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REVIEW

Violence by clients and patients against social and healthcare staff – An integrative review of staff's well-being at work, implementation of work and leaders' activities

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Abstract

Aim: The aim of this study was to compile, assess and synthesise empirical research on violence by social and healthcare clients or patients against staff and its connections to staff's well-being at work, implementation of work and activities of leaders related to it.

Background: Workplace violence against social and healthcare staff is a global and daily problem. One in three employees encounters violence from patients or clients and the risk of this is 16 times higher compared to other professions. None of the recent reviews on this topic were focused on the well-being at work, implementation of work or leaders' role in the cases of violence of clients or patients against the staff.

Design: An integrative review reported according to PRISMA Checklist.

Methods: The search was conducted to CINAHL, PubMed, PsychINFO and Scopus databases resulting in 21 articles. The quality of the articles was evaluated, and the data were analysed narratively.

Results: The workplace violence committed by clients and patients was negatively connected to staff's psychological, emotional and physical well-being at work and to their work performance and commitment. The leaders found this form of workplace violence challenging and ethically conflicted and felt that they were left alone without training and support. The employees expressed disappointment with their leaders' activities and suggested many measures to make environment safer to staff and patients.

Conclusions: In future, intervention studies are needed for prevention of workplace violence by patients and clients against staff and for supporting the well-being at work of staff in relation to violent incidents.

Relevance to clinical practice: Workplaces should introduce uniform protocols for reporting, preventing and processing workplace violence committed by clients and

patients. An open dialogue with leaders and co-workers of the cases is of high importance. Leaders and staff need training that ensure patient and work safety.

KEYWORDS
clinical, leadership, nurses, systematic review, violence, workforce issues

1 | INTRODUCTION

Workplace violence against social and healthcare staff is a global problem (Babiarczyk et al., 2020; Cebrino & de la Cruz, 2020; Hoyle et al., 2018; WHO, 2018) and has been referred to as a quiet epidemic (Hoyle et al., 2018). According to estimates, one in three healthcare workers have encountered a threat of violence, psychological or physical violence or sexual harassment from patients or their loved ones (Cebrino & de la Cruz, 2020). The risk of healthcare staff to become victims of workplace violence has been estimated to be up to 16 times higher compared to other professional groups (Rajabi et al., 2020).

Disruptive behaviour by social and healthcare service clients has been increasing and the amount of workplace violence experienced by those working in the sector is steadily increasing (Cebrino & de la Cruz, 2020). Encountering hostility or violence in a working environment for providing people with care and treatment can be highly stressful (Hills, 2018; Tölli et al., 2017), dangerous and frightening (Tölli et al., 2017). Violence by clients is particularly targeted against nurses as they are in close contact with clients and patients when providing care and treatment (Jakobsson et al., 2021). A lack of experience, a low professional self-esteem and dependence on co-workers expose newly graduated nurses to workplace violence and increase their intent to leave the profession (Ebrahimi et al., 2017). Perceived workplace violence significantly reduces employees' willingness to recommend a career in nursing for prospective nurses (Tian et al., 2020) and also affects the intent of experienced staff to stay in the profession (Ebrahimi et al., 2017).

The European Commission and International Labour Organisation (ILO. International Labour organization, 2021) defines workplace violence as situations in which an employee is harassed verbally or threatened or abused at work, which either directly or indirectly puts the employee's safety, health and well-being at risk. According to the World Health Organization (WHO, World Health Organization, 2021), workplace violence can be divided into physical, psychological, sexual and discriminatory violence. According to this definition, verbal violence is included in psychological violence. Workplace violence can also comprise verbal or written abuse (Hills, 2018). Workplace violence can emerge as threatening behaviour, harassment or intimidation. It can manifest as negligence (Fernandes et al., 2018), humiliation, criticism, sarcasm, threatening or coercion, obstruction of possibilities, suppression or frustration (Ebrahimi et al., 2017). There is also institutional violence in social and healthcare settings related to a poor quality of services, which may be either openly or covertly targeted against service users (Fernandes et al., 2018). Rigid operating approaches, bureaucratic processes and problems in service availability may cause anxiety and fear and frustration related to delays in receiving treatment, a lack of necessary care and a shortage of staff (Fernandes et al., 2018; Hoyle et al., 2018). As a result, the violence targeted against nursing staff by patients and their loved ones is not typically perceived as intentional cruelty but rather as an extreme and impulsive act (Fernandes et al., 2018).

It is difficult for social and healthcare staff to anticipate, identify, control and appropriately manage the violence that patients, clients or their family members target against them (Laeeque et al., 2019), as no evidence-based overall picture and jointly agreed operating models are available for the purpose. The diverse and sensitive nature of the topic also makes it difficult to approach. Workplace violence disrupts the safety culture of a working unit, the well-being of nurses and patient care (Al-Shiyab & Ababneh, 2018; Babiarczyk et al., 2020; Bromley & Painter, 2019; Cebrino & De la Cruz, 2020; Mento et al., 2020; WHO, World Health Organization, 2018). For instance, it increases employees' difficulties focusing on tasks and the subsequent probability of medication errors, therefore endangering patient safety (Hoyle et al., 2018). Workplace violence also increases costs that result from hiring guards (Cebrino & De la Cruz, 2020; WHO, World Health Organization, 2018), installing metal detectors (Cebrino & De la Cruz, 2020) or related to injuries and sickness absences among staff (Hills, 2018; Hoyle et al., 2018).

