

## ANALYSIS OF THE RELATIONSHIP BETWEEN NURSES' CAREER LEVELS AND WORKPLACE VIOLENCE IN HOSPITALS IN ACEH PROVINCE

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### ABSTRACT

Nurses are one of the health professions that are highly vulnerable to violence in the workplace. Violence against nurses, whether physical or non-physical/psychological, can have a negative impact on the quality of work and nursing services. The purpose of this study was to determine the relationship between the career level of clinical nurses and workplace violence, including physical violence and psychological violence against nurses at the Aceh Provincial Hospital. This study is quantitative a cross-sectional study design. The research employed a total sampling approach with 127 respondents meeting the inclusion criteria. Data on violence were collected using the Workplace

Violence in the Health Sector (WPVHS) questionnaire, while career-level variables were collected from demographic data. Data analysis was performed using descriptive statistics and the chi-square test. The results showed that the career level variable was not related to physical violence, but it was related to psychological/non-physical violence, with a p-value of 0.000. Based on the research results, it was proven that nurses are highly susceptible to violence in the workplace. Low career level is a predictor of violence. Violence can reduce nurse performance, increase turnover, anxiety, work stress, depression, sleep disorders, high fatigue levels, post-traumatic stress disorder (PTSD), physical injury, and death.

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### INTRODUCTION

Workplace violence (WPV) is a critical issue in the health sector, encompassing harassment, threats, and physical and psychological attacks that threaten staff safety (International Council of Nurses, 2017). WPV is categorized into physical violence such as beating and stabbing, and psychological violence in the form of intimidation, sexual harassment, racial harassment, and verbal threats (Harthi et al., 2020). Nurses are the most

vulnerable profession because they are at the forefront. Research in China notes that the risk of WPV among nurses reaches 62.7% (Lu et al., 2020), with 65.8% of nurses experiencing verbal, physical, and sexual violence, mainly committed by patients or their families (Shi et al., 2017).

The impact of WPV is very detrimental, ranging from decreased work motivation and service quality (Khan et al., 2021) to mental and physical disorders in victims (Demirci & Uğurluoğlu, 2020). Indirectly, this condition triggers job dissatisfaction and burnout, which threaten patient safety (Jiali Liu et al., 2019). The Emergency Room (ER) is the most at-risk unit with an incidence rate of up to 81.3% (Shi et al., 2017), where waiting time and triage systems are the main triggers (Spelten et al., 2020). In Indonesia, this phenomenon resembles an iceberg; although 54.6% of nurses experience non-physical violence in the ED, 55.6% are reluctant to report it, making the scale of the problem difficult to detect (Noorana & Feng, 2018).

The incidence of WPV is closely related to work experience and educational status (Dagnaw et al., 2021). Young nurses with minimal experience are more likely to face direct confrontation (Dehghan & Ghodousi, 2020), with the highest prevalence found at the diploma level (62.3%) compared to master's degree (3.9%) (Alam et al., 2019). In Indonesia, these variables of education and experience are integrated into the Clinical Nurse Career Ladder (PK I-V) system as regulated in PMK RI No. 40 of 2017. The implementation of appropriate clinical authority should reduce workload and burnout. However, research in Jakarta shows that there is still an overlap of authority, such as 28% of PK I nurses performing actions outside their competence due to an unbalanced nurse-to-patient ratio (Pertiwi et al., 2020). This indicates that career level optimization has the potential to be a WPV mitigation strategy that needs to be further explored.

This study aims to analyze the relationship between the implementation of clinical nurse career levels based on Minister of Health Regulation No. 40 of 2017 and the incidence of WPV among nurses in hospitals. Specifically, this study seeks to identify the prevalence and forms of violence experienced by nurses, evaluate the appropriateness of the implementation of clinical authority according to career level (PK I to PK V), and prove whether the level of work experience and educational status integrated into the career level system contributes to a reduction in the risk of violence in the work environment, particularly in the socio-cultural context of Aceh.

