). Moreover, the proportion

Table 4. Review of Types, Perpetrator, and Causes of Violence.

Authors	Types	Perpetrators	Cause
Stevenson et al. (2015)	V,P	Patient	Cognitive impairment due to illness
Hamdan and Hamra (2015)	V,P	Relative	Waiting time
Ataman and Gökhan (2016)	V,P	Relative	Relatives thinks patient's health is urgent
Sisawo et al. (2017)	V,P	Relative	Miscommunication, long wait (understaffing), shortage of drugs and supplies
Mishra et al. (2018)	V,P	Relative	Intense workload, high patient expectation, substance abuse
Olashore et al. (2018)	P	Relative	Overcrowded, understaffing
Hamzaoglu and Türk (2019)	V,P	Patient	Inadequate policies for workplace violence
Berlanda et al. (2019)	V,P	Patient	Patient pathologies, workplace crowded, work pattern
Tian et al. (2020)	‡	Patient	Staff shortage, high patient expectation
Davey et al. (2020)	V,P	Relative	Crowding, waiting time, lack of patient literacy
Boafo (2016)	V,P	‡	Waiting time, perceived unresponsiveness, miscommunication
Alkorashy and Al Moalad (2016)	V,P	Patient	Miscommunication due to language barrier, understaffing
Cheung and Yip (2017)	V,P	Patient	Understaffing (longer waiting time), high patient expectation
Lin et al. (2015)	V,P	‡	Heavier workload
Alsaleem et al. (2018)	V,P	‡	Lack of patient or relative education, long waiting time, culture and personality

V = Verbal; P = Physical.
‡Not mentioned in the study.

Table 5. Review of Effects of Workplace Violence on Healthcare Workers.

Author/S	Nurses	Doctors	Other
Stevenson et al. (2015)	Fear, anxiety and belittled	†	†
Hamdan and Hamra (2015)	Fear, anxiety and guilt	Hopeless, disappointment	Least violence effect
Ataman and Gökhan (2016)	Decrease performance and burnout	Decrease performance, burnout	Decrease performance, burnout
Sisawo et al. (2017)	Affect motivation and ability to offer effective care	†	†
Mishra et al. (2018)	Wants to leave the profession	†	†
Olashore et al. (2018)	Physical impairment and emotional disturbance	Physical impairment, emotional disturbance	Physical impairment, emotional disturbance
Hamzaoglu and Türk (2019)	Repeated disturbing memory of the violent attack	Repeated disturbing memory of the attack	Repeated disturbing memory of the attack
Berlanda et al. (2019)	‡	‡	†
Tian et al. (2020)	Burnout and decrease job satisfaction	Exhaustion	‡
Davey et al. (2020)	Low morale	Affect work pattern and efficiency	‡
Boafo (2016)	Reactive to violence experience	†	†
Alkorashy and Al Moalad (2016)	Subjective, less serious and can tolerate violence	†	†
Cheung and Yip (2017)	Affect job satisfaction and confidence, exhaustion, burnout and depression	†	†
Phillips (2016)	Affect negatively the quality of life and job performance	Affect negatively the quality of life and job performance	Affect negatively the quality of life and job performance
Alsaleem et al. (2018)	Affect job performance	Affect their job performance	Affect their job performance

‡Not mentioned.
†Not included in the study.

of patients who are aggressive toward healthcare professionals is not notably different (Alkorashy & Al Moalad, 2016; Berlanda et al., 2019; Cheung & Yip, 2017; Hamzaoglu & Türk, 2019; Stevenson et al., 2015; Tian et al., 2020). There are several antecedents for WPV, but the three common causes were: understaffing that causes delays in delivering service, which triggers violence (Alkorashy & Al Moalad, 2016; Tian et al., 2020); miscommunication due to language barrier, lack of education, and the tone of voice in talking with patients and their relatives (Alkorashy

& Al Moalad, 2016; Sisawo et al., 2017); and the cognitive impairment due to illness (Stevenson et al., 2015), substance abuse (Mishra et al., 2018), and inadequate policies that patients or their relatives must follow during their stay in the hospital, which includes security personnel and other devices that can prevent WPV from happening (Hamzaoglu & Türk, 2019).