What does this paper contribute to the wider global clinical community?

- The study provides an evidence-based overall picture to the workplace violence committed by clients and patients against social and health care staff and helps to identify a global, daily but still in silent kept problem.
- The results reveal many connections of the workplace violence committed by clients and patients to staff's well-being at work, work performance and commitment and underlines several developmental needs in leaders' activities to promote safe environment for staff and patients.
- The commitment to the systematic reporting of the workplace violence from clients and patients against social and health care staff is the primary act in proceeding into the development of uniform protocols and support at workplaces.

In recent years, literature reviews on encountering violence in social and healthcare have dealt with education and training for staff (Geoffrion et al., 2020; Tölli et al., 2017), the methods used to manage and prevent violence (Schmidt et al., 2019; Spelten et al., 2020) or the consequences of violence (Mento et al., 2020) and a link between changes in the nursing environment and the occurrence of violence (Spelten et al., 2020). None of the reviews were concerned with staff's well-being at work or leadership despite the critical role of leadership in building a safe and high-quality work environment, introducing new care practices, and promoting the well-being at work and health of nursing staff (Cummings et al., 2018).

2 | AIMS

The aim of this study was to compile, assess and synthesise empirical research on violence by social and healthcare clients or patients against staff and its connections to staff's well-being at work, implementation of work and the activities of leaders related to this. Research questions were:

1. What kind of violence do clients and patients commit against social and healthcare staff?
2. What kinds of connections does violence have on the well-being and the implementation of work of the staff?
3. What kind of support do nurses expect to receive from their leader when they encounter workplace violence by patient or clients?
4. How do leaders consider their opportunities for supporting their staff and which measures do they take?

3 | METHODS

3.1 | Design

The study followed Whittemore and Knafl's (2005) five-stage integrative review method to allow the inclusion of diverse study designs and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, PRISMA 2020 Checklist (File S1) in data search and collection (Page et al., 2021). The phases of Whittemore and Knafl's (2005) method are the identification of the research problems, data search and selection, the appraisal of the study quality, data extraction and analysis, and finally the synthesis of the results

3.2 | Search methods

A database search was carried out in the CINAHL, Scopus, PubMed and PsycINFO databases. After carrying out test searches and consulting an information specialist, the following search phrase was formed: (nurs* or 'nursing staff' or 'health personnel' or 'health care personnel' or 'healthcare work*' or 'social worker') AND ('workplace violence' or 'challenging behaviour') AND (lead* or manager* or 'head nurse' or 'charge nurse' or 'chief nurse' or 'managerial style'). The search was limited to peer-reviewed original research available electronically, conducted in English and published in the period 2015-2/2021. No limitations were set to the study design.

3.3 | Inclusion and exclusion criteria

The data included articles concerned with violence committed by patients or clients against employees, the harm caused by the violence to employees and/or leadership related to workplace violence or a threat thereof. Articles not concerned with workplace violence or focused on violence against only employee groups other than nurses or social workers working in social and healthcare services were excluded from the data. Further exclusion criteria were articles exclusively concerned with workplace bullying or other inappropriate behaviour among staff members and studies targeting doctors, nursing students or patients.

3.4 | Search results

The database search yielded 820 references (Figure 1). Two independently working researchers (JT & ST) participated in selecting data based on titles. They compared their respective results from the different phases of the selection process. In case of disagreement, the researchers discussed the selections and came to an agreement together. There was no need for consulting a third researcher in this context. If it was difficult to make a decision on whether to include an article in the data based on its abstract, the full text was read. Articles selected based on their titles (n = 271) were exported to RefWorks and any duplicates identified by the service (n = 159) were removed. The abstracts of these articles were read, based on which 152 full texts were selected. At this stage, articles published before 2015 were eliminated to ensure that this study can produce an up-to-date picture of the research topic. At this point, 25 articles retrieved from the CINAHL, 22 from Scopus, 18 from PubMed and 5 from PsycINFO were excluded, amounting to in total 74 articles. As a result, 78 articles remained for full text screening. Of these, 21 original studies were selected for quality appraisal.

3.5 | Quality appraisal

The quality appraisal process was carried out using the criteria developed by the JBI. Joanna Briggs Institute (2020) for various study designs. Qualitative studies (n = 9) and a mixed-methods study (n = 1) with a focus on qualitative methods were appraised using 10