## RESEARCH METHOD

This study consists of two variables, namely independent variables and dependent variables. The independent variable in this study is career level, which is adopted from the concept described by the Ministry of Health of the Republic of Indonesia in Minister of Health Regulation No. 40 of 2017 concerning the Development of the Professional Career of Clinical Nurses. Meanwhile, the dependent variable is WPV based on the concept from the WHO (2003). The operational definitions of the variables used in this study are as follows:

**Table 1.** Operational Definitions of the Study

Variable	Operational Definition	Measurement Method	Measurement Tool	Scale	Measurement Results
<b>Independent Variable</b>					
Career Level	The career level of clinical nurses (PK) is determined by the hospital nursing committee after a credentialing process conducted by the nursing committee as a limitation on the clinical authority of nurses.	Questionnaire	Demographic questionnaire	Ordinal	1. PK I = 1 2. PK II = 2 3. PK III = 3 4. PK IV = 4
<b>Dependent Variable</b>					
WPV (physical violence)	Attacks against nurses in hospitals, including during travel to and from the hospital, such as hitting, kicking, raping, slapping, stabbing, shooting, pushing, biting, and pinching, committed by patients/families /relatives of patients, and others.	Questionnaire	WPV in the Health Sector: Country Case Studies Research Instruments	Ordinal	1. Yes, if $x = 1$ 2. No, if $x = 0$
WPV (psychological)	Threats of physical violence against nurses in	Questionnaire	WPV in the Health Sector Country Case	Ordinal	1. Yes If $x \geq 1$ 2. No

Variable	Operational Definition	Measurement Method	Measurement Tool	Scale	Measurement Results
violence)	hospitals, including during travel to and from the hospital, consisting of verbal abuse, bullying, sexual harassment, and racial harassment committed by patients/families /relatives of patients, etc.		Studies Research Instruments		if x = 0

This study is quantitative in nature with a cross-sectional study design. The population in this study consisted of 161 respondents. In this study, the sampling process used total sampling technique, which included all nurses working in the emergency room, pediatric ward, pediatric surgery ward, male internal medicine ward, male digestive surgery ward, and female internal medicine ward at the Aceh Provincial Hospital. The sampling criteria used in this study included inclusion criteria.

**Table 2.** Population Size by Ward

No	Hospital	Number
1	Emergency Room (ER)	44
2	Men's Internal Medicine Room	25
3	Women's Internal Medicine Department	23
4	Pediatric ward	22
5	Pediatric surgery room	23
6	Male digestive surgery room	24
	<b>Number</b>	<b>161</b>

In an effort to maintain the homogeneity and validity of the data obtained, the researchers established several inclusion criteria for the nurses who would be involved as respondents. The main requirement was that respondents must have sufficient clinical work experience, namely a minimum of one year of continuous service in the room where the research was currently being conducted. This one-year experience is considered a sufficient adaptation period for a nurse to understand the work dynamics, standard operating procedures, and social environment in the unit. In terms of professionalism and legal practice, prospective respondents are required to have undergone a valid nursing credentialing process. This is evidenced by the existence of a valid Clinical Authority Details (RKK) decree, with a minimum classification of Clinical Nurse I (PK I). This criterion is crucial to ensure that the respondents providing information are practitioners whose competence has been formally recognized by the hospital's nursing committee.

Furthermore, to maintain the effectiveness and smoothness of the data collection process in the field, the selected respondents were those who were actively on duty. This means that the nurses were not on long-term leave, whether due to health recovery (illness), post-natal leave, or other forms of long-term leave that could hinder communication or observation during the study. The final aspect that formed the basis for involvement in this study was compliance with research ethics. Respondents had to voluntarily agree to participate without coercion. This commitment was realized through the provision of an explanation of the research objectives (debriefing), which was then followed by the completion and signing of an informed consent form as formal proof of the protection of the respondents' rights.

