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Workplace Violence by Patients and Their Families Against Nurses: Literature Review

Muayyad Ahmad[1], Rula Al-Rimawi[2], Arwa Masadeh[3], Maysoun Atoum[4]

[1]Clinical Nursing Department, Faculty of Nursing, The University of Jordan, Amman, Jordan
[2]Faculty of Nursing, Al-Balqa Applied University, Salt, Jordan
[3]Nursing Section, Arab Community College, Amman, Jordan
[4]Faculty of Nursing, Hashemite University, Zarqa, Jordan

Email address

mma4jo@yahoo.com (M. Ahmad), rulaalrimawi@yahoo.com (R. Al-Rimawi), arwabm@yahoo.com (A. Masadeh), maysoun_atoum@hu.edu.jo (M. Atoum)

Abstract

Many nurses have been subjected to violence in the workplace. The purpose of this review is to explore the profundity, aspects, and consequences of workplace violence against nurses by patients and their families. Electronic database searches were conducted for studies of workplace violence in all countries and departments published in the past ten years. The findings showed that most nurses experienced at least one type of workplace violence during their practice, either verbally or physically, but few incidents were reported. The most important reported risk factors of workplace violence were the night shifts and lengthy waiting times by patients and visitors. Workplace violence had impact not only on the quality of care, but also on the nurses' job satisfaction, leading to significantly increasing turnover of staff. In conclusion, this review focus on the role of managers and decision makers to take in consideration the application of protective and preventive measures to reduce the incidents of workplace violence.

1. Introduction

Violence is defined in the Oxford Dictionary as "Behavior involving physical force intended to hurt, damage, or kill someone or something" (OED, 2014). Workplace violence (WPV) is one of the main worldwide issues that are deeply-rooted but not well-recorded. Workplace violence has been significant since 1980s (Kinney & Johnson, 1993), whereas in 1992, the Centers for Disease Control and Prevention considered workplace homicide as a serious public health issue (Kinney & Johnson, 1993).

The World Health Organization (WHO) defined workplace violence as "Incidents where staff are 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" (Richards, 2003). Workplace violence must be addressed as it has serious consequences on employers, employees and clients. In 2002, WHO reported that WPV is one of the leading causes of death for workers aged 15-44 years (Krug, Mercy, Dahlberg, & Zwi, 2002). Workplace violence has major effects not only on lives but also on productivity and quality of customer care (Gates, Gillespie, & Succop, 2011).

The health sector is one of the largest sectors and one of the most exposed work places to violence. According to International Labor Organization (ILO), health care workers are in the second highest risk group for work violence (Ahmad, 2015; Chappell & Di Martino, 2006). In the United States of America (USA), the Bureau of Labor Statistics stated that there was a 6% increase in violence in private health care and social assistance sector, reaching 19,360 cases in 2012 (BLS, 2013). In Europe, 26% of educational and health workers thought that their safety or health was at risk. However, 12% of them were actually subjected to intimidation (Paoli & Merllié, 2001). In 2002, the WHO reported the incidents of physical and psychological violence against health care workers reached 37% in Bulgaria, 54% in

Thailand, 61% in South Africa, and 41% in Lebanon (WHO, 2002). Recently, WPV in healthcare settings has been identified in Jordan when the chairmen of the Jordanian Medical and Nurses Associations declared that incidents of violence against health care workers have been escalated (Sameh, 2006).

Although any health care worker is at risk for WPV, nurses and aides are the most vulnerable personnel to violence, as they have direct contact with patients, families, relatives (El-Gilany, El-Wehady, & Amr, 2010; Kitaneh & Hamdan, 2012). As shown in literature, 36% of nurses and midwives in Australia experienced violence by patients or their visitors (Farrell, Shafiei, & Chan, 2014); 49.4% of nurses reported the occurrence of aggression in Italy (Zampieron, Galeazzo, Turra, & Buja, 2010); 50% of nurses exposed to WPV in China (Wu et al., 2012); 80,4% of Palestinian nurses faced WPV (Kitaneh & Hamdan, 2012); and more than three quarters of Jordanian nurses (75.8%) were exposed to at least one type of violence in emergency departments (ED) (AlBashtawy, 2013). This high percentage of WPV against nurses in Jordan made it significant for investigators. Based on database search, there are scarce review papers investigating WPV against nurses by patients or their families, and it is limited to EDs (Anderson, FitzGerald, & Luck, 2010; Pich, Hazelton, Sundin, & Kable, 2010; Taylor & Rew, 2011). The aim of this review is to explore the profundity, aspects, and consequences of WPV against nurses by patient or their families and potential preventive measures.

