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Nurses' experience of workplace violence

A descriptive review

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Abstract

Background: Workplace violence (WPV) is a common and widespread phenomenon among the health care workers. The health care workers are at high risk of workplace violence, and nurses are among the most affected group. In recent years, workplace violence is an increasingly prominent problem in the health industry. Understanding nurses' experiences of workplace violence is of great significance to prevent and deal with WPV.

Aim: To describe the nurses' experiences of workplace violence.

Design: A descriptive review of qualitative studies.

Method: All scientific articles were searched in the databases PubMed and CINAHL. The selected articles were read and process carefully several times to determine the similarities and differences of nurses' experience towards workplace violence.

Results: A final total of 11 articles were included in the review. Three themes were derived from the findings: 1) Nurses' experiences of workplace violence's characteristic; 2) Nurses' experiences of workplace violence's risk triggers; 3) Nurses' experiences of workplace violence impacts on nurses' life.

Conclusions: Nurses were a vulnerable group and played an important role in the medical system. Nurses were targets for workplace violence. Workplace violence not only caused negative emotion, but also influenced the way of future personal and career development for nurses. Based on nurses' experience of workplace violence, mangers would realize that there were great obstacles to overcoming workplace violence and that more efforts were needed. Mangers would be able to know nurses' experiences and found the risk triggers of workplace violence and provide useful advice.

Key words: Experience, Nurses, Workplace violence.

摘要：

背景：职场暴力(WPV)是医护人员中普遍存在的现象。医护人员是工作场所暴力的高危人群，护士是受影响最严重的人群之一。近年来，职场暴力是卫生行业日益突出的问题。了解护士职场暴力的经历，对预防和处理职场暴力具有重要意义。

目的：描述护士在工作场所遭受暴力的经历。

设计：定性研究的描述性综述。

方法：在 PubMed 和 CINAHL 数据库中检索所有科学论文。对所选文章进行多次仔细阅读和加工，以确定护士经历工作场所暴力的异同点。

结果：最后共有 11 篇文章被纳入综述。从研究结果中得出三个主题：1） 护士对职场暴力的特征的经历；2） 护士对职场暴力的危险诱因的经历；3） 护士关于职场暴力对护士生活的影响。

结论：护士是一个弱势群体，在医疗系统中起着重要的作用。护士是工作场所暴力的目标，工作场所的暴力不仅会造成负面情绪，还会影响护士的个人和职业发展。根据护士职场暴力的经历，管理者将认识到克服职场暴力存在很大障碍，需要作出更多努力。管理者应该了解护士的经历，发现职场暴力的危险诱因，并提供有用的建议。

关键词：经历，护士，职场暴力。

Content

1. Introduction

Workplace violence (WPV) is a common and widespread phenomenon among the health care workers (Fute *et al.*, 2015). The health care workers are at high risk of workplace violence, and nurses are among the most affected group (WHO, 2018). About seventy-six point three percent nurses reported personal experience of WPV (Fafliora *et al*., 2015). Nurses are a vulnerable group (Shi *et al.*, 2017). The nurses are victims of all kinds of workplace violence, including physical violence, psychological violence and sexual harassment, and their colleagues and superiors do not show support and trust in them (Yang *et al*., 2018). Therefore, hospitals need to improve the ability of nurses to cope with and prevent workplace violence, also strengthen the training and management of nurses to reduce the physical and psychological harm caused by WPV (Shi *et al.*, 2017).

1.1 Definition

1.1.1 Definition of workplace violence

The workplace violence is defined by International Labour Organization (ILO) as an event in which a worker is subjected to abuse, threat or attack in relation to his/her work, including a clear or hidden challenge to his/her safety, happiness or health (ILO, 2002). According to the National Institute for Occupational Safety and Health (NIOSH), WPV is defined as any attribute of violence, including threats and physical violence against staff on duty (NIOSH, 1996).

1.1.2 Definition of nurses and experience

Nurses are a group that uses clinical judgment to provide nursing measures, enable people to improve, maintain or recover health (RCN, 2003). Experience is an impressive event that has happened to people (Oxford Living Dictionaries, 2018).

1.2 Prevalence of workplace violence

The incidence of violence in different countries was different (Spector, Zhou & Che, 2014). Shea *et al.* (2017) study showed that 67% of respondents experienced WPV in the past 12 months in Australia (Shea *et al.*, 2017). In Southern Ethiopia, about 1/3 of nurses had experienced various forms of workplace violence at least once in the past six months (Fute *et al.*, 2015). Shi *et al.* (2017) study showed that during the 12-month study period, 10502 nurses in China had experienced WPV, with a total prevalence of 65.8 percent (Shi

et al., 2017). Over the past year, 44% of respondents had experienced WPV several times and 6% experienced WPV every month (Shea *et al.*, 2017). In a word, workplace violence was common in the work of nurses.

1.3 Management of workplace violence

In view of the occurrence of workplace violence, the following countermeasures had some guiding significance for how to prevent and respond to workplace violence.

At the individual level, most nurses were willing to receive psychological education and practical skills training to improve their communication skills (Yang *et al*., 2018). For their safety, nurses thought hospitals should provide 24-hour police service for them because they felt that tall and strong security personnel brought in an important sense of security that made them less afraid of violence in the workplace (Abed & Sobers-Grannum, 2016). What's more, mutual understanding and respect could help to establish a friendly nurse-patient relationship, and reduce the incidence of violence in the workplace (Shi *et al*., 2017). The last but not least, nurses could learn to use law to protect themselves (Xing *et al*., 2016).

At the organizational level, organizations should provide adequate personnel and facilities to facilitate emergency services to patients (Shi *et al.*, 2018). Also, hospitals should actively deal with medical disputes and eliminate negative effects as soon as possible (Xing *et al*., 2016). What's more, managers needed more formal professional education for nurses. For example, hospitals could provide violence-related training to nurses and provided psychological support or counselling rooms for nurses who had experienced workplace violence, instructing nurses to understand their values and develop pride and reduce their negative emotions (Shi *et al.*, 2017).

At the government level, strengthen supervision as a supportive strategy had a great positive impact (Yang *et al*., 2018; Xing *et al*., 2016). The negative report of media also affected the relationship between nurses and patients. Therefore, the government should strengthen supervision over the media to ensure the accuracy and authenticity of media reports (Shi *et al.*, 2017). Meanwhile, the government should step up punishment for superficial and erroneous reporting of medical disputes (Shi *et al*., 2017).

1.4 Nurses' role in workplace violence

When nurses provide care for patients, they assume multiple roles. These roles often exist at the same time (Kozier *et al.*, 2012).

1.4.1 The role of caregiver of nurses in WPV

The role of caregivers traditionally takes care of patients from physiological and psychological aspects while preserving their dignity (Kozier *et al*., 2012). From psychological aspect, some patients may be aggressive. Patients may hurt themselves or hurt the people around them. The nurses are the kind of person who came in close contact with them and provided care for them. Thus, nurses will be the easiest to threaten by workplace violence.