After the researchers collected the data, out of a total of 161 respondents, 127 respondents met the inclusion criteria in this study, resulting in a response rate of 78.9%. A total of 34 samples were excluded from the prospective respondents because they did not meet the inclusion criteria during the screening process. Based on the initial selection of prospective respondents, there were several categories that prevented subjects from participating in this study. The main obstacle was found in the aspect of job continuity, where nine prospective respondents had taken or were currently taking long-term leave within the past year.

In addition, limited work experience was another disqualifying factor. Eight prospective respondents were new staff members who had not yet completed one year of service at the hospital. A similar situation was found in six prospective respondents who were staff members transferred from other units, where their length of service in their current position had not yet reached the minimum requirement of one year. In terms of professional qualifications, six prospective respondents could not be included because they did not have a nursing education background, making them irrelevant to the clinical competency focus of this study. Finally, based on research ethics principles that respect individual autonomy, five prospective respondents objected and officially refused to participate as respondents in this study.

This study used a questionnaire consisting of two parts. The first part was a demographic characteristics and initial violence data questionnaire consisting of age, gender, employment status, career level of clinical nurses (PK), average number of working hours per month, marital status, income, highest level of education, length of service, concerns about violence in the workplace, availability and knowledge of violence

reporting procedures, and whether there is encouragement to report violence, as well as several other questions.

The second questionnaire used in this study was the standard WPV In The Health Sector Country Case Study (WPVHS) questionnaire developed by the ILO, ICN, WHO, and PSI. (World Health Organisation, 2003). The WHO has given open permission to use this questionnaire. The questionnaire has been modified by the author in the demographic characteristics section with the addition of several questions such as the number of working hours per month and the determination of the career path of nurses, as well as the removal of inappropriate items such as profession type, work experience, position, work shift questions, work room, and others. This questionnaire categorizes two types of WPV: physical violence and psychological/non-physical violence. This questionnaire has been translated by experts using the back-translation method.

**Table 3.** Breakdown of the WPVHS Questionnaire

Dimension	Type of WPV	Breakdown
Workplace Violence	Physical Violence	Assault/attack
		Verbal Abuse
	Psychological Violence	Bullying/Mobbing
		Sexual Harassment
		Racial Harassment

In this study, content validity and construct validity (validity and reliability) tests were conducted. Content validity consists of face validity and logical validity, which were assessed by expert judgment. The validity test was conducted at a significance level of 95%. The calculated r-value in this study for a sample of 16 respondents was 0.4973, which is considered valid if the calculated r-value of the variable is  $\geq 0.4973$ . The r-count value of the variable from the item validity test obtained a Corrected Item-Total Correlation value for all items  $> 0.4973$  ( $r_{table\ value}$ ), so all items were declared valid. This study also conducted a reliability test using the Cronbach's Alpha if Item Deleted method and obtained an overall result of 0.991. The reliability test results for the questionnaire items obtained a Cronbach's Alpha if Item Deleted value for all items  $> 0.80$ , so all items are declared reliable.

The data analysis to be conducted in this study is univariate analysis and bivariate analysis. Univariate analysis is performed to obtain an overview of the distribution of univariate analysis conducted with descriptive statistical tests to analyze career levels and WPV against nurses. The bivariate analysis conducted in this study is the Chi Square test ( $X^2$ ). The chi square test is the most widely used non-parametric test. However, it is important to note the requirements for this test, which is that the frequency of

respondents or samples used must be large, because there are several requirements for the chi square to be used, namely that there are no values of 0 in any of the contingency value columns. If the contingency table is 2 X 2, then no cell may have an expected count < 5. If the table is larger than 2 x 2, for example 2 x 3, then the expected count may be < 5 but may not exceed 20%.