2. Methods

2.1. Searching

All available databases were used for searching, including CINAHL, PubMed, Mosby's Nursing Consult, Springer-Link, SAGE publications, Wiley Online Library, and Google-Scholars. Searches were performed using single and/or combined keywords including: violence, workplace violence, physical violence, psychological violence, verbal abuse, aggression, nurses, and assault. Results of the searches revealed many studies; however, the selected articles were limited to studies in English full-text articles, related to workplace violence against nurses by patients or their families, and published in the past 10 years. Studies were excluded if they were written in a language other than English, describing violence against healthcare providers (other than nurses), and if published before 2009. The initial searches yielded 96 articles, including abstracts and full-text articles. These articles were reviewed to find out relevant studies for inclusion. Of these, 12 abstracts and 40 articles were excluded as they did not meet the inclusion criteria. Forty four articles met the inclusion criteria; including five organizational reports, three review articles, and 36 research studies containing surveys, Delphi and qualitative studies. Studies which met the inclusion criteria were conducted in parts of the world including Asia, Europe, Africa, Australia, USA, and Canada (Figure 1).
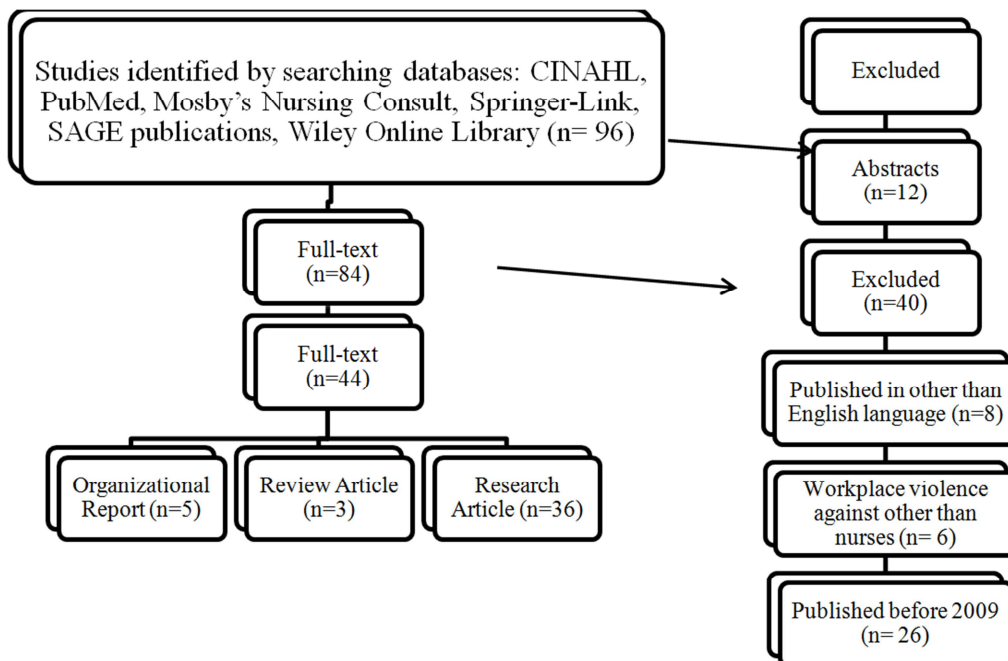

Figure 1. Flow diagram of methodology of including and excluding the studies.

2.2. Studies Designs and Sample Sizes

Twenty-nine quantitative design studies met the inclusion criteria. Of these, 22 were non-experimental, cross-sectional, descriptive design studies (constitute half of all included studies), with sample sizes ranged from 123 to 8134 participants; three cross-sectional retrospective design studies, with their sample sizes ranged from 291 to 762 participants; one cross-sectional comparative study between 128 ED nurses and 147 medical nurses; two interventional

program studies were applied in two hospitals, and one Delphi quantitative design study with 11 experts recruited. Also, five qualitative design studies met the inclusion criteria. Of these, four were qualitative descriptive design studies, with sample size ranged from 10 to 471 participants and one Delphi qualitative design study with 10 experts. Furthermore, there were two descriptive combined qualitative and quantitative design studies included with sample sizes of 110 and 162 participants. Additionally, there were three review paper articles. Finally, four organizational reports also were included.

2.3. Sampling Method

Twenty-four of the included studies recruited non-probability convenience samples; four studies employed non-probability purposive samples; 6 studies recruited probability simple random samples, and two studies employed stratified random samples.

3. Results

3.1. Studies Overview

Thirty-nine articles met the final inclusion criteria and of these studies, two were conducted in Jordan, one in Palestine, one in Kingdom of Saudi Arabia (KSA), one in Turkey, one in Israel, one in Iran, one in Pakistan, one in China, one in India, one in Taiwan, one in Egypt, two in South Africa, one in United Kingdom (UK), two in Italy, one in Switzerland, one in Denmark, one in Germany, seven in Australia, and nine in USA.

3.2. Types of Violence

Physical and verbal violence are the major types reported. Verbal violence was reported more frequently than physical violence (Balamurugan, Joseb, & Pc, 2012; Farrell et al., 2014; Pinar & Ucmak, 2011).