1.4.2 The role of communicator of nurses in WPV

As a role of a communicator, communication is indispensable in any nursing role (Kozier *et al.*, 2012). Effective communication is an important factor affecting the quality of nursing work (Kozier *et al.*, 2012). Although some patients may express aggression, nurses should communicate with them to reduce workplace violence. It may maintain the relationship between nurses and patients and improve the quality of nursing.

1.5 Nursing Theory—Roy's adaption model

Nursing is an applied discipline. The Roy's adaptation model provides a way to acquire professional knowledge (Roy, Whetsell & Frederickson, 2009). The Roy's theory regard person as a constant and integral adaptation system, participating in the interaction between the internal and external environment to achieve different adaptation results (Roy, 2009). Roy's theory can improve adaptability and enhance transformation between person and environment (Alligood, 2014). As a professional, nurses use their expertise to contribute to the demands of society for health and well-being (Roy, Whetsell & Frederickson, 2009). In addition to the concepts of Roy's theory model, the concept of person, environment, health, nursing in nursing is also identified (Roy, 2009). As an open life system, nurses may accept stimuli from the environment (Alligood, 2014). These adaption results may be large or small, negative or positive (Alligood, 2014).

In this study, nurses accept stimuli from environment, such as different types of workplace violence. However, when nurses react positively to workplace violence in hospitals, nurses may adapt to workplace violence, and adaptive responses to workplace violence promote nurses to become healthy individuals. On the contrary, if nurses react ineffectually to workplace violence, they may be depressed for a long time in this violent environment, which may make nurses' psychology unhealthy.

1.6 The early review of workplace violence

Some authors did reviews about workplace violence. In Schablon's cross-sectional review, it described the prevalence of workplace violence towards nursing and care staff in Germany (Schablon *et al.,* 2018). The results of Schablon's cross-sectional review showed that the prevalence of physical and verbal violence had increased compared with the study in 2009 and workplace violence was part of the daily work lives of many nurses (Schablon *et al.,* 2018). Kowalenko *et al.* (2012) study's objective was to identify the incidence of Emergency Department (ED) workplace violence and there was evidence that nurses working in the emergency department were more vulnerable to violence and physical assault than other nurses (Kowalenko *et al.,* 2012). Nikathil's systemic review aimed to explored the association of WPV to drug and alcohol exposure in the emergency department and showed that one in two victims of violence was related to drugs and alcohol (Nikathil *et al.,* 2017). The three reviews included in this study were the results of quantitative researches.

1.7 Problem statement

In recent years, workplace violence was an increasingly prominent problem in the health industry. The incidence of workplace violence in the health care workplace was very high in any country. Some management ignored the preventive measures against workplace violence and others suggested measures to respond to workplace violence.

Many researchers had paid the attention to workplace violence and had done some research on it. Earlier reviews showed that nurses were at high risk of workplace violence and the rates of workplace violence varied depending on the violence type and employment setting. Especially in emergency department, the incident of workplace violence reached a new height. However, earlier reviews focused on the prevalence of workplace violence or single risk influenced the prevalence of workplace violence. Experienced with workplace violence among nurses were rarely reviewed. Therefore, this review of qualitative papers may provide information on nurses' experiences of workplace violence in order to provide evidence for clinical interventions and better understand their professional and personal responses.

1.8 Aim and specific question

The aim of the study was to describe the nurses' experiences of workplace violence.

What experience did nurses have towards workplace violence in their work?

2. Method

2.1 Design

A descriptive review was used (Polit & Beck, 2017).

2.2 Search strategy

Electronic searches were undertaken in order to access total articles published in PubMed, CINAHL, with certain limits, see Table 1 and Figure 1. The search terms were "Workplace violence", "Nurse", "Experience" different combinations with each other. The Boolean term AND was used, because it could combine the search terms (Polit & Beck, 2017). Indexed search terms were fetched from MeSH and Cinahl headings. MeSH provided consistent methods for retrieving different terms of the same concept (Polit & Beck, 2017). Authors could explore the database's thesaurus' structure to get additional search leads in CINAHL (Polit & Beck, 2017).

The search term "nurse" uesd in MeSH, but the result came 10 articles. So authors changed to use the free text to expand the articles in PubMed. This search was restricted to papers that were published from January 2008 to December 2018.

Table 1. Results of preliminary database searches.

Database	**Limits and search date**	**Search terms**	**Hits**	**Possible Articles (excluding doubles)**
Medline via PubMed	2008-2018, English, University of Gävle, 2018-5-15	"Workplace violence" (MeSH)	409	
Medline via PubMed	2008-2018, English, University of Gävle, 2018-5-15	"Experience" (free text)	206796	
Medline via PubMed	2008-2018, English, University of Gävle, 2018-5-15	"Nurses" (free text)	67578	

Medline via PubMed	2008-2018, English, University of Gävle, 2018-5-15	“Workplace violence” (MeSH) AND ”Experience” (free text) AND “Nurses” (free text)	32	17
Cinahl	2008-2018, English, Peer review, 2018-5-15	“Workplace violence” (Heading)	1413	
Cinahl	2008-2018, English, Peer review, 2018-5-15	“Nurses” (Heading)	10499	
Cinahl	2008-2018, English, Peer review, 2018-5-15	“Workplace violence” (Heading) AND ”Experience” (free text) AND “Nurses” (Heading)	21	14
				Total 31

2.3 Selection criteria

Inclusion criteria: Empirical studies. Articles from nurses’ perspective; Articles were relevant for the aim of the review study (nurses’ experiences of workplace violence); Articles were used a qualitative approach, because this approach might be closer to the subject of our study.

Exclusion criteria: Articles that the participants were not nurses or nurses who had not experienced workplace violence; The content of articles was not relevant to the aim of the study; Articles were review study or quantitative study.

2.4 Selection process

The authors were careful during the whole selection process. The articles excluded after review of title and abstract, the remaining articles were 31 articles (PubMed: 17; Cinahl: 14). Then, according to the relevance for inclusion criteria, aim and specific questions, authors added 2 more articles from the reference of the selected articles. Through screening duplicates, 2 duplicates were found. After removing 2 duplicates, the remaining articles were 31 articles. Among the rest of 31 articles, authors read the full

text carefully, then deleted 5 articles with no nurses' experience, 2 articles without workplace violence, 12 articles of quantitative study and 1 article of review. Finally, the authors eventually adopted 11 articles.