If the above conditions cannot be met, then Fisher's Exact Test is used. Some literature also states that the chi-square test has conditions and limitations. The requirements that must be met are a sample size of > 40 respondents. If the sample size is between 20-40, there are no contingency table cells with an expected value < 5. Meanwhile, the chi-square test cannot be used (this condition requires the Fisher Exact test) if the sample size is < 20 respondents. If the sample size is between 20 and 40, and there are contingency table cells with an expected value < 5, more than 20% of each total cell. If both research variables have a categorical scale, normality is not necessary. This is because it automatically uses chi-square/Fisher's exact test. For tables larger than 2x2, the Fisher's exact test cannot be performed directly, for example, a 2x3 table. Therefore, small cell values must be combined with other cells to form a 2x2 table. If there are still expected values below 5 in the 2x2 table, then the Fisher's exact test is performed.

## RESULTS AND DISCUSSION

The frequency distribution of demographic data and initial violence data shows that of the 127 nurses who responded at the Aceh Provincial Hospital, 89 nurses (70.1%) were female, 82 nurses (84.6%) had a DIII Nursing education, 103 nurses (81.1%) were married, 84 s of nurses (66.1%) had contract employee status, 58 respondents (45.7%) had worked at the hospital for a total of 6-10 years, and 71 nurses (55.9%) had 6-10 years of experience in the ward at the time of the study. A total of 31 nurses (24.4%) expressed concern about violence in the workplace, 48 nurses (37.8%) expressed the unavailability of a reporting channel for WPV, and the majority of 120 (94.5%) nurses expressed a desire to report violence, and the majority of nurses, 122 (96.1%), had never participated in training on dealing with violence in the workplace. The career level of clinical nurses was 54 (42.5%) nurses as PK II.

**Table 4.** Frequency Distribution of Demographic Data and Initial Violence Data

No	Respondent Characteristics and Data	Frequency	Percentage
1	Gender		
	Male	38	29.9
	Female	89	70.1

No	Respondent Characteristics and Data	Frequency	Percentage
2	Marital Status		
	Married	103	81.1
	Not Married	23	18.1
	Divorced	1	0.8
3	Employment Status		
	Civil Servant	43	33.9
	Contract Employee	84	66.1
4	Highest level of education		
	D3 Nursing	82	64.6
	Nurse	45	35.4
5	Years of service at the hospital		
	1-5 years	45	35.4
	6-10 years	58	45.7
	> 10 years	24	18.9
6	Current room experience		
	1-5 years	53	41.7
	6-10 years	71	55.9
	> 10 years	3	2.4
7	Concerns about violence		
	Not at all concerned	19	15
	Somewhat Concerned	27	21.3
	Not Concerned	21	16.5
	Concerned	31	24.4
	Very Concerned	29	22.8
8	Availability of violence reporting channels	79	62.2
	Knowing Availability	48	37.8
	Do not know availability		
9	Knowing how to report violence		
	Yes	79	62.2
	No	48	37.8
10	Motivation to report violence		
	Yes		
	No	120	94.5
		7	5.5
11	Received training on dealing with violence		
	Yes	5	3.9
	Never	122	96.1
12	<b>Career Path</b>		
	PK I	52	40.9
	PK II	54	42.5
	PK III	20	15.7
	PK IV	1	0.8

a. Incidents of non-physical violence in the workplace.

**Table 5.** Frequency Distribution of Physical Violence Incidents in the Workplace

No	Physical Violence	Frequency	Percentage
1	Yes	10	7.9
2	No	117	92.1

Table 5 shows that out of 127 respondents, 10 nurses (7.9%) had experienced physical violence. The majority of perpetrators were relatives of patients.

b. Incidents of non-physical violence in the workplace.