3.3. Verbal Violence

Among studies, incidence of verbal violence against nurses was more frequently reported in Australia (92%) (Chapman, Styles, Perry, & Combs, 2010), Iran (92%) (Esmaeilpour, Salsali, & Ahmadi, 2011), and Turkey (91%) (Pinar & Ucmak, 2011). Verbal violence was less frequently reported in China (Wu et al., 2012), Palestine (40%) (Kitaneh & Hamdan, 2012), South Africa (45%) (Khalil, 2009) the UK (45%), and among nursing students (Ferns & Meerabeau, 2009).

Nurses have been reported to be subject to several forms of verbal violence including shouting or yelling; swearing or cursing (Gacki-Smith et al., 2009; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014); racial statements (Franz et al., 2010), and threats (Roche, Diers, Duffield, & Catling-Paull, 2010). The highest incidence of threatening nurses was in Australia (66%) (Roche et al., 2010) and Germany (55%) (Franz et al., 2010), and the lowest incidence was in Palestine

(20%) (Kitaneh & Hamdan, 2012) and in China (24%) (Wu et al., 2012).

3.4. Physical Violence

Studies revealed that physical violence against nurses was experienced more frequently in Turkey (75%) (Pinar & Ucmak, 2011), Switzerland (Hahn et al., 2010), and Egypt (62%) (Abou-ElWafa, El-Gilany, Abd-El-Raouf, Abd-Elmouty, & El-Sayed, 2014). Physical violence was reported less frequently in Italy (5%) (Zampieron et al., 2010), and in Israel (13%) (Natan, Hanukayev, & Fares, 2011).

Nurses experienced physical violence in the form of bullying, mobbing, grabbing, punching, hitting by objects, spitting, slapping, kicking, shoving, chocking, biting, being thrown on the floor, twisting of body, scratching, and hair pulling (Franz et al., 2010; Moylan & Cullinan, 2011; Zampieron et al., 2010).

3.5. Sexual Harassment

Sexual harassment was reported by many studies. It was the least reported of all types of WPV. It was least frequently reported in Palestine (2%) (Kitaneh & Hamdan, 2012), and more frequently in Germany (21%) (Franz et al., 2010).This huge variance is mostly related to religious and cultural differences (Ahmad & Dardas, 2016).

3.6. Measurement of Workplace Violence

Seven studies measured WPV using the questionnaire developed by the WHO, the ILO, the International Council of Nurses (ICN), and Public Services International (PSI) in 2003 (Abou-ElWafa et al., 2014; AbuAlRub & Al-Asmar, 2011, 2013; El-Gilany et al., 2010; Esmaeilpour et al., 2011; Kitaneh & Hamdan, 2012; Pai & Lee, 2011). Another two studies measured WPV using two aggression scales developed by two different authors (Hahn et al., 2010; Zampieron et al., 2010).

3.7. Settings of Workplace Violence

Workplace violence may occur in any department in the hospital or nursing home, but nurses who worked in ED were more likely to experience WPV than in any other department as reported (Abou-ElWafa et al., 2014; AbuAlRub & Al-Asmar, 2011, 2013). The mental health unit (Chapman et al., 2010) and intensive care unit (ICU) (AbuAlRub & Al-Asmar, 2011, 2013) shared the second rank of most frequently reported department where WPV took place, followed by nursing homes and aged care departments (Farrell et al., 2014), surgical and medical departments (AbuAlRub & Al-Asmar, 2011, 2013; Chapman et al., 2010).

Nurses who worked in maternal or pediatric departments were less likely to be exposed to WPV (Chapman et al., 2010; Gacki-Smith et al., 2009). And one of these studies indicated that there was no incidence of WPV in the gynecology department (Ahmad & Alasad, 2007; Zampieron et al., 2010). These differences among words related to patients gender, severity of the illness, and mental status.

3.8. Risk Factors of Workplace Violence Against Nurses

Studies identified many risk factors for WPV occurrence. (Tables 1-3) summarizes these risk factors or causes focused on the major characteristics of the basic involved members in WPV, who are the nurse, patient, patient's family, organization, and the community. It is very important to identify these risk factors to minimize the incidence of WPV.