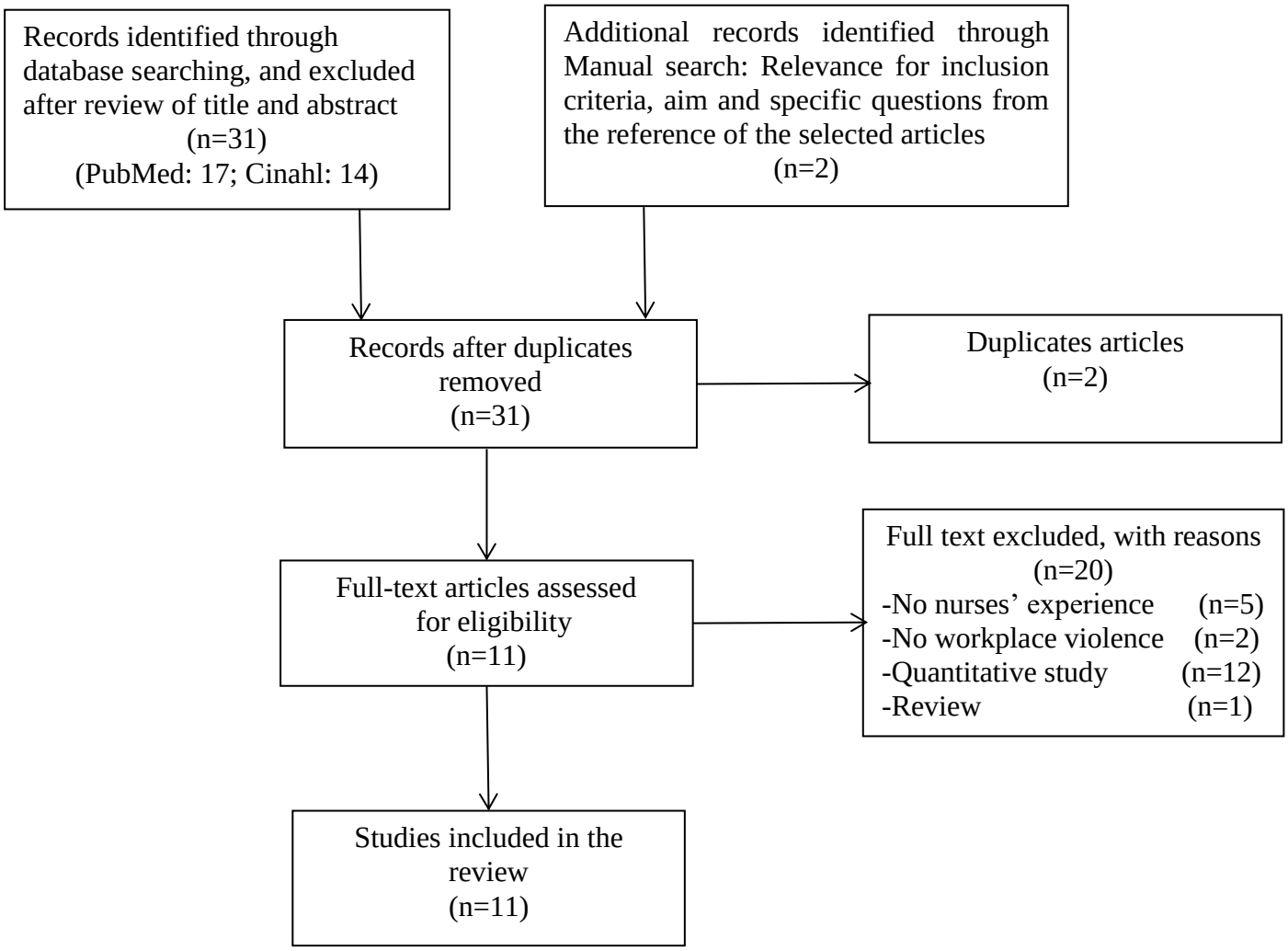

Figure 1: Flow chart of the systematic literature search

2.5 Data analysis

Each selected article was marked with an alphabet code to facilitate the analysis of the findings (A-K) (Appendix 1) (Lommi *et al*., 2015). The authors abstracted key descriptive details of the included studies, included selected articles' authors, titles, designs/possibly approaches, participants, data collection methods and data analysis methods, see appendix 1. Authors read and re-reading the "results" or "findings" section of each article, then listed the results of each article in appendix 2 and numbers the results. According to Polit & Beck (2017), this process could made it easier for authors to summarize each topic and identify the categories under each topic to help authors

complete the review. Any disagreement between the authors was resolved through discussion. After a deeper analysis, three themes were clarified, classified the findings according to similarity in the sense of meaning, integrated these categories and analyzed them to form a comprehensive findings (Joanna Briggs Institute, 2014).

2.6 Ethical considerations

The articles had been read and commented objectively, without the influence of the authors' opinion and attitude. The degree project was free from plagiarism. These cited articles did not change the actual results or meanings of the articles according to the authors' wishes.

3. Results

The results were based on 11 articles, which were qualitative studies. The articles presented nurses' experiences of workplace violence. The themes and sub-themes of the results were presented in Table 2. Three themes were summarized as nurses' experience of workplace violence: 1) Nurses' experiences of workplace violence's characteristic; 2) Nurses' experiences of workplace violence's risk triggers; 3) Nurses' experiences of workplace violence impacts on nurses' life.

Table 2 The themes and sub-themes of the results

Themes	Sub-themes
Nurses' experiences of workplace violence's characteristic	Violence was unexpected
	Violence was normal
Nurses' experiences of workplace violence's risk triggers	Nurse-related triggers
	Patient-related and patients' relatives triggers
	Organizational triggers
Nurses' experiences of workplace violence impacts on nurses' life	Impact on nurses' emotional changes
	Impact on nurses' relationship changes
	Impact on nurses' attitude to change

3.1 Nurses' experiences of workplace violence's characteristic

3.1.1 Violence was unexpected

Some nurses thought workplace violence was unpredictable and occurring suddenly (Yang *et al.*, 2016). Some nurses indicated that violence could happen even if no one wanted violence to happen, especially in the medical environment (Baby *et al.*, 2014). They found that even though the early warning signal was more obvious, the lack of identification experience prevented them to discover the cues of violence (Wolf, Delao & Perhats, 2014). In the other aspect, though the nurses thought they had enough experience for caring for violent patients, it was unexpected every time with no warning signs of an attack (Yang *et al.*, 2016).

3.1.2 Violence was normal

This part reflected the nurses' perception about workplace violence. Seven studies

reported workplace violence was a part of working (Baby *et al.*, 2014; Han *et al.*, 2017; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). Nurses reported that it was a common occurrence that nurses who came to the post all experienced more or less different types of violence (Stevenson *et al.*, 2015). Some nurses thought experiencing workplace violence was a normal state (Ramacciati, Ceccagnoli & Addey, 2015).

3.2 Nurses' experiences of workplace violence's risk triggers

3.2.1 Nurse-related triggers

The increase in violence was linked to many factors. Some nurses found they were not only victims but also triggers, such as the differences among nurses' personality traits, professional expertise (Baby, Glue & Carlyle, 2014). In terms of the personality differences, Najafi *et al.* (2018) study showed that some nurses were easily fly into a rage and had poor stress management, which increased the incidence of workplace violence (Najafi *et al.*, 2018). In terms of the professional expertise, some nurses felt they might be lack of adequate clinical competence, which induced delayed in giving appropriate care (Najafi *et al.*, 2018). Based on the some nurses' view, they might be lack of care, responsibility or empathy. For example, while patients were under stress and nurses were laughing and telling jokes with their co-workers (Najafi *et al.*, 2018). These might easily to trigger violence. Communication was a major part in nursing, and the nurses found inappropriate communication caused the workplace violence (Najafi *et al.*, 2018; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015). In terms of the clinical roles, from some nurses' viewpoint, unmet expectations of patients/relatives or not fulfil patients' needs would make nurses a poor pubic image (Najafi *et al.*, 2018; Yang *et al.*, 2016).