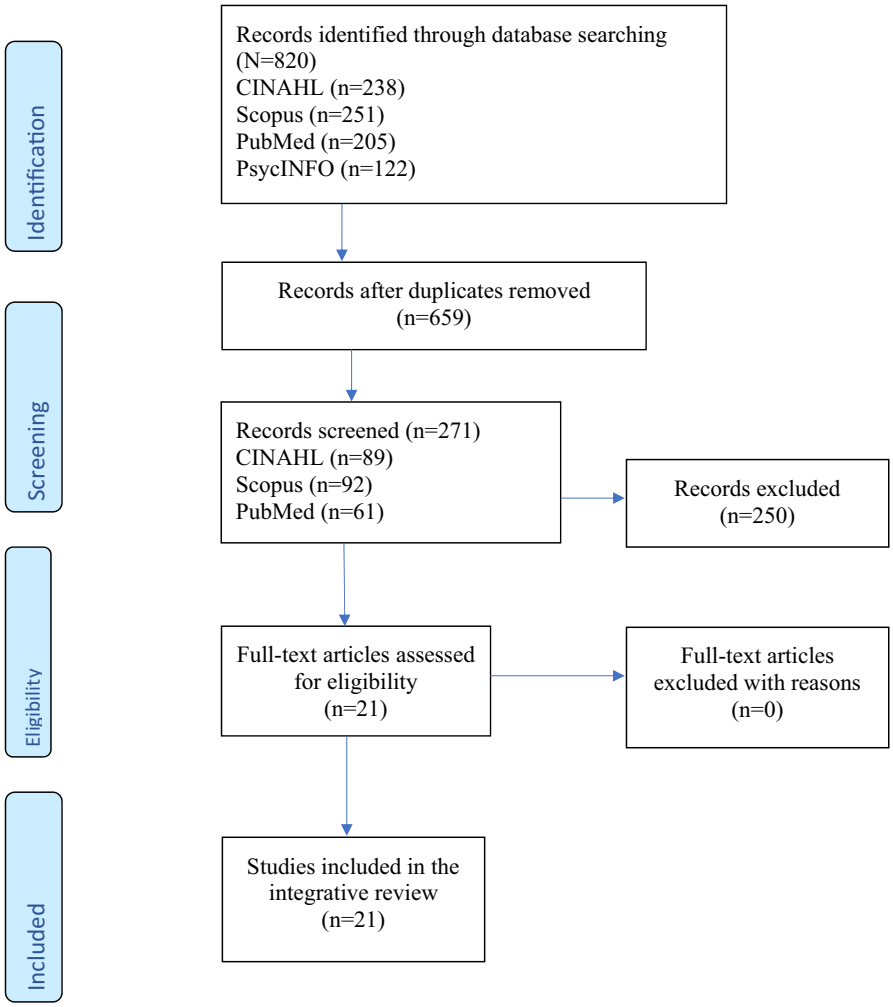

FIGURE 1 PRISMA flow chart of the literature search process

criteria, while cross-sectional studies ($n = 7$) and a participatory action research ($n = 1$) using eight criteria, and two correlation studies and one quantitative survey with eight criteria designed for prevalence studies. Two researchers worked independently to assess the quality of the studies and subsequently compared their appraisals. In case of disagreement, the researchers reassessed the related studies and decided on the appraisal together.

The scores given to qualitative studies ($n = 9$) ranged from 6/10 to 10/10 (Table S1). In all the qualitative studies, the methodology and research questions and the methodology and data collection methods were compatible. This was also the case with methodology and the interpretation of research. Quality was reduced by the impact of the researcher's cultural or theoretical background on the research and the assessment of the researcher's impact on the study. These had been only described in four studies (Heckemann et al., 2020; Morken et al., 2015; Najafi et al., 2018; Shafran-Tikva et al., 2017). The scores given to the cross-sectional studies ($n = 7$) and the participatory action research ($n = 1$) ranged from 4/7 to 7/8 (Table S1b). All the studies included a clear description of the target group and research setting as well as valid and reliable measurement of variables and use of applicable statistical methods. The quality appraisal was undermined by ignoring confounding factors. These had only been identified in two studies (Hemati-Ismael et al., (2018; Jeong & Kim, 2018). The scores given to correlation studies and quantitative surveys ranged from 5/9 to 7/9 (Table S1c). All the studies had used an appropriate sampling frame, adequate sample size, appropriate implementation of sampling and appropriate statistical methods. None of the studies had identified the clinical state of the research subjects and this had not been measured using a standardised and reliable tool (Eslamian et al., 2015; Hamzaoglu & Türk, 2019; Rayan et al., 2019). The validity of the studies was ensured with the quality appraisal, and as the aim was to form a versatile picture of the topic through different study designs, no studies were rejected based on the quality appraisal. As a result, the final data comprised 21 research articles.

3.6 | Data extraction and narrative summaries

Data from the studies selected for this review ($N = 21$) were extracted to a matrix designed for the purpose. The matrix was used to describe the authors, country and year of publication, purpose of study, data, research methods and key results of each article (Table S2). The results were analysed narratively (Whittemore & Knafl, 2005). They were read several times to form a comprehensive picture. When reading the materials, the data were reduced by

coding the original expressions related to the three research questions using different colours. The data were grouped, joined and categorised. Any discovered similarities or differences were combined into themes for each research question.

4 | RESULTS

4.1 | Description of the data

The studies selected for the final data ($N = 21$) had been published in the period 2015–2020, over half of them ($n = 13$) in the period 2018–2020. The sample sizes in the studies ranged from 13 to 4125 participants. Most ($n = 18$) of the studies described the experiences of social and health service staff on the issue. In addition to nurses, the studies included doctors, assisting staff, hospital safety coordinators and heads of unit. Only three articles described the leaders' own experiences. The research articles represented 13 countries and four continents: Asia (12), Australia (4), North America (1) and Europe (4). The studies published in Asia were from Iran (1), Israel (1), Japan (1), China (2), Korea (1), Saudi Arabia (2) and Taiwan (1). The study published in North America had been carried out in the United Sates, while the European studies had been implemented in Norway (1), Germany (1), Switzerland (1) and Turkey (1) (Table S2).