Table 1. *Review of Patients, patients' family, and visitors risk factors.*

Patient, patient's family or visitor risk factor	Authors
Male gender	(Farrell, Shafiei, & Chan, 2014; Hahn et al., 2010; Kitaneh & Hamdan, 2012; Magnavita & Heponiemi, 2011; Pich, Hazelton, Sundin, & Kable, 2010; Pinar & Ucmak, 2011; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014)
Medical Diagnosis	Physical illness (Chapman, Styles, Perry, & Combs, 2010b, Kitaneh & Hamdan, 2012), psychological illnesses (Chapman et al., 2010b, Gacki-Smith et al., 2009, Zampieron, Galeazzo, Turra, & Buja, 2010), dementia (Hahn et al., 2010, Speroni et al., 2014), Alzheimers (Gacki-Smith et al., 2009, Speroni et al., 2014), confusion, disorientation, hypoxia, and physical pain (Pich et al., 2010), and critically ill children (Speroni et al., 2014).
Alcohol and drug abuse	(Chapman et al., 2010b, Gacki-Smith et al., 2009, Hahn et al., 2010, Kitaneh & Hamdan, 2012, Pich et al., 2010, Speroni et al., 2014)
Dissatisfaction of patients with the quality, delay or lack of care.	(Chapman et al., 2010b, El-Gilany, El-Wehady, & Amr, 2010, Roche, Diers, Duffield, & Catling-Paull, 2010, Wu et al., 2012, Zampieron et al., 2010)
Patients' or their family's unrealistic expectations of care	(Speroni et al., 2014, Wu et al., 2012)
Anxious and stressed patients or families	(AbuAlRub & Al-Asmar, 2011, El-Gilany et al., 2010, Hahn et al., 2010, Truman, Goldman, Lehna, Berger, & Topp, 2013)
Age	Younger age
	Old age
Cultural aspects	(AbuAlRub & Al-Asmar, 2011, Pich et al., 2010, Speroni et al., 2014)
Illiteracy or language barriers	(El-Gilany et al., 2010, Speroni et al., 2014)
Having previous impressions about poor quality of care	(AbuAlRub & Al-Asmar, 2011, Gacki-Smith et al., 2009, Speroni et al., 2014)
Patients' low socioeconomic status	(Pich et al., 2010)
Refusing provided care	(Chapman et al., 2010b)
Misconceptions about staff behavior	(Gacki-Smith et al., 2009, Speroni et al., 2014)
Deficits in comprehending any situation	(Hahn et al., 2010)

Table 2. *Review of Risk Factors Related to Nurses.*

Nurses' Risk Factor		Author
Young to middle aged nurses		(El Ghaziri, Zhu, Lipscomb, & Smith, 2014, Hegney, Tuckett, Parker, & Eley, 2010, Kitaneh & Hamdan, 2012, Pai & Lee, 2011, Pich et al., 2010, Sharipova, Hogh, & Borg, 2010, Wu et al., 2012)
Gender	Male	(Esmaeilpour, Salsali, & Ahmadi, 2011, Gacki-Smith et al., 2009, Kitaneh & Hamdan, 2012, Moylan & Cullinan, 2011, Wu et al., 2012)
	Female	(Balamurugan, Joseb, & Pc, 2012, Zampieron et al., 2010)
Experience	Expert and senior nurses	(Balamurugan et al., 2012, Chapman, Styles, Perry, & Combs, 2010a, Hahn et al., 2010, Moylan & Cullinan, 2011, Wu et al., 2012)
	Lower experience	(Chapman et al., 2010b, El-Gilany et al., 2010, Kitaneh & Hamdan, 2012, Pich et al., 2010, Sharipova et al., 2010)
Education	Higher levels of education	(Chapman et al., 2010a, El-Gilany et al., 2010, Hahn et al., 2010, Hinchberger, 2009, Pai & Lee, 2011)
	Lower levels of education	(Hegney et al., 2010, Kitaneh & Hamdan, 2012, Roche et al., 2010, Speroni et al., 2014)
Rotating nurses		(Abou-ElWafa, El-Gilany, Abd-El-Raouf, Abd-Elmouty, & El-Sayed, 2014, AbuAlRub & Al-Asmar, 2011, Farrell et al., 2014, Zampieron et al., 2010)
Enrolled nurses		(Farrell et al., 2014, Hegney et al., 2010)
Exposure to stress at work		(Magnavita & Heponiemi, 2011, Pai & Lee, 2011, Sharipova et al., 2010, Zampieron et al., 2010)
Lack of special skills	Lack of effective communication among nurses	(AbuAlRub & Al-Asmar, 2011, El-Gilany et al., 2010, Khalil, 2009, Wu et al., 2012)
	Inadequate anger management training	(AbuAlRub & Al-Asmar, 2011, Khalil, 2009, Pinar & Ucmak, 2011)
	Lack of leadership skills	(Roche et al., 2010, Sharipova et al., 2010)
Working time in direct contact with patients		(El Ghaziri et al., 2014, Hahn et al., 2010, Speroni et al., 2014)
Holding or boarding patients		(Gacki-Smith et al., 2009, Sharipova et al., 2010, Speroni et al., 2014)
Fallacious beliefs of experiencing violence as being:	Part of the job	(Gacki-Smith et al., 2009, Gates, Gillespie, & Succop, 2011, Hinchberger, 2009, Pich et al., 2010)
	A sign of incompetence, or a reason for retaliation from management	(Gacki-Smith et al., 2009, Gates et al., 2011)

Nurses' Risk Factor		Author
Values and norms	Nurses who didn't care about the feelings of patients or their families, or those who lacked religious and ethical values when dealing with others	(AbuAlRub & Al-Asmar, 2011)
	Nurses who lacked respect	(Khalil, 2009)
Nurses who usually didn't report WPV incidents		(Gacki-Smith et al., 2009, Pich et al., 2010)

Table 3. Review of Organizational Risk Factors.