The Impact of WPV on Healthcare Workers

Table 5 shows the impact of WPV on the physical and psychological well-being of the healthcare worker victims. Seven reviewed studies didn't mention the effects of violence on doctors and other healthcare workers (Alkorashy & Al Moalad, 2016; Berlanda et al., 2019; Boafo, 2016; Cheung & Yip, 2017; Mishra et al., 2018; Sisawo et al., 2017; Stevenson et al., 2015). The nurses voice out that they're afraid, especially when it is a physical attack, and feel very low self-esteem and confidence whenever they're verbally abused, especially for degrading words coming from the aggressor, which negatively affects their job performance. There are some instances when they feel depression, burnout, post-exposure trauma, and guilt, which affect their well-being (Ataman & Gökhan, 2016; Cheung & Yip, 2017; Hamdan & Hamra, 2015; Tian et al., 2020). Surprisingly, the nurses in a study from Ghana stated that they were reactive to whatever violence they experienced (Boafo, 2016). One study in Saudi Arabia said that nurses are subjective to violence and can tolerate it and consider it less serious (Alkorashy & Al Moalad, 2016). The psychiatric nurses in Canada said that violence and patients hurting them are part of their job they need to face every day. Thus, it's quite difficult to explain the violence that psychiatric nurses face because many of their patients are mentally impaired or challenged. Doctors, on the other hand, felt hopeless, disappointed, exhausted, burned out, and experienced repeated mental disturbances that affected their job performance. The rampant violence against doctors has been noted in studies conducted in China, India, and Palestine. The other healthcare workers are also undergoing physical and mental exhaustion, but they are not as exposed to violence. They are the least affected. Nevertheless, all the respondents agreed that WPV is not something that must be tolerated because it affects the quality of service and causes delays in the delivery of care that healthcare workers render to patients. Instead of doing routine physical assessment and history, especially in the emergency department, they cannot process it as they are trying to calm the patient or the relative.

Strategies Used to Prevent WPV

The recommended strategies and solutions to prevent WPV are compiled in Table 6. According to the respondents' feedback, education programs play a crucial role and should be reinforced within the healthcare system (Alkorashy & Al Moalad, 2016; Alsaleem et al., 2018; Berlanda et al., 2019; Boafo, 2016; Cheung & Yip, 2017; Davey et al., 2020; Hamdan & Hamra, 2015; Hamzaoglu & Türk, 2019; Mishra et al., 2018; Olashore et al., 2018; Phillips, 2016; Sisawo et al., 2017; Stevenson et al., 2015). Additionally, administrative support emerged as a crucial factor, healthcare workers refrain from reporting violence due to a lack of managerial support, perceiving it as futile since no changes are implemented (Hamzaoglu & Türk, 2019).

Other suggestions listed include debriefing sessions, particularly in the psychiatric unit, to foster reflection and prevent future incidents (Gillespie et al., 2015). Encouraging incident reporting is also essential, prompting the administration to take appropriate actions and ensuring consequences for the aggressor (NHS Health Scotland, 2010). Moreover, there is a need to review and reinforce hospital policies and regulations to safeguard the well-being of healthcare workers. Additionally, creating a comfortable and less stressful environment, particularly in the emergency room, can help mitigate chaos and conflicts that may trigger violence. Informing patients and their relatives about existing protocols for managing their cases is equally important. Finally, implementing security features like manpower or personal alarms can serve as preventive measures against assaults (Zhang et al., 2023).

Discussion

This review found that the majority of victims were nurses, who constitute the highest proportion of the healthcare

Table 6. Review of Strategies to Prevent Workplace Violence Included in the Reviewed Studies.

Author/s (Year)	Education	Security	Administrative support
Stevenson et al. (2015)	Yes	Yes	Yes
Hamdan and Hamra (2015)	Yes	Yes	Yes
Ataman and Gökhan (2016)	‡	Yes	Yes
Sisawo et al. (2017)	Yes	Yes	Yes
Mishra et al. (2018)	Yes	Yes	Yes
Olashore et al. (2018)	Yes	Yes	Yes
Hamzaoglu and Türk (2019)	Yes	Yes	Yes
Berlanda et al. (2019)	Yes	Yes	Yes
Tian et al. (2020)	‡	‡	Yes
Davey et al. (2020)	Yes	Yes	Yes
Boafo (2016)	Yes	Yes	Yes
Alkorashy and Al Moalad (2016)	Yes	Yes	Yes
Cheung and Yip (2017)	Yes	Yes	Yes
Phillips (2016)	Yes	Yes	‡
Alsaleem et al. (2018)	Yes	Yes	Yes

workforce. There are more females in the sample population, which might be related to the higher number of females in nursing. Nurses are more susceptible to WPV as they spend more time with patients. Moreover, female nurses are more susceptible to WPV compared to doctors because being a doctor carries more prestige as a profession.