4.2 | Prevalence and manifestations of the violence committed by clients and patients

The prevalence and manifestations of violence by clients and patients against staff was discussed in 12 studies, three of which were qualitative (Beattie et al., 2018; Morken et al., 2015; Morphet et al., 2019), six cross-sectional studies (Alkorashy & Al Moalad, 2016; Hemati-Esmaeili et al. (2018); Jeong & Kim, 2018; Schablon et al., 2018; Zhang et al., 2017; Wu et al., 2020), two correlation studies (Eslamian et al., 2015; Rayan et al., 2019) and one quantitative questionnaire survey (Hamzaoglu & Türk, 2019).

Only four of the studies included quantitative examination of workplace violence and the results were similar particularly in relation to verbal violence. Verbal workplace violence had been experienced by nearly all (94%) respondents ($n = 1984$) in Schablon et al.'s (2018), over 85% of them in Hamzaoglu and Türk's (2019); $n = 234$) and all ($n = 42$) in Hemati-Esmaeili et al.'s (2018) study within the previous year. Fewer research participants had been subjected to physical workplace violence: nearly 70% in Schablon et al.'s (2018) study and 34% in Hamzaoglu and Türk's (2019) and 22% in Hemati-Esmaeili et al.'s (2018) study. In a study by Jeong & Kim (2018), 37% of research participants ($n = 214$) were subjected to nearly daily verbal violence by patients and 34% by patients' loved ones. Schablon et al. (2018) noted that workplace violence had increased between 10 and 20% in recent years compared to a study they had conducted in 2009. Due to the prevalence of workplace violence, staff considered this an everyday occurrence and part of their job (Morphet et al., 2018; Morphet et al., 2019; Schablon et al., 2018). Employees were particularly exposed to workplace violence when working with urgent care patients and geriatric and psychiatric clients (Morphet et al., 2019; Schablon et al., 2018).

Verbal workplace violence included both verbal abuse and offensive written texts, such as emails (Alkorashy & Al Moalad, 2016; Beattie et al., 2018). It was characterised by threats and insults (Schablon et al., 2018) and could also include racism (Rayan et al., 2019; Schablon et al., 2018). Physical violence included pinching, scratching, biting, hitting, kicking or the use of a weapon against staff members (Schablon et al., 2018). Social and healthcare employees also encountered sexual violence at work, which manifested as sexual harassment or assaults (Alkorashy & Al Moalad, 2016; Schablon et al., 2018).

4.3 | Connections of workplace violence to well-being at work and the implementation of work

The connections between perceived workplace violence and well-being at work as well as work itself were described in ten studies, two of which were qualitative (Beattie et al., 2018; Najafi et al., 2018), five cross-sectional studies (Chang et al., 2019; Hemati-Esmaeili et al., 2018; Jeong & Kim, 2018; Schablon et al., 2018; Wu et al., 2020), two correlation studies (Eslamian et al., 2015; Rayan et al., 2019) and one quantitative questionnaire survey (Hamzaoglu & Türk, 2019). The experienced workplace violence was connected to reduced psychological, emotional and physical well-being at work. Workplace violence also undermined work performance and commitment. In addition to experiencing workplace violence personally, witnessing violence towards a co-worker also had a negative connection to employee's well-being at work (Chang et al., 2019; Table 1).

The connections of workplace violence to negative experiences on well-being at work (Table 1) included stress (Jeong & Kim, 2018; Rayan et al., 2019; Schablon et al., 2018), post-traumatic stress reactions (Schablon et al., 2018), burnout (Beattie et al., 2018; Jeong & Kim, 2018; Rayan et al., 2019; Wu et al., 2020), decrease in motivation (Schablon et al., 2018) and depression (Najafi et al., 2018). The connections to emotional well-being at work included fear (Hemati-Esmaeili et al., 2018; Najafi et al., 2018; Schablon et al., 2018), a feeling of insecurity (Najafi et al., 2018; Wanda, 2015) and a belief that experiencing violence in the future was unavoidable (Hemati-Esmaeili et al., 2018). Loss of self-respect, self-blaming, mood changes, anger, restlessness, disappointment and humiliation were also reported (Hamzaoglu & Türk, 2019; Najafi et al., 2018). The connections of violence to physical well-being at work included sleep problems, chronic headache (Hamzaoglu & Türk, 2019; Najafi et al., 2018) and pains, and injuries requiring medical treatment (Schablon et al., 2018). Employees who had been subjected to psychological or physical workplace violence were suffering from psychological trauma (Hamzaoglu & Türk, 2019) and the impacts were common and lasted a long time (Najafi et al., 2018).

TABLE 1 The connections of violence committed by clients and patients against social and healthcare staff on well-being at work and work performance and commitment