**Table 6.** Frequency Distribution of Non-Physical Violence Incidents in the Workplace

No	Non-Physical Violence	Frequency	Percentage
1	Yes	72	56.7
2	No	55	43.3

Table 6 shows that of the 127 respondents, 72 nurses (56.7%) had experienced non-physical violence. The most common form of non-physical violence was verbal abuse, followed by bullying/mobbing. The majority of perpetrators were relatives of patients.

c. The Relationship Between Career Level and Physical Violence

Analysis to determine the relationship between career level and physical violence using the chi-square test. The results of the analysis show that in the 4x2 table, there is an expected frequency value below 5 (five) of 62.5%. Next, the cells were merged into a 3x2 table and analyzed again, and the expected frequency value below 5 (five) was still 50%. The next step was to merge the cells again into a 2x2 table, and the results can be seen in Table 6. Based on the chi-square test results, it was found that of the 106 PK I-II nurses, 98 (92.5%) did not experience physical violence. The statistical test results show a p-value = 0.670 > 0.05. Thus, it can be concluded that there is no relationship between career level and physical violence at the Aceh Provincial Hospital.

**Table 7.** Relationship between Career Level and Physical Violence

No	Career Level	Physical Violence				Total	%	p-value
		Yes	%	No	%			
1	PK I-II	8	7.5	98	92.5	106	100	0.670
2	PK III-IV	2	9.5	19	90.5	21	100	
	<b>Total</b>	10	7.9	117	92.1	127	100	

d. Relationship between Career Level and Non-Physical Violence (psychological violence)

Analysis to determine the relationship between career level and physical violence using the chi-square test. The results of the analysis show that in the 4x2 table, there is an expected frequency value below 5 (five) of 25%. Next, cell merging was performed to create a 3x2 table, which was then reanalyzed, yielding

an expected frequency value below 5 (five) of 0%. The results can be seen in Table 6. Based on the chi-square test, it was found that of the 52 PK I nurses, 49 (94.2%) experienced non-physical violence. The statistical test results showed a  $p\text{-value} = 0.000 < 0.05$ . Thus, it can be concluded that there is a relationship between career level and non-physical violence at the Aceh Provincial Hospital.

**Table 8.** Relationship between Career Level and Psychological/Non-physical Violence

No	Career Level	Non-physical Violence				Total	%	<i>p-value</i>
		Yes	%	No	%			
1	PK I	49	94.2	3	5.8	52	100	0.000
2	PK II	17	31.5	37	68.5	54	100	
3	PK III-IV	6	28.6	15	71.4	21	100	
<b>Total</b>		72	56.7	55	43.3	127	100	

Career progression is a path of vertical mobility achieved through competency improvement, where competencies are obtained from formal education, relevant informal education, and recognized clinical practice experience (PMK No. 40 of 2017). Based on the research results, it is known that the career path of clinical nurses (PK) is predominantly PK I with 52 (40.9%), PK II with 54 (42.5%), PK III with 20 (15.7%), and PK IV with 1 (0.8%). This is consistent with the data on the limited work experience of nurses in hospitals, namely 58 nurses (45.7%) with 6-10 years of service in hospitals. The research also found that the majority of nurses had a Diploma III (D3) in nursing as their highest level of education, namely 82 nurses (64.6%).

The percentage of psychological/non-physical violence against nurses was higher among nurses with PK I career levels, at 49 (94.2%). Statistical tests between career level and non-physical violence found a significant relationship between these variables ( $p\text{-value} 0.000$ ), with 66 (52%) nurses considering training related to violence in the workplace to be important and 76 (59.8%) nurses considering human resource development to be important. Thus, it can be concluded that nurses with minimal work experience and/or a D3 education level are more prone to non-physical violence. One study reported several predisposing factors for violence against nurses, including nurses' clinical experience, education level, and communication skills (Varghese et al., 2021).

The results obtained from this study are almost the same as those reported by Zhang et al., (2017), which reported that novice nurses are more prone to experiencing violence in the workplace than experienced nurses. Similarly, in terms of education level, Alam et al., (2019) revealed that nursing diploma graduates

experienced violence at a very significant rate of 62.3%. Nursing bachelor's degree holders experienced violence at a rate of 33.8%, and master's degree holders at 3.9%. This is further supported by Mento et al., (2020), which reports that younger individuals experience more WPV than older age groups. Additionally, educational specialization and work experience are also significantly associated with exposure to WPV.