Organizational risk factors		Author
Shift	Night shift	(El-Gilany et al., 2010, Farrell et al., 2014, Gacki-Smith et al., 2009, Pai & Lee, 2011, Pich et al., 2010, Shahzad & Malik, 2014, Sharipova et al., 2010, Truman et al., 2013, Wu et al., 2012)
	Evening shift	(AbuAlRub & Al-Asmar, 2011, El-Gilany et al., 2010, Kitaneh & Hamdan, 2012)
	Morning shift	(Shahzad & Malik, 2014)
Holidays or weekends		(Gacki-Smith et al., 2009, Pich et al., 2010)
Lengthy waiting times by patients, their families, or visitors		(Gacki-Smith et al., 2009, Hahn et al., 2010, Pich et al., 2010, Roche et al., 2010, Speroni et al., 2014, Wolf, Delao, & Perhats, 2014, Wu et al., 2012, Zampieron et al., 2010)
Lack of resources	Staff shortages	(AbuAlRub & Al-Asmar, 2011, 2013, Chapman et al., 2010b, Gacki-Smith et al., 2009, Hahn et al., 2010, Speroni et al., 2014)
	Lack of equipment and instruments	(AbuAlRub & Al-Asmar, 2011, 2013)
Crowding of patients		(El-Gilany et al., 2010, Gacki-Smith et al., 2009, Speroni et al., 2014)
Workload on staff		(AbuAlRub & Al-Asmar, 2011, Chapman et al., 2010b, El Ghaziri et al., 2014, Magnavita & Heponiemi, 2011, Roche et al., 2010)
Lack of policies:	Visiting policies	(AbuAlRub & Al-Asmar, 2011, Gacki-Smith et al., 2009, Speroni et al., 2014)
	Smoking policies	(Speroni et al., 2014)
	Policies or legislations against WPV	(AbuAlRub & Al-Asmar, 2011, 2013, El-Gilany et al., 2010)
	Ambiguous ED violence reporting policies	(Gacki-Smith et al., 2009)
Security and safety factors	Lack of security measures	(AbuAlRub & Al-Asmar, 2011, El-Gilany et al., 2010, Hinchberger, 2009, Pinar & Ucmak, 2011)
	Easy public access to hospitals	(AbuAlRub & Al-Asmar, 2011, Pinar & Ucmak, 2011, Wolf et al., 2014)
	Lack of institutional recognition of high risk patients	(AbuAlRub & Al-Asmar, 2011, Wolf et al., 2014)
	Working alone	(AbuAlRub & Al-Asmar, 2011, El-Gilany et al., 2010)
Managerial or administrative issues regarding dealing with WPV	Poor management of incidents of WPV	(AbuAlRub & Al-Asmar, 2011, 2013, McCullough, 2011, Pai & Lee, 2011, Pinar & Ucmak, 2011)
	Staff feelings of being unsupported by the managers	(Gacki-Smith et al., 2009, Magnavita & Heponiemi, 2011, Pich et al., 2010, Pinar & Ucmak, 2011, Truman et al., 2013)
	Underreporting of WPV incidents by nurses	(Gacki-Smith et al., 2009, Pich et al., 2010)
Lack of services in hospitals for patients of visitors	Limited access of food and beverages, lack of quiet rooms	(Speroni et al., 2014)
	Inappropriate environments for providing health care services	(AbuAlRub & Al-Asmar, 2011)
Threatened patient's safety	Falling down	(Roche et al., 2010)
	Medical errors	(AbuAlRub & Al-Asmar, 2011, Roche et al., 2010)
Public hospitals	(Farrell et al., 2014)	
Request for many medical exams and tests	(Hahn et al., 2010)	
High cost of treatment	(Wu et al., 2012)	
Enforcement of hospital rules	(Hahn et al., 2010)	
Staff who removed personal items from patients	(Speroni et al., 2014)	

3.9. Nurses' Responses to Workplace Violence

Nurses responded to violent incidents differently: 45% of nurses reported the incident to the head nurse or the nursing department management (Zampieron et al., 2010); 24.3% (AbuAlRub & Al-Asmar, 2013) and 70.2% (Pai & Lee, 2011) reported it to a senior staff member; 55.7% (Ferns & Meerabeau, 2009) and 76% (Pai & Lee, 2011) handled the event by disclosing with friends/ family members; 46% complained to medical personnel (e.g., medical doctor in

charge of the unit, the doctor on call, or the hospital's medical director) (Zampieron et al., 2010); 72% (Zampieron et al., 2010) and 49.1% (Ferns & Meerabeau, 2009) spoke to a colleague; only one respondent stated that he/she was offered formal counseling (Ferns & Meerabeau, 2009); and 2.8% took legal action (Pinar & Ucmak, 2011).During assault, 37.5% (AbuAlRub & Al-Asmar, 2013) and 44.7% (Pai & Lee, 2011) of nurses reported that they told the person to stop the verbal violence, and almost half of nurses (45%) tried to defend themselves physically during the physical violence (AbuAlRub & Al-Asmar, 2011).