Connections of workplace violence	Detailed descriptions of the connections	Designs and references
Psychological well-being at work	Stress	• Two cross-sectional studies (Jeong & Kim, 2018); Schablon et al., 2018) • Correlation study (Rayan et al., 2019)
	Post-traumatic stress reaction	• Cross-sectional study (Schablon et al., 2018)
	Fatigue	• Two cross-sectional studies (Jeong & Kim, 2018; Wu et al., 2020) • Qualitative study (Beattie et al., 2018) • Correlation study (Rayan et al., 2019)
	Loss of motivation at work	• Cross-sectional study (Schablon et al., 2018)
	Depression	• Qualitative study (Najafi et al., 2018)
	Burnout	• Two cross-sectional studies (Jeong & Kim, 2018; Wu et al., 2020) • Correlation study (Rayan et al., 2019) • Qualitative study (Beattie et al., 2018)
Emotional well-being at work	Discouragement	• Cross-sectional study (Jeong & Kim, 2018)
	Anger, distress, sadness, depression, disappointment	• Qualitative study (Najafi et al., 2018) • Cross-sectional study (Schablon et al., 2018)
	Helplessness	• Cross-sectional study (Schablon et al., 2018)
	Disappointment, humiliation, satisfaction, impatience, restlessness	• Qualitative study (Najafi et al., 2018)
	Fear	• Cross-sectional study (Schablon et al., 2018) • Two qualitative studies (Heckemann et al., 2020; Najafi et al., 2018)
	Insecurity	• Two qualitative studies (Najafi et al., 2018; Wanda, 2015)
	Loss of self-esteem, self-blaming	• Cross-sectional study (Jeong & Kim, 2018) • Case study (Hamzaoglu & Türk, 2019)
	Concern	• Qualitative study (Eslamian et al., 2015)
Physical well-being at work	Pain	• Cross-sectional study (Schablon et al., 2018)
	Chronic headache	• Case study (Hamzaoglu & Türk, 2019)
	Sleep difficulties	• Case study (Hamzaoglu & Türk, 2019)
	Injuries that need to be treated	• Cross-sectional study (Schablon et al., 2018)
Work performance	Less interaction with patients and staff	• Cross-sectional study (Schablon et al., 2018)
	Carefulness, increase in sensitivity	• Cross-sectional study (Schablon et al., 2018)
	Difficulty making decisions	• Qualitative study (Beattie et al., 2018)
	Decline in creativity	• Case study (Hamzaoglu & Türk, 2019) • Cross-sectional study (Jeong & Kim, 2018)
	Loss of professional self-esteem and work motivation	• Cross-sectional study (Schablon et al., 2018)
	Negative attitude towards work	• Cross-sectional study (Eslamian et al., 2015)
Work commitment	Increase in sickness absences	• Qualitative study (Beattie et al., 2018) • Cross-sectional study (Schablon et al., 2018)
	Increase in turnover intentions	• Three cross-sectional studies (Chang et al., 2019; Jeong & Kim, 2018; Wu et al., 2020)
	Early retirement	• Cross-sectional study (Jeong & Kim, 2018)

The connections of workplace violence on work performance (Table 1) included a decline in the employee's work motivation and professional confidence, a negative attitude towards work, a decline in creativity and interaction with patients and co-workers and increase in caution. (Schablon et al., 2018.) Workplace violence had also a connection to work commitment as it increased turnover intentions (Chang et al., 2019; Jeong & Kim, 2018; Najafi et al., 2018; Wu et al., 2020), sickness absences (Beattie et al., 2018; Schablon et al., 2018) and early retirements (Najafi et al., 2018).

4.4 | Expectations and experiences of leaders' activities on workplace violence

Nearly all the studies (n = 18) described the expectations and experiences of healthcare workers related to their leader's behaviour when staff had been subjected to violence by clients and patients (Table 2). The study designs used were qualitative in seven (Beattie et al., 2018; Morken et al., 2015; Morphet et al., 2018; Najafi et al., 2018; Rahmani et al., 2020; Shafran-Tikva et al., 2017; Wanda, 2015) and cross-sectional in eight studies (Alkorashy & Al Moalad, 2016; Chang et al., 2019; Hemati-Esmaeili et al., 2018; Jeong & Kim, 2018; Schablon et al., 2018; Shea et al., 2018; Wu et al., 2020; Zhang et al., 2017), and correlation study in one (Eslamian et al., 2015; Rayan et al., 2019) and a quantitative questionnaire survey in one study (Hamzaoglu & Türk, 2019).

The employees expressed disappointment and dissatisfaction with their leaders' activities in cases of violence committed by clients and patients against staff (Hamzaoglu & Türk, 2019). They felt that their leader had left them alone in coping with the situation (Morken et al., 2015) also in cases where the violence had been reported (Sato et al., 2016). The employees had been left traumatised as their leader had failed to prioritise their safety in these situations (Sato et al., 2016), instead only caring about the patients (Wanda, 2015). The employees called the reporting of workplace violence into question as this had resulted in no measures by the management (Heckemann et al., 2020; Hemati-Esmaeili et al., 2018; Wanda, 2015). On the other hand, the employees presumed that the leadership was unaware of the violence they had experienced as it failed to take measures (Wanda, 2015). If the employees felt that they had been supported by their organisation and leader, they felt safer at their workplace, which also had a positive impact on the quality of patient care (Morken et al., 2015).

The measures that employees felt that their leaders could take to support their well-being at work affected by workplace violence and a threat thereof were categorised into the leader's presence, ensuring a safe work environment, creating a safe operating culture and strengthening the staff's competence (Table 2). The employees wished that their leader would take the incidents seriously and take rapid measures as necessary (Morken et al., 2015). The leader was expected to encourage employees instead of blaming or condemning them (Chang et al., 2019). The employees expected their managers to treat them with respect (Chang et al., 2019) and provide them with protection (Chang et al., 2019; Wanda, 2015). Increasing staff's well-being required leaders to keep regular contact with the staff and be available to them in accordance with an 'open door' policy (Beattie et al., 2018).