3.2.2 Patient-related and patients' relatives triggers

From some nurses' statement, patients and their families were the perpetrators of workplace violence (Najafi *et al.*, 2017). Four studies mentioned under the influence of alcohol or drug, patients and their relatives behaved aggressively or threateningly (Avander *et al.*, 2016; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). From the nurses' experience of WPV, nurses found cultural or social discrepancies also played an important role in workplace violence (Najafi *et al.*, 2018; Ramacciati *et al.*, 2018). Nurses thought cultural or social discrepancies made patients didn't trust them and didn't understand their working status (Najafi *et al.*, 2018). What's more, nurses

believed patients' unstable physical and mental status was one of triggers of workplace violence (Najafi *et al.*, 2018; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016).

3.2.3 Organizational triggers

The occurrence of violence was closely related to the management of the organizati on. Most nurses believed that there was a lack of management input in the nursing environment (Baby, Glue & Carlyle, 2014; Ramacciati *et al.*, 2018). Some of them made a complaint against that organization didn't take enough measurement to protect the nurses who would face the workplace violence (Ramacciati *et al.*, 2018). Because organization didn't teach nurses how to identify signs of pre-violence in the workplace, some nurses found themselves lack of recognition of the high-risk patients, which led to an unsafe workplace (Wolf, Delao & Perhats, 2014). Inefficient organizational management caused the limited or restricted physical space, which made a crowding/high patients visitor volume (Najafi *et al.*, 2018; Stevenson *et al.*, 2015).

3.3 Nurses' experiences of workplace violence impacts on nurses' life

3.3.1 Impact on nurses' emotional changes

Workplace violence was a major problem affecting nurses' life. Emotional consequences were often the first to occur, influencing nurses' future personal and career development.

Fear, anxiety and frustrating

Fear was described most strongly when nurses faced workplace violence. Eight studies all mentioned fear (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Han *et al.*, 2017; Najafi *et al.*, 2018; Ramacciati, Ceccagnoli & Addey, 2015; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). When the patients appeared to be violent, the nurses were afraid, and sometimes refused to meet the patients' demands because of fear, which in turn might have led to more violence (Avander *et al.*, 2016). A sense of fear and anxiety always increased among nurses after workplace violence (Stevenson *et al.*, 2015). Some nurses felt unsafe in the workplace, and they continued to feel anxious and afraid that the violence would recur (Najafi *et al.*, 2018).

The experience of workplace violence was traumatic and continued to affect the personal lives of nurses. Nurses mentioned persistent psychological trauma that, after

violence in the workplace, fear of contacting with patients, even hindered their normal nursing work (Wolf, Delao & Perhats, 2014). Some nurses worried that patients would come to attack them, or even that patients would harm their families (Han, *et al.*, 2017). They were afraid of going to work and unwilling to face violent situations (Wolf, Delao & Perhats, 2014). Although some nurses had not yet recovered from attacks and trauma, their role as nurses needed to continue to care for violent patients, and then they became anxious and afraid of being hurt again (Yang *et al.*, 2016). The nurses were frustrated with the way of the patients and their family spoke and behaved to the nurses (Child & Sussman, 2017). It was disappointing that no action had been taken to prevent from violence in the workplace (Ramacciati *et al.*, 2018). Some nurses who were attacked more than once were frustrated by no protection for attacking violence (Wolf, Delao & Perhats, 2014).

Insecurity, vulnerable and alone

Six studies all mentioned nurses felt vulnerable, alone and insecure in the face of workplace violence (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Han *et al.*, 2017, Najafi *et al.*, 2018; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018). It was not known when a crisis situation would arise and how nurses would act and react, which was the root of insecurity (Avander *et al.*, 2016). After the violence, the nurses felt unsafe in the workplace, were always in a state of vulnerability, and became alert to every patient (Najafi *et al.*, 2018). Some nurses thought they were lonely because no one supported them (Child & Sussman, 2017). When exposed to workplace violence, no one supported or helped nurses escape this dangerous situation or provided comfort and protection, nurses always felt alone and abandoned (Ramacciati, Ceccagnoli & Addey, 2015).

3.3.2 Impact on nurses' relationship changes

The experience of workplace violence shared by nurses showed that regardless of the nature of the violence, it was a violation of personal safety and influence the nurses' relationship. Three studies reported workplace violence had a profound impact on nurses' interpersonal relationships (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Najafi *et al.*, 2018). Nurses found it was often encroached on their social circles and personal spaces (Baby, Glue & Carlyle, 2014). Nurses were afraid to be identified in public in their spare time or that some patients would try to know where they lived which results in their over-protection of their families and loved ones (Avander *et al.*, 2016). What's more,

from some nurses' narrative, the impact of workplace violence was not limited to the workplace, but also created strained family and social relations (Baby, Glue & Carlyle, 2014; Najafi *et al.*, 2018). Some nurses mentioned that workplace violence prevented nurses from assuming the same responsibility of raising children as normal parents (Baby, Glue & Carlyle, 2014).

3.3.3 Impact on nurses' attitude to change

In addition to the mentioned changes in emotional and interpersonal relationships, nurses also further emphasized the impact on the nursing profession under such circumstances. Nurses often clashed between two roles, one was to serve patients and the other was to act in a way that protected their health and safety (Stevenson *et al*., 2015). Some nurses were negatively affected for a long time, they noted that experience of workplace violence had a direct impact on their practices, opinions, and even their ability to sympathize with patients' deteriorating health (Han *et al.*, 2017). In situations dominated mainly by fear, many nurses often chose to sacrifice patients care to maintain their health and safety or some nurses wished to work with other patients who was less threaten to protect themselves (Stevenson *et al.*, 2015; Avander *et al*., 2016). Even some nurses claimed that sometimes they retaliated against violence by patients/relatives, such as reducing the quality of care (Najafi *et al.*, 2018).

For some nurses, this ongoing trauma had a negative impact on building and maintaining friendly relationships with patients, such as keeping a safe distance from violent patients and refused to interact with such patients (Yang *et al.*, 2016). Some nurses mention that workplace violence not only undermines their satisfaction with nursing career choices, but also seriously undermines their professional dignity and self-confidence (Child & Sussman, 2017; Najafi *et al.*, 2018). After experiencing workplace violence, nurses tended to be indifferent to work and reduce their desire for work (Najafi *et al.*, 2018; Han *et al.*, 2017).

Some nurses stressed that career changes were often interrelated, which was the beginning of a new learning process in which skills were relearned and new practical experiences and knowledge were acquired (Baby, Glue & Carlyle, 2014). Some nurses stated that good communication was a key factor in reducing dangerous situations, and mild tone communication helped to create a calm atmosphere (Avander *et al.*, 2016). In some cases, nurses changed the priority of nursing interventions and actions to meet the needs of some patients (Avander *et al.*, 2016). Nurses believed they should learn to seek

help from colleagues, develop plans to deal with aggressive patients, and adjust interactions with patients to ensure themselves safety (Yang *et al.*, 2016).