3.10. Consequences of Workplace Violence

There are numerous consequences of WPV as reported by studies. Most of these consequences considered psychological consequences, that may include becoming suspicious, feeling anger (El-Gilany et al., 2010; Truman, Goldman, Lehna, Berger, & Topp, 2013); embarrassment (Ferns & Meerabeau, 2009; Truman et al., 2013); depression (Zampieron et al., 2010); lack of nurses' safety in the workplace (Esmaeilpour et al., 2011); feeling of being unsafe all the time in the work place (Pinar & Ucmak, 2011); fear or stress (Al-Ghabeesh & Ahmad, 2012; Zampieron et al., 2010); becoming anxious (Pai & Lee, 2011); being "super-alert" or watchful and on guard (AbuAlRub & Al-Asmar, 2013; Gates et al., 2011); and PTSD symptoms for all types of psychological violence, but not for physical violence (Pai & Lee, 2011). Also, psychological consequences may include the scenarios where victims continued to think about the incident (Truman et al., 2013); repeated and disturbing memories, thoughts, or images of the attack (AbuAlRub & Al-Asmar, 2013). Although almost all the nurses remained on duty, more than half of them stated they had the fear of experiencing another incidence of violence (Pinar & Ucmak, 2011).

On the other hand, WPV correlated with nurses' work contentment and lead to work dissatisfaction (El-Gilany et al., 2010; Gates et al., 2011; Truman et al., 2013); decreased performance and efficiency (El-Gilany et al., 2010); impact on the decision making and quality of patient care (Ahmad, Alasad, & Nawafleh, 2010; Esmaeilpour et al., 2011); negative impact on productivity (Gates et al., 2011); and correlated with nurses' intent to leave (Roche et al., 2010).

However, nurses' administrators must be aware of the expenses of WPV that related to dissatisfaction of the way that incidents were being handled (Esmaeilpour et al., 2011); and its effect on increasing burnout (Truman et al., 2013; Zampieron et al., 2010); turn over; absenteeism; medical and psychological care; property damage; increased security; increased workers' compensation; and decreased morale (Gates et al., 2011); and they must take in consideration the importance of counseling and psychological support for victims of violence (Zampieron et al., 2010).

3.11. Reporting of Workplace Violence Incidents and Barriers

Although WPV is well a recognized problem in many

countries, 85.4% of nurses indicated that there was no procedure to report violent incidents in the workplace (Esmaeilpour et al., 2011). Eighty percent of nurses did not report violence in Turkey (Pinar & Ucmak, 2011), and 37.3% in UK (Ferns & Meerabeau, 2009). Only 24.7% of all the participants had been encouraged to report violence and their colleagues were the main source of the encouragement (45.5%) (Esmaeilpour et al., 2011). While 52.6% reported that their supervisors or managers offered them an opportunity to speak or report about violent incidents (AbuAlRub & Al-Asmar, 2013). Only 26.6% of all those affected by violence reported the incidents in a written form (Natan et al., 2011).

A Turkish study found that 64.6 and 55.6% of nurses who reported verbal and physical violence, respectively, received inefficient responses in preventing violence; there was no obvious follow-up in place for reports; they were anxious of losing their jobs, being blamed by administrators, and feared legal procedures that would follow the incidents (Pinar & Ucmak, 2011).

However, an American study revealed that nurses believed that reporting incidents of violence might have an adverse effect on customer service. On the other hand, nurses perceived reporting ED violent incidents as a sign of incompetence or weakness; it was not important because of lack of physical injury to staff as a result of WPV. Thus, they looked at violence as it was something that came with the job. Finally, lack of support from administration/ management was the main barrier for reporting violence (Gacki-Smith et al., 2009).

3.12. Prevention and Control

Most literature results were consistent with each other in prevention and controlling of WPV, which recommended that workplaces should have policies, safety measures, education and training, and public awareness. On the other hand, it is suggested not only to encourage nurses into the profession, but also to produce a working environment that supports and protects them while providing care.

3.13. Safety Measures

It is vital to nurses that hospitals adopt prelisted protective factors for WPV (Pich et al., 2010; Wolf, Delao, & Perhats, 2014). These factors includes providing security, assessment and documenting the risk of violent behavior of patients, alarm systems (Zampieron et al., 2010), providing fair assignments, and restricting public access during providing care for patients; improving security systems and measures, restricting public access, and controlling visiting times (AbuAlRub & Al-Asmar, 2011, 2013); security officers (Abou-ElWafa et al., 2014; Pinar & Ucmak, 2011), camera systems, a closed-door policy (Pinar & Ucmak, 2011); police presence (El-Gilany et al., 2010; McCullough, 2011); and adequate staff numbers are very helpful in dealing with workplace violence (AbuAlRub & Al-Asmar, 2013).