The responsibilities of the leader in ensuring a safe work environment were considered to include the assessment of the employees' work environment, ensuring that these are designed to promote the prevention of violence (Zhang et al., 2017) and the procurement of tools supporting safety and security, such as alarm systems (Morken et al., 2015; Morphet et al., 2018). Prohibiting violence is part of a safe operating culture (Hamzaoglu & Türk, 2019). The leader's tasks were also considered to include preparing safety strategies and plans to prevent workplace violence (Alkorashy & Al Moalad, 2016; Chang et al., 2019; Eslamian et al., 2015; Hamzaoglu & Türk, 2019; Jeong & Kim, 2018; Najafi et al., 2018; Rayan et al., 2019; Sato et al., 2016; Schablon et al., 2018; Wanda, 2015) and identifying (Najafi et al., 2018) and eliminating (Chang et al., 2019; Morken et al., 2015) the risk factors of violence.

The identification of the risk factor was complicated by the incomplete reporting of workplace violence (Beattie et al., 2018; Hamzaoglu & Türk, 2019; Morphet et al., 2019), which was considered to result from a failure to take measures when violence had been reported (Hamzaoglu & Türk, 2019; Hemati-Esmaeili et al., 2018; Wanda, 2015). The staff also left workplace violence unreported out of fear of negative consequences (Hamzaoglu & Türk, 2019) or a worry that their leader or co-workers would label them unqualified (Schablon et al., 2018) or as their leader was busy (Wanda, 2015). On the other hand, the employees were aware of the fact that their leadership would not know about the workplace violence unless they reported it (Wanda, 2015). Employees expected that their leader would create a simple, accessible and non-blaming protocol for reporting workplace violence that clients and patients have committed against employees (Chang et al., 2019; Hamzaoglu & Türk, 2019; Morphet et al., 2018). Employees also expected their leader to strengthen their motivation to manage workplace violence (Wanda, 2015) and guide the employees to familiarise themselves with violence prevention programmes (Shea et al., 2018), as they were not necessarily aware of these (Shafran-Tikva et al., 2017). In addition, employees expected their leaders to encourage staff to report workplace violence (Jeong & Kim, 2018), make sure that debriefing was organised (Morken et al., 2015; Shea et al., 2018; Wu et al., 2020) and provide the staff with an opportunity to discuss any feelings stirred by the violence (Jeong & Kim, 2018) and create a zero-tolerance policy for workplace violence (Alkorashy & Al Moalad, 2016).

To strengthen employees' competence, leaders were expected to organise training interventions to reduce workplace violence (Morphet et al., 2019) and other safety training for staff (Beattie et al., 2018; Eslamian et al., 2015; Jeong & Kim, 2018; Rahmani et al., 2020; Schablon et al., 2018; Shafran-Tikva et al., 2017; Shea et al., 2018). A need for preparing for traumatic situations and the emotions stirred by them was also recognised (Beattie et al., 2018). (Table 2.)

4.5 | Leaders' experiences of workplace violence situations

Only three of the qualitative interview studies (Heckemann et al., 2020; Morphet et al., 2019; Sato et al., 2016) discussed leaders' own experiences of workplace violence committed by clients and patients against staff. The studies found that leaders found this form of workplace violence challenging, were aware of the risks faced by their staff and their own responsibility (Morphet

TABLE 2 Leaders' activities in cases of workplace violence by patients or clients against staff

Activities in cases of workplace violence	Detailed descriptions of the activities	Designs and references
Leaders' presence	Supporting staff before and after the incident	• Two qualitative studies (Beattie et al., 2018; Wanda, 2015) • Cross-sectional study (Shea et al., 2018)
	Taking the situations seriously and reacting to them	• Qualitative study (Morken et al., 2015)
	Encouragement without blame	• Cross-sectional study (Chang et al., 2019)
	Respect and protection	• Cross-sectional study (Chang et al., 2019) • Qualitative study (Wanda, 2015)
	Regular contacts with staff	• Qualitative study (Beattie et al., 2018)
Leading safe work environment	Safety planning in the work environment	• Cross-sectional study (Zhang et al., 2017)
	Preparing strategies and prevention plans	• Five qualitative studies (Alkorashy & Al Moalad, 2016; Eslamian et al., 2015; Najafi et al., 2018; Sato et al., 2016; Wanda, 2015) • Three cross-sectional studies (Chang et al., 2019; Jeong & Kim, 2018; Schablon et al., 2018) • Case study (Hamzaoglu & Türk, 2019) • Correlation study (Rayan et al., 2019)
	Creating a reporting system	• Cross-sectional study (Chang et al., 2019) • Case study (Hamzaoglu & Türk, 2019) • Qualitative study (Morphet et al., 2018)
	Creating zero tolerance	• Qualitative study (Alkorashy & Al Moalad, 2016) • Case study (Shafran-Tikva et al., 2017)
	Identification and elimination of risk factors	• Qualitative study (Najafi et al., 2018)
Creating a safe operating culture	Introducing safety protocols into practice	• Cross-sectional study (Shea et al., 2018)
	Creating a positive work environment	• Cross-sectional study (Wu et al., 2020)
	Encouraging employees to report violence	• Cross-sectional study (Jeong & Kim, 2018)
	Ensuring the implementation of debriefing	• Cross-sectional study (Wu et al., 2020)
	Strengthening communications	• Cross-sectional study (Jeong & Kim, 2018)
Strengthening staff competence	Organising safety training	• Two qualitative studies (Beattie et al., 2018; Eslamian et al., 2015; Rahmani et al., 2020) • Three cross-sectional studies (Jeong & Kim, 2018; Schablon et al., 2018; Shea et al., 2018) • Case study (Shafran-Tikva et al., 2017)
	Providing training on the impacts of trauma	• Qualitative study (Beattie et al., 2018)

et al., 2019) and felt stressed and faced an ethical conflict related to the issue as they were responsible for both the patients' and their employees' safety (Sato et al., 2016). While leaders considered the prevention, extinguishment and aftercare of the workplace violence committed by clients and patients against staff as an important area of leadership, they had not been trained in the matter or received support from their own organisation. Leaders also questioned the relevance of reporting workplace violence as it had not led to any measures by executive management. Workplace violence was not considered acceptable, but it was part of the managers' day-to-day work (Heckemann et al., 2020).