On the contrary, Hamdan and Hamra (2015) found that doctors had a higher risk among healthcare workers, as explicated by the dominant culture that holds doctors ultimately accountable for patient care, which frequently exposed them to dissatisfied patients and relatives. Phillips (2016) indicated that emergency medicine physicians are subjected to extreme physical violence, like gunshots. Nearly seven out of 10 emergency physicians believe that emergency department violence is increasing, and 47% of physicians have said that they have personally been physically assaulted (Stephens, 2019).

The most common form of WPV is verbal abuse, at 39.2% (Cheung & Yip, 2017). Phillips (2016) stated that the annual Minnesota Nurse's Study has a 39% incidence of verbal assault, while only 13% of physical assaults are recorded. A study indicated that 35.6% of staff had been exposed to physical assaults and 71.2% had been exposed to nonphysical assaults (Hamdan & Hamra, 2015). Furthermore, verbal abuse seems to be ignored by healthcare workers as long as they are not hurt by a patient or relative. Healthcare workers think that it is part of the job, and they will not bother to report it because no one gets hurt physically. In addition, verbal abuse does not have physical evidence, especially in healthcare settings that are not equipped with security features such as recorded cameras and security personnel. However, verbal abuse must be protected because of its great impact on the psychological well-being of the victim, and the persistent occurrence of such forms could affect the attraction and retention of the workforce (Sisawo et al., 2017).

Meanwhile, the top three perpetrators are relatives, but the difference is not so evident with the patient percentage. The ratio is not so different between the patient and the aggressor in cases of violence. Sun et al. (2017) found that relatives are more abusive and aggressive toward healthcare workers compared to the patient because they are worried and anxious, which triggers lashing out and frustration, especially when they are waiting so long. Moreover, relatives cannot understand the prioritizing of patients in the emergency room because the area contributes more to the agitation that the patient may experience. That's why patients and relatives must be oriented and informed once they step into the hospital to avoid miscommunication, which leads to conflict.

The causes of violence in this study were cognitive impairment for psychiatric patients; miscommunication due to language barriers, culture, diversity, and literacy; understaffing, which resulted in an intense or heavier workload and longer waiting times; relatives' thinking that patients need to be seen immediately or patients' perception that they are being ignored; cognitive impairment due to pathology or illness; overcrowded space; lack of supply and drugs; and inadequate policies that will prevent the attack from happening. There are three main causes. First, the interaction between healthcare workers and patients is complex due to complex processes that point out the importance of clear and effective communication with patients and relatives so that the exchange of information will be healthy. Second, organizational factors such as lack of infrastructure and equipment, understaffing, long waiting times, delayed appointments, excessive workload, adverse working conditions, lack of time for hospitalization, bed shortages, and safety. Third, social variables such as societal culture toward nursing, crime rate in the community, poverty level, and other environmental factors (Ataman & Gökhan, 2016). Given the reasons why WPV against healthcare workers is still happening, it is important to note that employers are required to provide a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious harm.

Nurses also explain that being exposed to violence has an impact on their physical and psychological well-being. Workplace violence can jeopardize patient safety and have serious short- and long-term effects on the mental well-being of healthcare workers (Ataman & Gökhan, 2016). Also, their findings show that 30% of the victims were psychologically affected, and this led to fear, anxiety, hopelessness, and feelings of guilt. Experiencing violent incidents can lead to depression, low self-esteem, self-blame, deterioration of interpersonal relationships, mood disorders, job loss, decreased job satisfaction, anxiety, anger, restlessness, stress disorder, sleeping problems, and chronic headaches (Hamzaoglu & Türk, 2019). Stevenson et al. (2015) discovered that these events hurt patient care because nurses have difficulty doing their tasks, have less interaction with patients, and have less empathy.

There are quite a few strategies that were proposed, such as education, security in the workplace, and administrative support. Hamdan and Hamra (2015) stated that well-prepared emergency personnel through education programs that teach them to deal with aggression and protect themselves from violence can be effective in the workplace. Also, Hamzaoglu and Türk (2019) found measures to reduce incidence by applying deterrent penalties to deterrent people; adequate staffing; arranging security personnel 24/7; establishing metal detectors for ammunition and control points; processing oral and written complaints of patients and relatives and communicating them to authorized administration; and developing training and programs that improve communication among staff, patients, and relatives both during academic training and with patient information boards. Staff must be trained to recognize, manage, cope, adopt de-escalation, and develop skills to resolve conflict (Berlanda et al., 2019).