3.4 The chosen articles' information

After consulting eleven articles in the review, it was found that data collection methods were described in all of the literature.

These eleven studies were from seven countries: America (Child and Sussman, 2017; Wolf, Delao & Perhats, 2014), Iran (Najafi *et al.*, 2017; Najafi *et al.*, 2018), Italy (Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018), Taiwan (Han *et al.*, 2017; Yang *et al.*, 2016), Canada (Stevenson *et al.*, 2015), Sweden (Avander *et al.* 2016), New Zealand (Baby, Glue & Carlyle, 2014).

In nine of the articles, authors performed in-depth interviews with the nurses, without an interview guide (Baby, Glue & Carlyle, 2014; Child and Sussman, 2017; Han *et al.*, 2017; Najafi *et al.*, 2018; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). In the remaining two articles, it was made clear that authors used an interview guide with questions for semi-structured interviews (Avander *et al.* 2016; Najafi *et al.*, 2017). In two of the chosen articles, semi-structured, in-depth group interviews in the form of focus groups were employed (Avander *et al*., 2016; Ramacciati, Ceccagnoli and Addey, 2015). However, it was only in the study by Avander *et al.* (2016) that the authors used an interview guide. In the study Ramacciati, Ceccagnoli and Addey (2015) the researcher was described as a leader with the ability to keep the whole interview in an active atmosphere, they tended to listen and observe, not participants but bystanders.

In six of the chosen articles, the interviews were recorded and transcribed verbatim (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Najafi *et al.*, 2017; Najafi *et al.*, 2018; Yang *et al.*, 2016; Han *et al.*, 2017). In two of the selected articles, the data collection was carried out during the interview and take field notes (Child and Sussman, 2017; Ramacciati, Ceccagnoli & Addey, 2015). In the studies by Wolf, Delao and Perhats (2014) and Ramacciati *et al.* (2018) the researchers did not carry out the data collection themselves. In just one of the selected articles, the data collection was performed by telephone, the researcher did not perform the data collection themselves (Stevenson *et al.*, 2015).

In seven of the studies, it was made clear that all interviews were carried out by the same researcher (Baby, Glue & Carlyle, 2014; Child and Sussman, 2017; Han *et al.*, 2017;

Najafi *et al*., 2017; Najafi *et al.*, 2018; Stevenson *et al.*, 2015; Yang *et al.*, 2016). In the remaining four articles, there was no information on whether the same researcher carried out all the interviews (Avander *et al.*, 2016; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018; Wolf, Delao & Perhats, 2014).

In eight of the studies, the data collection took place on on just one occasion (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Child and Sussman, 2017; Han *et al.*, 2017; Najafi *et al.*, 2017; Najafi *et al.*, 2018; Ramacciati, Ceccagnoli & Addey ,2015; Yang *et al.*, 2016). In the remaining three studies, it were not made clear whether data was collected on more than one occasion (Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014).

In six of the selected studies, the participants themselves chose the location for the interview (Baby, Glue & Carlyle, 2014; Child and Sussman, 2017; Han *et al.*, 2017; Najafi *et al.*, 2017; Najafi *et al.*, 2018; Yang *et al.*, 2016). In five of the studies, the location for the data collection was not specified (Avander *et al.*, 2016; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014). In the study by Avander *et al.* (2016), one could infer from the text that the convenience of the participants was taken into account in selecting the location of the group interview. In the study by Child and Sussman (2017) and Najafi *et al.* (2018), interviews were carried out in the hospital where the nurses could continue to work.

4. Discussion

4.1 Main results

This review described the nurses' experiences of workplace violence. Nurses reported that workplace violence was characterized by unexpected and normal. Nurses' poor personality and lack of professional competence, patients' distrust and no protection for nurses from violence attack were triggers of workplace violence. After experiencing workplace violence, nurses felt fear, anxiety, insecurity and other negative emotions, resulting in tense family and social relations. Even nurses expressed a wish to keep a safe distance from violent patients and refused to care such patients.

4.2 Results discussion

4.2.1 Nurses' experiences of workplace violence's characteristic

Nurses were at high risk of violence in the workplace. The nurses' role as a caregiver put them in close contact with patients and faced potential workplace violence at any time. The results stated that nurses concluded that violence was characterized by unexpected and normal. In terms of the characteristic of unexpected, some nurses thought the patients' violent behavior was unpredictable (Baby *et al.*, 2014; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). This finding was similar with the study (Kowalenko *et al.*, 2012). Kowalenko *et al*. (2012) reported that because the factors that affected the occurrence of workplace violence were complex and cannot be easily predicted based on patients' characteristics or early warning signals (Kowalenko *et al.*, 2012). So setting up training courses for nurses to make them aware of the signs of potential violence was important, which could help nurses to respond to early and appropriate responses to patients who show aggression and to provide crisis intervention to the injured nurses (Kowalenko *et al.*, 2012). In terms of the characteristic of normal, workplace violence became the part of nurses' daily life (Baby *et al.*, 2014; Han *et al.*, 2017; Ramacciati, Ceccagnoli & Addey, 2015; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). This finding was similar with the study (Schablon, *et al.*, 2018; Kowalenko *et al.*, 2012). Schalon's study mentioned that workplace violence seemed inevitable, as if it were part of a day-to-day job, and that nurses' constant tolerance made them get used to it, so the low rates of reported workplace violence (Schablon, *et al.*, 2018). In Most nurses tended to tolerate the verbal violence and slowly get used to verbal abuse of

patients and their families. Nurses should be inspired to learn to use law to protect their own rights and interests.

In Roy's adaptation model, as an open life system, nurses might accept stimuli from internal and external environments. In this review, the stimuli might be different types workplace violence and self-insecurity. The output might be adaptive or ineffetive responses. For a adaptive responses, the results reported that some nurses believed that such violence was tolerated, not reported. For an ineffetive responses, workplace violence might cause nurses to lose confidence, it might affected their normal interpersonal activity or even families relationships. Nurses might burnout and aversion to nursing, eventually choose to leave.

4.2.2 The risk triggers of WPV

The results showed three risk triggers of workplace violence: nurse-related triggers, patient-related and patients' relatives triggers, organizational triggers (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Najafi *et al.*, 2017; Najafi *et al.*, 2018; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016).

For nurse-related triggers, nurses' poor personality and lack of professional competence which could not meet patients' needs could be two reasons induced the happening of workplace violence (Baby, Glue & Carlyle, 2014; Najafi *et al.*, 2018; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015; Yang *et al.*, 2016). It was consistent with the study (Schablon, *et al.*, 2018). Schablon showed that failure to meet reasonable or unreasonable expectations from patients and family members was the most important source of workplace violence (Schablon, *et al.*, 2018). Thus, nurses should be able to relieve stress correctly and maintain good mental health. Nurses should not bring their emotions to work. As a role of communicator, communication was indispensable in any nursing role and effective communication was an important factor affecting the quality of nursing work. The results of this review indicated that inappropriate professional communication was an important source of violence (Najafi *et al.*, 2018; Ramacciati *et al.*, 2018; Stevenson *et al.*, 2015). Previous studies had also noted that poor nursing-patient relationships were mostly due to poor interpersonal communication (Nikathil, *et al.*, 2017). Thus, nurses should receive psychological education and practical skills training to improve their communication skills. It was necessary to emphasize that nurses' own work, proper communication with patients to express respect and other interactions could regulate the atmosphere of the workplace.