5 | DISCUSSION

5.1 | Consideration of results

The studies included in this review were concerned with workplace violence by clients and patients against staff from the viewpoint of the employees working close to them. There was little research available concerning nurse leaders in this context event though their role is known to be important in creating a work environment and culture promoting patient and occupational safety (Baptista et al., 2015; Cummings et al., 2018). Similarly, as employees, nurse leaders felt

that this was a difficult topic and caused different kinds of strain on their well-being at work. These results support previous research on the topic (Baptista et al., 2015) have found out that nurse leaders experience demanding the struggle for finding a balance between the health of staff and patient safety in the cases of workplace violence by clients and patients.

Based on this review, there was a difference between leaders' and employees' views on the reactions to workplace violence by patients and clients against staff. According to employees, leaders are either unaware of or indifferent to the violence staff endures and, as a result, fail to take measures to promote safety at work, instead, only caring about the patients and perceiving workplace violence as part of nurses' work. Meanwhile, leaders noted that they were aware of the violence that employees are subjected to and their own responsibility in protecting employees. According to a study by Bromley and Painter (2019), due to insufficient reporting, leaders may not be fully aware of the amount and frequency of violence occurring in their work unit or the trauma this causes to staff. This finding emphasises the importance of interaction between staff and leadership and shows that more attention must be paid to this in the future. Having a shared view of how violence occurs in workplaces and the approaches used to intervene in workplace violence is meaningful for a sense of security among staff as well as patient safety. Leaders' workloads are also likely to be reduced if their views and challenges related to mitigating violence are made known in joint discussions, increasing employees' understanding of their leaders' choices. The leader's presence at a unit during or after a violent incident brings visibility to the situations and enables sharing observations and supporting employees subjected to violence. Leaders are expected to independently do their part in preventing new high-risk incidents. If a leader fails to show their support, express concern, have awareness of challenges related to safety and fail to engage in open discussion about violent incidents with staff, there is a negative impact on nurses' well-being at work, work performance and intentions to leave the profession. (Bromley & Painter, 2019.)

Previous studies (Bromley & Painter, 2019; Stene et al., 2015) strengthen the results of this review on how employees get acclimatised to workplace violence and experiencing it as an everyday occurrence that is part of their job. According to Stene et al. (2015) and Bromley and Painter's (2019), employees feel that they can only control their own behaviour, not that of others, and that violence has been accepted for too long, employees have been desensitised to it and no investments have been made in preventing it. However, changes in attitudes have also been observed (Chang et al., 2019; Stene et al., 2015). Nursing staff is less likely to hide their emotions as before. They perceive workplace violence as an occupational issue and particularly those with longer work experience wish that their work would be appreciated in this context. Even though workplace violence occurs in social and healthcare settings, it should not be considered acceptable (Stene et al., 2015).

The results of this review on the lack of reporting workplace violence as well as the experiences of employees working closely with patients and their leaders both show that the issue is stigmatised and often hushed up in work communities. This trend was also identified in the cross-sectional study among nurses in five European countries (Babiarczyk et al., 2020). According to previous research, up to 88% of workplace violence cases remain unreported (Gillespie & Leming-Lee, 2019). Nurses do not report the workplace violence they are exposed to as they believe that treating aggressive patients is part of their duties, reporting takes too much time (Bromley & Painter, 2019) and they feel that reporting will not lead to preventing violence (Babiarczyk et al., 2020; Bromley & Painter, 2019; Spelten et al., 2020). According to a study by Lanza et al. (2011), organisations may also fear negative repercussions on their reputation if the prevalence of workplace violence was revealed. Indeed, the present review indicates that one of the most important tasks of the leader involves encouraging staff to report workplace violence. When workplace violence goes unreported, it is more difficult to determine what caused it, prevent and manage further incidents and provide debriefing sessions and, ultimately, support the well-being at work and work performances of staff. Experienced workplace violence may have long-term effects that can emerge as narcotics use, increased alcohol consumption, mental health issues, self-destructive thoughts, depression and anxiety (Lanza et al., 2011; Mento et al., 2020). Discussing the reports at workplaces and open conversations on potential solutions promote addressing workplace violence committed by patients and clients against staff in work communities and promotes patient safety.

Based on this review, the most typical form of workplace violence by clients and patients is verbal abuse. The result is in line with previous research (Babiarczyk et al., 2020; Edward et al., 2014; Stene et al., 2015). National and cultural factors have been found to be connected to the manifestations of violence and how this is regarded (Babiarczyk et al., 2020; Laeeque et al., 2019; Rahmani et al., 2020), and social and healthcare leaders should be aware of these. Tools used for preventing, monitoring and managing workplace violence must be implemented at the national level (Babiarczyk et al., 2020; Najafi et al., 2018) to provide good and uniform protocols for dealing with workplace violence cases and ensure that employees and managers do not feel left alone in these situations. More research is needed to prepare such protocols.