3.14. Education and Training

A study found that 50% of nurses didn't have self-confidence to manage WPV in the general health care setting (Hahn et al., 2010), which addressed the need for re-education and training needs (Moylan & Cullinan, 2011) and prevention/de-escalation training programs in order to decrease the prevalence of WPV against nurses (Abou-ElWafa et al., 2014; Shahzad & Malik, 2014; Speroni et al., 2014). These training programs reflected the nurses' needs as they ensured the importance of taking these training programs as part of their in-service education (Pinar & Ucmak, 2011).

Educational programs should be designed for health care providers and patients that will create awareness of the phenomenon of workplace violence (AbuAlRub & Al-Asmar, 2013), and training programs should be developed for nurses and security staff about effective dealing with violent acts (Hinchberger, 2009). Not only nurses should be re-educated, but nursing students should learn to recognize signs of impending violence in colleagues, patients, and visitors and be willing to inform their faculty preceptor, or manager (Hinchberger, 2009).

Another American study investigated the effectiveness of nurse led programs applied in psychiatric settings. A violence prevention community meeting focused not only on nurses and patients, but also on cultural aspects of WPV. This program consisted of meetings between patients and nurses to discuss all WPV dimensions and protective interventions. After implementation of these meetings, WPV incidents decreased significantly (Lanza, Rierdan, Forester, & Zeiss, 2009).

3.15. Required Skills for Nurses

Nurses need to be skillful in violence assessment to assist prevention and instigate aversion strategies (Hegney et al., 2010), identify indicators of violence at patients' first point of contact with the health system (Ahmad., 2010), learn breakaway techniques to promote personal safety (Hahn et al., 2010), self-defense techniques (McCullough, 2011), and ways to avoid provoking patients (Ahmad, 2014; Zampieron et al., 2010). Other essential skills include assessment of the work environment for hazards (McCullough, 2011); escape routes (Hinchberger, 2009), effective communication strategies and skills (AbuAlRub & Al-Asmar, 2013); assertiveness techniques, conflict resolution, stress and anger management (Ahmad & Al Nazly, 2014; Tawalbeh & Ahmad, 2012; Wu et al., 2012).

An American study applied "Code S" which was a rapid response skillful team approach to deal with incidents of violence in ED. This "de-escalation team" consisted of nurses, physicians, social workers, security guards and other staff to communicate with aggressors in the presence of security guards in the background, to prevent provoking the situation. This approach reduced the need for using restraints and seclusion in ED; patients' and staff physical and psychological trauma, besides the financial costs of these injuries (Kelley, 2014).

3.16. Organizational Responsibilities

Most literature assured that presence of a formal hospital policy for dealing with WPV will probably reduce nurses' perception of the occurrence of WPV (Hahn et al., 2010; Pich et al., 2010). The philosophy of WPV must be changed and professional nursing organizations should use their power to facilitate a revolution in public policy and legislative action with management (AbuAlRub & Al-Asmar, 2011; Moylan & Cullinan, 2011).

Studies identified many policies that should be considered such as crucial zero tolerance policies (Shahzad & Malik, 2014; Wolf et al., 2014), occupational health and safety legislation (Pich et al., 2010), and departments' written policies for preventing and managing violence (Pinar & Ucmak, 2011). Most of these polices have been adopted in many countries including Australia, the UK, European countries, and the USA. Therefore, policy-makers and administrators should recognize this issue as a priority for prevention (Pich et al., 2010).

Although the role of supportive leadership is central to reducing incidents of violence in an organization, nurses have to report when they experience or witness any violence incident. Hospital managers and leaders should fortify reporting mechanisms of WPV in the hospitals and encourage nurses to report these incidents (Shahzad & Malik, 2014). On the other hand, it was recommended to develop appropriate policies and strategies on WPV against health workers and to consider these policies as a basis for future studies in the country (Kitaneh & Hamdan, 2012).

3.17. Community Awareness

In order to increase community awareness, public-based 'violence prevention' educational programs must be held where males should be the target group as potential future perpetrators (McCullough, 2011). Also, different mass media methods can be used to enhance the nursing profession's image in the community and towards the negativity of the phenomenon of WPV (AbuAlRub & Al-Asmar, 2013).

4. Discussions

The Purpose of this literature review was to explore the profundity, aspects, consequences of WPV against nurses. This review provides up-to-date evidence about the nature, frequency, origin and the outcome of WPV against nurses in many countries. According to literature, WPV becomes a major concern for nurses, administrators, health care providers, organizations, and patients as it affects the quality of service provided for them.

This review revealed that most nurses experienced at least one type of WPV during their practice, either verbally or physically. Workplace violence was shown to be caused mainly by patients and their families or visitors in emergency and mental health departments. Risk factors of WPV were

investigated according to the parties involved: the nurse, patient, patient's family, organization, and the community. It was possible to conclude that the most important reported risk factors were night shifts and lengthy waiting times experienced by patients and visitors. According to the literature, WPV had impact not only on the quality of care, but also on the nurses' job satisfaction and significantly increasing staff turnover (Ahmad, Daken, & Ahmad, 2015). Although WPV became a major problem, it was neither well reported by nurses, nor managed by administrators appropriately. Finally, the most preventive measures reported by studies included, but was not limited, to training and education of staff and patients, security measures, and setting organizational or public policies in order to reduce the incidence of WPV.