For patient-related and patients' relatives triggers, the patients' distrust of nurses was also one of the causes of workplace violence. Consistent with Schablon, *et al.* (2018) study, this review observed that nurses considered their low working social status to be one of the reasons. They found patients didn't understand the nurses' working status, so patients despised the nurses and sometimes even showed a violent response to nurses (Najafi *et al.*, 2018; Ramacciati *et al.*, 2018). Hospitals should show the good image of nurses to the public through the media and strive to improve the social status of nurses. The government should severely punish bad media for malicious reporting on the image of nurses.

For organizational triggers, lack of input from manager could be a normal phenomenon. Manager had shown little support for either the safety of nurses or changing the incentives for violence. More interestingly, workplace violence caused by the above-mentioned patients and nurses could also be linked to manager, such as nurses who were unable to provide patients care in a timely manner, because the staffs of the management was not harmonious. The crowded queue kept the patients waiting, led the patient to feeling anxious and violent (Najafi *et al.*, 2018; Stevenson *et al.*, 2015). The findings was consistence with the study of Kowalenko *et al.* (2012). Kowalenko showed the management was a central incentive during the workplace violence. Therefore, organizational support and care could greatly reduce the harm caused by workplace violence to nurses. Manager should assign medical staff reasonably, revised hospital rules, and limited the presence of a large number of family members in wards. Manager should also invest in the medical workplace and plan for overcrowded patient visitors to alleviate overcrowding, such as online reservation. In Roy's adaptation model, the stimuli was the most important element in the theory, the three triggers of workplace violence could cause the stimuli. If workplace wanted to get rid of stimuli, it had to control the incentives that stimulate patients.

4.2.3 Workplace violence affects of nurses' life

Nurses who had experience the workplace violence would suffer a process of emotional changes. They felt fear, anxiety, frustrating, insecurity, lone and other negative feelings (Avander *et al.*, 2016; Baby, Glue & Carlyle, 2014; Han *et al.*, 2017; Najafi *et al.*, 2018; Ramacciati, Ceccagnoli & Addey, 2015; Stevenson *et al.*, 2015; Wolf, Delao & Perhats, 2014; Yang *et al.*, 2016). It was in line with the result in these early review (Kowalenko, *et al.*, 2012; Schablon, *et al.*, 2018), as they mentioned that emotional

consequences were often the first to occur, influencing the way of future personal and career development for nurses. After experiencing workplace violence, nurses described emotional reactions such as fear, depression and insecurity (Schablon, *et al.*, 2018). Thus, hospitals could provided psychological consultation for nurses who had experienced workplace violence, and reduce the psychological impact of workplace violence on nurses.

This review found that working in an environment where threats and violence occur to a degree of terror, nurses had direct and long-term consequences, both at work and in private. In private life, workplace violence might create strained family and social relations. In work part, nurses did not report any physical damage, more of a psychological concern: keeping a safe distance from the patients and wanting to work with other less threatening patients (Stevenson *et al.*, 2015; Avander *et al*., 2016). The findings was consistence with the study (Kowalenko *et al.*, 2012; Nikathil *et al.*, 2017). These studies had shown that workplace violence was not just physical damage but also long-term psychological and social changes, such as satisfaction with nurses' career choices and reduced desire for work (Kowalenko *et al.*, 2012; Nikathil *et al.*, 2017). Nurses entered the profession to help people overcome disease, but they were frustrated by the constant violence in the workplace. It might not have seriously affected nurses to leave the profession, but it did affect the nursing quality of patients and nurses' satisfaction with career choices to some extent. Therefore, organizations should provide a safe environment to protect nurses and encourage nurses to provide optimal service to patients while maintaining job satisfaction.

However, some nurses stressed that career changes were often interrelated. Some of them regarded the experience of workplace violence as the beginning of a new learning process in which skills were relearned and new practical experiences and knowledge were acquired (Baby, Glue & Carlyle, 2014). This finding in this research was different with earlier reviews, because earlier reviews only mentioned the negative impact of violence in the workplace, not mentioned the positive impact (Kowalenko, *et al.*, 2012; Nikathil, *et al.*, 2017; Schablon, *et al.*, 2018). The positive impact might be a sign of post-traumatic growth. Thus, mangers could change the perceptions of nurses and let nurses who had experienced workplace violence regarded the experience of workplace violence as a learning experience, so that nurses could learn how to deal with workplace violence and to better protect themselves in the future. Meanwhile, managers could strengthen the psychological quality education for nurses and improve their ability to resist stress and cope with violence in the workplace.

In Roy's adaptation model, the output might be adaptive or ineffetive responses. For an adaptive responses, nurses adjusted ways of interacting with patients to reduce workplace violence actively. For an ineffetive responses, workplace violence might affected their normal interpersonal activity or even families relationships, eventually choose to leave. In order to change the ineffetive responses, positive feedback could be achieved by eliminating risk triggers, as mentioned above. Nurses could also start with negative results, such as the above-mentioned psychological counseling given to nurses to alleviate negative emotions.

4.3 Methods discussion

This review extracted what the authors wanted by reading articles relevant to the research's aim. The authors set the exclusion criteria and inclusion criteria, and then logged in to the database PubMed and Cinahl to search for articles that are consistent with the research's aim. All articles were drawn from both databases. This was the descriptive review of the qualitative literature on nurses' experience of workplace violence. The results were based on qualitative articles that correspond with the present study's aim, which according to Polit & Beck (2017) that was a good choice when the aim was to describe individuals' experiences of something.

According to Polit's study, the authors of this study used clear and specific inclusion and exclusion criteria, which enhanced the plasticity of the study (Polit & Beck, 2017). The authors searched two different databases: PubMed and CINAHL, to improved the credibility of the results, which may help to reinforce the current results. The authors used MeSH terms and free text searches were used in order to obtain more results relevant to the purpose of this study.

However, there were several limitations. First, the authors first browsed the title and the summary and found out the general outline, and selected the articles related to the study's purpose. But many potential articles had been omitted. Although they could not be found in the title and summary, their content was also relevant to the aim of the research. Second, this research belonged to the descriptive research and the authors used only two databases to search for articles, the sample size was small, the research scope was limited. Third, authors didn't have a quality appraisal of review. This research did not exclude low-quality articles, and high-quality articles had not received much attention. Thus, the credibility and authenticity of this research had not been improved. Fourth, by contrast, only 11 articles (published between January 2008–December 2018) were

included, authors could search for updated articles to get the latest ones and more comprehensive results and only a decade's worth of papers limited the results of older studies. Fifth, the authors considered English as an inclusive criterion, which might lead to the exclusion of the results of other countries. Therefore, the results of this review might not convince everyone.