The results of this review on the prevalence of workplace violence in certain units, such as in urgent care and geriatric and psychiatric wards support the findings of a previous review (Babiarczyk et al., 2020; Mento et al., 2020) and a study concerning 10 European countries (Edward et al., 2014) pointing out that it is important to particularly pay attention to workplace and patient safety in those sectors with considerable prevalence. Caution should be exercised in examining the results on the prevalence and manifestation of workplace violence by clients and patients against staff, as the sensitive nature of the topic and difficulties concerning reporting may distort the overall picture. Few of the studies examined in this review concerned this issue and the level of evidence was low due to deficient study designs. There is therefore need for further research on the topic.

Similarly, as in previous research, this review found that training interventions related to safety at work and the processing of work-related trauma provide an important tool for reducing workplace violence. Training that involves strengthening empathy and emotional intelligence or looking at situations through the patient's eyes is particularly beneficial for employees who repeatedly encounter violence by patients. This is as recurrent workplace violence committed by patients may reduce empathy among staff due to exhaustion. (Laeeque et al., 2019.) In their study, Bromley and Painter (2019) present an optimal staff training model that includes both violence prevention and interactive sections. Employees should develop or increase their competence related to encountering an agitated patient, which may include confusion, suspicions and verbal or physical threats. Intervening in a timely manner can mitigate violence. An ability to identify such situations enables staff to assess patients and disclose critical information to the next care provider. Training on preventing violence should be included in new employees' job orientation. (Bromley & Painter, 2019.) In this review, employees provided several concrete suggestions for preventing workplace violence against staff. These suggestions should be taken into consideration as they improve leaders' activities and promote a safe work environment and an operating culture that supports this.

5.2 | Strengths and limitations

Omitting grey literature, excluding articles published before 2015 and focusing search on the studies including leaders' activities can be considered limitations of this review. However, the database searches showed that research on this topic has only been more active very recently. The final data included studies from around the world. As a result, it can be presumed that this review was able to reach the most essential findings from research on the topic. The topic was discussed from different viewpoints in the articles. Some of them, such as the experiences of nurse leaders and the prevalence of the workplace violence committed by clients and patients, had only been explored in a few studies. Especially the fact that the prevalence of the workplace violence was considered based on the studies dealing with leadership issues deviates the result. The review focusing solely on it, would provide more reliable and accurate picture of it. The level of evidence in the studies remains low as the evidence was based on individual qualitative or cross-sectional studies. The studies were self-assessments of the topic being a further limitation of this review.

6 | CONCLUSION

The review provides an evidence-based overall picture to the workplace violence committed by clients and patients against social and health care staff from the viewpoint of the leadership and helps to identify a global, daily but still in silent kept problem. The most salient data from the review focused on the connections of the workplace violence to employees' well-being at work, work performance and commitment and on the measures that the leaders should take over. The workplace violence committed by clients and patients burdens staff, reduces their well-being at work and work performance, and increases intentions to leave. The employees expressed disappointment with their leaders' activities and suggested many measures to make environment safer for them and patients. The measures that the employees suggested were the leader's presence, ensuring a safe work environment, creating a safe operating culture and strengthening the staff's competence. Most of all, the workplace violence by clients and patients against social and health care staff must be made visible by reporting it. The lowest evidence was received of the experiences of the leaders. The leaders found this form of workplace violence challenging and ethically conflicted and felt that they were left alone without training and support.

Due to the low level of research evidence, the topic should be explored further. Besides to employees' experiences, which were the main source of the information in this review, more data are needed from the perspectives of the leaders and the organisations. Further studies should be conducted on the tools and on the uniform protocols for reporting, monitoring, preventing and managing workplace violence. A simple, systematic and nationally common way of reporting enables the use of registers in further studies to identify workplace violence among organisations in more comparable and reliable way. The registers should also be used in addition to self-assessment tools to provide more accurate information of the effectiveness of the measures. There is a particular need for intervention studies on the ways to prevent workplace violence by patients and clients against social and healthcare staff and for supporting the well-being at work of staff in relation to violent incidents.

7 | RELEVANCE TO CLINICAL PRACTICE

The commitment to the systematic reporting of the workplace violence from clients and patients against social and health care staff is the primary act in proceeding into the development of uniform protocols and support at workplaces. Employees and leaders need encouragement and support of their executive management for the reporting. Reports of the workplace violence must be taken seriously. Employees and leaders need to see what kind of measures the reports lead to concerning their well-being at work and patient safety. An open, unblamed dialogue and the debriefing situations of the violence cases with leaders and co-workers are of high importance. The measures that the employees suggested in this review to their leaders were very concrete and are as such easy to implement in the organisations by the support of the organisations' executive management. Organisations' executive management must also take responsibility of the development of the reporting systems and managing protocols of workplace violence committed by clients and patients. Special attention must be paid to the work settings where the prevalence of violence is

potential. The collaboration on workplace violence issues at national level is important.

Leaders and the staff need to be trained in preventing and processing workplace violence cases. Leaders need also training on the strategic development of safe workplaces and patient safety practices. Poor capabilities of leadership to prevent and intervene in workplace violence and provide aftercare further reduces the coping of employees. Having a shared view of how violence occurs in workplaces and the approaches used to intervene in workplace violence is meaningful for a sense of security among staff as well as patient safety.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

DATA AVAILABILITY STATEMENT

The data are available as it consist of previously published articles. The articles are declared in the references list of our review.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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