On the other hand, there are additional schemes acknowledged. Alsaleem et al. (2018) stated that healthcare providers must be trained, advised, and encouraged to report incidents,

and the administrators must follow up on the incidents, take action against the perpetrators, provide feedback to the victims, and protect the victims from repercussions. However, patients and relatives must be educated about their rights and the policy on how to report such incidents for it to be just and fair for both parties. While Stevenson et al. (2015) included debriefing as one key factor in the psychiatric nurses' ability to avoid violence.

Strengths and Limitations

Review studies rely on respondents' memories of incidents of violence that happened to them. The studies didn't include the viewpoint of the patient or the relatives about the problem, so we cannot be sure what went wrong and what the healthcare workers must do more to avoid violence.

Implications for Practice

It is paramount to underscore the importance of occupational health surveillance and workplace health promotion programs in preventing burnout, PTSD symptoms, and suicide. These programs play a vital role not only in preserving the quality of patient care and nurturing the patient–physician relationship but also in maintaining the effective operation of the healthcare systems (Chirico & Leiter 2022; Chirico & Nowrouzi-Kia 2022; Di Prinzio et al., 2022). In addition, some important works on WPV against HCWs before and during the pandemic (Chirico et al., 2021, 2022; Chirico & Nucera, 2020; Nucera et al., 2023; Zhang et al., 2023).

It is crucial to note that the available studies exhibit disparities in quality and primarily concentrate on addressing WPV strategies. Based on the insights gleaned from these studies, the initial strategy involves mandatory in-service education and training. This encompasses comprehensive training in effective communication, participation in workshops focused on psychological and service behavior, conflict resolution, and de-escalation techniques for handling aggressors. Additionally, healthcare workers should receive safety training to enable them to recognize potential dangers and respond to assaults appropriately. They should also be trained on the proper procedures for reporting incidents and undergo debriefing immediately following any violent encounter to prevent personal bias.

The second strategy emphasizes bolstering security measures, which encompasses the recruitment of skilled security personnel, the installation of alarm systems or CCTV cameras, and the establishment of standardized check-in procedures across all units.

The third strategy pertains to the role of managers and leaders, as some managers tend to blame nurses and overlook the gravity of violent incidents. It is imperative to ensure that healthcare workers are well-trained, instructed, and supported in reporting any instances of violence. Organizations should actively advocate for the rights of healthcare workers and explore potential solutions that can be implemented within the workplace. Effective management should encompass providing support for staff, honing communication skills, offering psychological and behavioral therapy, conducting debriefing sessions post-exposure, balancing the responsibility to self with the duty to care, encouraging empowerment and influence in clinical settings, creating well-defined policies based on evidence-based guidelines, enhancing the clinical environment to reduce congestion and overcrowding, and fostering a culture that emphasizes "no shame, no blame."

Furthermore, it is crucial to educate and inform patients about their rights and what to expect during their hospitalization. This includes providing clear explanations of each step in the medical procedure to manage expectations and prevent dissatisfaction. Nurses should also focus on building rapport, displaying empathy, and embodying the 6Cs: care, compassion, courage, confidence, communication, and competence.

Conclusion

Workplace violence is one of the most complex occupational hazards that healthcare workers have faced. There is strong evidence that administration support will lessen the occurrence of WPV against healthcare workers. The initiative of the managers to protect and advocate for healthcare workers against violence can ensure the provisions of tougher policies are followed by perpetrators. Also, providing a safe working environment is important because the violence that healthcare workers experience has a negative impact on their clinical judgment and job performance and can compromise a patient's safety.

Underreporting of WPV to managers is happening because healthcare workers are resilient to violence and think it is considered part of their job. They are no longer reporting, especially if they did not get physically hurt, because violence is already a normal thing that happens. Also, staff are not bothered to report any incidents of violence because of the complexity of the reporting process, the managers are not helpful, and they think that nothing will happen even if they report it.

Nevertheless, even after the incident of violence, healthcare workers will continue their job and provide the care needed. However, the turmoil of violence against healthcare workers' well-being, psychologically and physically, is unfathomable, especially for the susceptible ones who cannot endure any form of violence. On the other hand, healthcare workers, especially nurses, endorsed the need to improve education and training, security, and administrative support to have a safe workplace.

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