4.4 Clinical implication for nursing

In this review, three themes were induced. With knowing the nurses' experience of workplace violence, the authors summarized the risk triggers of WPV and the influence of WPV after occurrence. From the results, nurses needed to learn how to communicate effectively with patients and their families and could develop training to develop communication skills. Identifying the risk triggers that contribute to violence in the workplace helped to record and report such incidents and to develop the interventions to reduce them. In addition, manager should ensure that nurses had acquired knowledge and skills to avoid powerlessness in the face of workplace violence or, if necessary, to defend themselves against attacks and protect themselves. At present, this review could be added to the nursing curriculum. The authors hope that this research will convey important insights and meaningful connections, help nurses avoid workplace violence, and help students and managers who are about to become nurses, understand what workplace violence is and its impact, and actively address workplace violence.

4.5 Suggestions for further research

In terms of data collection, the authors found that most nurses interviewed only once and authors suggested following up on different stages of workplace violence. For example: three months, six months, nine months after nurses suffered from workplace violence, thus the changes in nurses' experiences could be tracked dynamically.The authors also suggested that patients could be interviewed to find out why were they violent against nurses. What's more, interviewing head nurses from different departments to learn how they managed violence in the workplace. The changes in workplace violence among nurses in various departments could be studied in greater detail, and a department could be targeted to obtain more specific information in future research.

5. Conclusions

Nurses were a vulnerable group and played an important role in the medical system. Nurses were targets for workplace violence. Workplace violence not only caused negative emotion, but also influenced the way of future personal and career development for nurses. Based on nurses' experience of workplace violence, mangers would realize that there were great obstacles to overcoming workplace violence and that more efforts were needed. Mangers would be able to know nurses' experiences and found the risk triggers of workplace violence and provide useful advice.

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APPENDIX 1
Overview of selected articles

Author(s) +year/country of publication	**Title**	**Design (possibly approach)**	**Participants**	**Data collection method(s)**	**Data analysis method(s)**	**Codes**
Avander K. Heikki A. Bjerså K. EngströmM. 2016+Sweden	Trauma nurses' experience of workplace violence and threats: Short- and long-Term consequences in a Swedish setting	A descriptive design A qualitative approach	**Number** : 14 **Age:** mean age 36.5 years **Gender:** All women **Worked years on average :** No information **Average years of work on trauma unit** :4.5 years Nurses had worked for 1 year at the present trauma ward	Focus group, semi-structured interviews using an interview guide. Length of interview:40-70 minutes Interviews were audiotaped and transcribed verbatim	Content analysis (Elo and Kyngäs 2008)	A
Baby M. Glue P. Carlyle D. 2014+New Zealand	'Violence is not part of our Job': A thematic analysis of psychiatric mental health nurses' experiences of patient assaults from a New Zealand perspective	A descriptive design A qualitative approach	**Number** : 14 The participants in the study included both registered and enrolled nurses	Semi-structured interviews Length of interview: 30 and 40 minutes. Interviews were audiotaped and transcribed verbatim	Thematic analysis (Boyatzis' 1998)	B

Child R.J.H. Sussman E.J. 2017+America	Occupational disappointed: Why did I even become a nurse?	A descriptive design A qualitative approach	**Number** : 28 **Age:** No information **Gender:**17 females and 11 males **Worked years on average :** No information **Average years of work on the emergency department:** 11.07 years The educational levels of our participants included Associate Degree RN: 25% (n=14), Bachelors in Nursing: 50% (n=7), and Masters in Nursing: 25% (n=7)	Nonstructured, in-depth interviews (face-to-face interview and electronic interview) and take field notes. Length of interview: 50 to 130 minutes. Interviews were audiotaped and transcribed verbatim.	Constant comparative ; grounded-theory	C
Han C-Y. Lin C-C. Barnard A. Hsiao Y-C. Goopy S. Chen L-C. 2017+Taiwan	Workplace violence against emergency nurses in Taiwan: A phenomenographic study	A descriptive design A qualitative approach	**Number** : 30 **Age:** aged 20 years and older Participants had experience WPV in the ED.	Semi-structured interviews by drawing and verbal. Length of interview: 50 and 70 minutes. Interviews were audiotaped and transcribed verbatim	Phenomenographic analysis (Sjöström & Dahlgren, 2002; Pihl et al., 2011).	D
Najafi F. Fallahi-Khoshknab M. Ahmadi F. Dalvandi A. Rahgozar M. 2017+Iran	Human dignity and professional reputation under threat: Iranian Nurses' experiences of workplace violence.	A descriptive design A qualitative approach	**Number** : 22 **Age:** mean age 33.9 years **Gender:**18 females and 4 males **Worked years on average :** 11.5 years **Average years of work on the emergency department:** 10 years Registered nurses who had experienced workplace violence and had at least six months' clinical work experience	In-depth unstructured interviews. Length of interview: 30–75 minutes Interviewers use the opening questions. The interviews were recorded and transcribed verbatim.	Content analysis (Elo et *al*., 2014).	E

Najafi F. Fallahi-Khoshknab M. Ahmadi F. Dalvandi A. Rahgozar M. 2018+Iran	Antecedents and consequences of workplace violence against nurses: A qualitative study	A descriptive design A qualitative approach	**Number** : 22 **Age:** mean age 33.9 years **Gender:**18 females and 4 males **Worked years on average :** 11.5 years **Average years of work on the emergency department:** No information Participants had at least 6 months of work experience.	In-depth, unstructured interviews Length of interview: 30 to 75 minutes. The interviews were recorded and transcribed verbatim.	Qualitative content analysis approach (Graneheim and Lundman 2004)	F
Ramacciati N. Ceccagnoli A. Addey B. 2015+ Italy	Violence against nurses in the triage area: An Italian qualitative study	A descriptive design A qualitative approach	**Number:**9 participants **Age**: average 44 years. **Gender**:6 females and 3 males **worked years on average :** 18 years **Average years of work in the emergency department:** 11 years Nurses with experience of triage who had been involved in episodes of violence.	A focus group interview and take field notes. Length of interview : 100 minutes A short questionnaire The interviews were audiotaped and transcribed verbatim	Colaizzi method	G
Ramacciati N. Ceccagnoli A. Addey B. Rasero L. 2018+ Italy	Violence towards emergency nurses. The Italian national survey 2016: A qualitative study	A descriptive design A qualitative approach	**Number :** 1100 **Age:** mean age 41 years (range 20–65). **Gender:**599 females，430 males and 71 not mentioned **Worked years on average :** 16 years(range 1–40) **Average years of work in accident and emergency:** 10 years(range 1-38) All questionnaire responders were state registered nurses working in the Accident and Emergency service	Use the questionnaire and the last item was an open question “Free comments on workplace violence towards accident and emergency nurses”	Van Kaam method (Van Kaam, 1984); Theme analysis	H