Previous reviews focused on the WPV occurring in EDs (Anderson et al., 2010; Pich et al., 2010; Taylor & Rew, 2011), and one of them focused on interventional approaches to reduce the occurrence of WPV (Anderson et al., 2010). Two review articles noted the high incidence of WPV in ED (Pich et al., 2010; Taylor & Rew, 2011), as revealed by this review. Also, these studies indicated the importance of reporting (Pich et al., 2010; Taylor & Rew, 2011), and the effects of under-reporting WPV incidents on tracking the WPV problem (Taylor & Rew, 2011); acceptance of WPV as a part of the nurse's job, inhibition of developing protective policies and threatening the safety of the workplace environment (Pich et al., 2010). The review revealed that most nurses didn't report WPV incidents, but it didn't focus on the effects of under-reporting, except noting that under-reporting was identified as a risk factor for WPV (Gacki-Smith et al., 2009). Two review articles emphasized the importance of investigating intervention strategies rather than describing the nature of WPV phenomenon (Anderson et al., 2010; Taylor & Rew, 2011). Correspondingly, this review highlighted not only the nature of WPV, but rather the applied or recommended interventional measures to reduce the occurrence of WPV (AbuAlRub & Al-Asmar, 2011; Farrell et al., 2014). Furthermore, one review article recommended interventional measures to reduce WPV that were classified as environmental, practices and policies, and skills (Anderson et al., 2010). The other study classified these measures as safety and security measures, and policies (Pich et al., 2010). Similarly, this review classified the interventional measure as safety and security, education and training, organizational policies and community measures.

In this review, night shift was the most frequently reported risk factor among all studies. This may be related to shortage of security staff. Conversely, nurses might be exposed to WPV in evening shifts. This may be attributed to increased visitors numbers and workload - especially in ED. Lengthy waiting times experienced by patients or families was the second most frequently reported risk factor of WPV. This may be related to staff shortages leading to crowding, increased workload, and delay of care provision. Although there may be restricted visiting hours in most hospitals, many visitors don't commit to these hours which could lead to confrontation with nurses. Many hospitals don't have specific policies for reporting WPV specifically which may lead to ambiguity of procedures for reporting and, as a result, under-reporting of these incidents. Moreover, several organizations don't employ enough number or competent security staff which leads to easy access of visitors to hospital departments. Another important issue is the lack of assessment tools to recognize high risk patients, especially in the ED. One study developed a violence assessment tool to identify behavioral cues among such patients.

This review was limited to studies conducted in the past 10 years, and focused on the WPV caused by patients or visitors rather than health care providers. In summary, WPV is a multi-faceted problem; risk factors cannot be limited to patients and families, although it was revealed that WPV is primarily caused by them. Based on reviewers' clinical practice, nurses' risk factors must be taken into account, as many nurses lack therapeutic communication skills, a sense of responsibility, patience, competence, and evidence-based practices. On the other hand, the demanding nature, impatience, and diversity of patients and visitors have a critical influence on escalating WPV.

5. Conclusion

Workplace violence is a serious problem that affects nurses worldwide. It involves several parties including nurses, patients and their families, hospitals, and the community. Workplace violence has negative physical and emotional impacts on nurses. It doesn't affect nurses only, but it has negative influences on patients and organizations. Underreporting of WPV is very common among nurses which lead to exacerbation of the problem. Nurses' managers and leaders should take all necessary measures to encourage nurses to report incidents of violence. Application of preventive measurements to reduce the incidence of WPV should be considered by all involved parties, especially decision makers.

5.1. Implications for Nursing Practice

This review recommends not only employing enough staff according to the recommended nurse to patient ratio in different departments, but also recruitment of competent, patient, and skillful nurses, especially in therapeutic communication skills. Development of violence assessment tools to recognize high risk patients, especially in ED. This review also confirms the importance of managers and administrators support for the staff, either in reporting, or in the management of WPV consequences in terms of offering paid leave, psychological support, and referral to specialized counselor if required, and imposing policies against WPV, and policies for reporting these incidents. Another important issue is the permanent presence of security personnel in the hospital.

5.2. Implications for Nursing Education

This review highlights the importance of obligatory

provision of in-service educational programs about handling of WPV incidents, communication skills and anger management for all hospital staff. Moreover, there should be collaboration between hospitals, universities and community colleges in order to implicate these subjects in curriculums for nursing students. However, organizations should provide educational brochures about their rights and how to express themselves in every room, and if possible to provide appropriate educational programs for patients. Educational programs should be included in mass media to increase community awareness about WPV and its serious impact on all community members.

5.3. Recommendations for Future Research

Further studies should be conducted to highlight appropriate preventive and protective measures and policies, and investigate the efficiency of these measures. Since there is a scarcity of experimental studies evaluating the effectiveness of preventive measures, such studies should be conducted.

Acknowledgment

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