The high prevalence of violence against nurses with low career levels may be caused by their experience, communication skills, and maturity in dealing with violence, which may be the reason why violence occurs frequently at low career levels. Research by reports that there are more cases of violence against younger staff than older staff. Work experience in healthcare services is found to be a risk factor for WPV. Lack of experience and exposure to clinical care can result in less effective clinical and communication skills (Dagnaw et al., 2021). Healthcare staff who experience higher levels of WPV tend to be dissatisfied with their careers, so interventions to reduce violence must be implemented by policymakers to create a violence-free work environment (Tian et al., 2020).

Career experience was found to have an influence on nurses' experiences of verbal abuse. Nurses with 6 or more years of career experience experienced less verbal abuse than those with 2 or fewer years of career experience (Park & Choi, 2020). Healthcare facility leaders should encourage nurses to report all types of abuse to ensure compliance with the healthcare system. Serious measures must be implemented to address WPV, especially verbal abuse, which is common. These measures include developing policies and procedures and improving intervention strategies to reduce or even prevent violence (Alfuqaha et al., 2022).

Low levels of education can be a factor in increasing the rate of errors related to patients, especially academic ability and quick decision-making in the emergency room. Therefore, it is necessary to consider the academic abilities of medical staff during the recruitment process and, possibly, to reconsider the recruitment criteria for emergency health workers in order to reduce incidents of violence in the workplace (Golzare et al., 2018). Educational attainment has been shown to be associated with WPV among professional groups and interactions with patients during work (Fisekovic et al., 2015). The occurrence of violence significantly increases the likelihood of emotional exhaustion and depersonalization, as well as low professional performance and burnout syndrome. Therefore, WPV prevention

strategies need to be implemented to provide a safe workplace for workers to perform their nursing duties (Aparecida et al., 2021).

Proper career level determination and placement of nurses in the correct career level can prevent potential violence in the workplace. Iftikhar & Qureshi, (2018) argue that to address the issue of verbal violence against nurses in the workplace, tasks should be assigned based on the career level of nurses, assertive attitudes should be implemented in the workplace, and the factors causing violence in the workplace should be addressed and improved. Nurse managers must act as liaisons with the organization to formulate and implement WPV prevention strategies. Skills-based training programs that demonstrate appropriate communication and aggression management techniques should be conducted as part of continuing education programs. Furthermore, special attention should be given to novice and young nurses who are at higher risk of experiencing violence. Nurse managers must ensure that appropriate measures are in place to make nurses sensitive to reporting violence (Varghese et al., 2021).

Based on the above discussion, it can be concluded that career level is related to incidents of violence, particularly psychological/non-physical violence. Those with low PK are more likely to experience violence than those with higher PK. Possible reasons for this are that experienced nurses are more adept at reading emotional states during interactions and identifying early warning signs, have better negotiation skills, and know more about how to handle patients who are potentially violent than less experienced nurses.

## **CONCLUSION AND RECOMMENDATIONS**

The results of this study conclude that although there is no significant relationship between the career level of clinical nurses and physical violence, a significant correlation was found with the prevalence of psychological violence in Aceh Provincial Hospital. Therefore, further research with a qualitative approach is needed to explore the psychosocial dynamics that occur, as well as experimental research designs to test the effectiveness of specific interventions in mitigating these incidents of violence.

The implications of these findings require strategic steps from hospital management to develop more comprehensive health worker protection policies, including the implementation of a zero-tolerance pact against violence and the provision of a confidential incident reporting system. Operationally, nursing management needs to

redistribute nurses by considering the balance of career levels in each work shift to ensure supervision for practicing nurses. In addition, providing training in conflict management, de-escalation techniques, and therapeutic communication, especially for PK I and PK II nurses, is crucial to equip them to deal with stressful situations involving patients and their families. Through the integration of psychosocial support and the strengthening of a supportive work culture, it is hoped that the risk of psychological violence can be significantly reduced in order to create a safe and professional practice environment.

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