Stevenson K.N. Jack S.M. O'Mara L. LeGris J. 2015+Canada	Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study.	A descriptive design A qualitative approach	**Number** : 12 **Age:** mean age 37.5 years (range 27–57). **Gender:**8 females and 4 males **Worked years on average :** median of 6 years(range 4–23) **Average years of work on the wards:** No information All were RN.	Individual, semi-structured interviews by telephone Length of interview: Averaged 60–90 minutes. Interviews were audiotaped and transcribed verbatim	Narrative analysis and constant comparison approach.	I
Wolf L.A. Delao A.M. Perhats C. 2014+America	Nothing changes, nobody cares: understanding the experience of emergency nurses physically or verbally assaulted while providing care	A descriptive exploratory design A qualitative approach	**Number** : 46 **Age:** No information **Gender:** 8 men, 37 women and 1 unknown gender **Worked years on average :** No information **Average years of work on the wards:** No information	Emergency nurses written narratives submitted by e-mail. The question asked of all participants was as follows: "Tell me about your experience of violence in the Emergency setting."	Narrative analysis and constant comparison	J
Yang C-I. Hsieh W-P. Lee L-H. Chen S-L. 2016+Taiwan	Assault experiences: Lessons learned from mental health nurses in Taiwan	A descriptive design A qualitative approach	**Number** : 10. **Age:** 32.7 years (range: 30–36) **Gender:**9 females and 1 male **Average years of work on the psychiatric wards:**9.2 years (range=3–16) Most had been assaulted at least four times (n= 7/10 participants) in psychiatric wards. All participants received violence management-related in-service education.	Individual, semistructured, in-depth interview Length of interview: 30min–2 hours. The interviews were recorded and transcribed verbatim.	thematic analysis (Braun & Clarke 2006)	K

APPENDIX 2

Author(s) +year/country of publication	Aim	Results	Codes
Avander K. Heikki A. Bjerså K. EngströmM. 2016+Sweden	To explore experiences of threats and violence and the consequences of these among nurses in a Swedish trauma ward setting.	A1 Behaved aggressively or threateningly. A2 Fear, a sense of being violated, stress and insecurity A3 Nurse should improve communication skill A4 Change the priority of nursing interventions and actions. A5 The influence of alcohol or drug A6 Being overprotective toward their family and loved ones A7 Wish to work with other patients who is less threaten.	A
Baby M. Glue P. Carlyle D. 2014+New Zealand	To explore and describe mental health nurses' experiences of patient assaults.	B1 Personality traits, professional expertise, clinical roles. B2 Violence is a possibility may happen. B3 Part of working. B4 Fear, anxiety, frustration, vulnerability, anger B5 Violence is invaded social circles and personal spaces B6 Break the ice of fear for self B7 Cause strained family and social relationships B8 Nurse can't cope any longer with the general parenting role. B9 It's a learning experience, enhanced practice and expertise gained. B10 Lack of input from management	B
Child R.J.H. Sussman E.J. 2017+America	To explore the experience of VWPV directed at ED RNs from patients or family members.	C1 Disheartens, awful, frustrating, angry C2 Affects nurses' job satisfaction and performance, subsequent patient care C3 Unrealistic patient expectations C4 The existence and impact of management seem to be small C5 The environment of the triage was problematic C6 Lacking in a strong security department C7 The courses have limited usefulness in a time-pressed environment	C

Han C-Y. Lin C-C. Barnard A. Hsiao Y-C. Goopy S. Chen L-C. 2017+Taiwan	To understand ED nurses' WPV experience and perspective.	D1 Part of working. D2 Vulnerable, frightened, alone D3 Worried about personal safety and that of family members. D4 Diminishes the desire to work D5 The continuous impact of WPV on nurses' social and personal lives D6 WPV has a direct impact on nurses' practice, views, and even their ability to sympathize with the patients' deteriorating health	D
Najafi F. Fallahi-Khoshknab M. Ahmadi F. Dalvandi A. Rahgozar M. 2017+Iran	To explore nurses' perceptions of workplace violence committed by patients, patients' relatives, colleagues, or superiors	E1 Have a threat to the dignity and professional reputation E2 Some discriminatory behavior and unequal work atmosphere E3 Patients and their families were the perpetrators of workplace violence E4 Lack of understanding about nurses' working conditions E5 Nurses feel isolated and undefended in the workplace	E
Najafi F. Fallahi-Khoshknab M. Ahmadi F. Dalvandi A. Rahgozar M. 2018+Iran	To explore the origins and consequences of workplace violence based on the perceptions of nurses who are the victims of such violence	F1 Unmet expectations of patients/relatives F2 Delays in giving care F3 Lack of care, responsibility or empathy. F4 Inappropriate professional communication F5 Lack of trust to nurse F6 Unstable physical and mental status. F7 Not understand the nurses' working status F8 Lack of adequate clinical competence F9 Personality differences, poor stress management of nurses F10 Cultural discrepancies F11 Poor public image F12 Inefficient organizational management F13 Crowding/high patient visitor volumes F14 Fear, insecurity,awful, anger, anxiety, feel tense F15 Family relationship become tense F16 Reduce the quality of patient care F17 Job indifference F18 Damage professional dignity and professional confidence	F
Ramacciati N. Ceccagnoli A. Addey B. 2015+ Italy	To investigate the feelings experienced by nurses following episodes of violence in the workplace.	G1Vulnerable, fear, alone G2 A normal state G3 Unsupported by management G4 Part of working	G

Ramacciati N. Ceccagnoli A. Addey B. Rasero L. 2018+ Italy	To analyze the characteristics of workplace violence and determine how widespread it was in Italian Accident and Emergency Departments.	H1 Part of working. H2 Alone, frustrated and abandoned H3 Inappropriate professional communication H4 Poor stress management of patients' relatives H5 Bad manners, disrespect for nurses H6 Cultural discrepancies H7 Disinterest of managers and leaders H8 No protecting. H9 Unreasonable staffing of nursing staff H10 Nurse want more training about WPV	H
Stevenson K.N. Jack S.M. O'Mara L. LeGris J. 2015+Canada	To describes psychiatric nurses' personal experiences of patient violence.	I1 Common occurrence I2 Inappropriate professional communication I3 The influence of alcohol or drug I4 Not sufficiently supportive from managers I5 Part of working. I6 Limited or restricted physical space I7 Desire to withdraw or avoid working with the patient I8 Role conflict: self and own safety and care for patients I9 Unreasonable staffing of nursing staff I10 Feeling fearful, in shock or being numb, anger ,anxiety	I
Wolf L.A. Delao A.M. Perhats C. 2014+America	To better understand the experience of emergency nurses who have been physically or verbally assaulted while providing patient care in US emergency departments	J1 Unsafe workplace J2 The presence of psychiatric patients,a history of violence J3 Part of working J4 Frustration, anxiety, and afraid J5 Cues of violence were often ignored J6 Lack of recognition of the high-risk patient J7 The influence of alcohol or drug	J
Yang C-I. Hsieh W-P. Lee L-H. Chen S-L. 2016+Taiwan	To understand mental health nurses' experiences of being assaulted, the influences on their patient care, and their perspectives of the effectiveness of in-service, violence-prevention education	K1 Unexpected , occurring suddenly K2 Lack of traceable external clues or identifiable warning signs K3 Part of working. K4 The presence of psychiatric patients,a history of violence K5 The influence of alcohol or drug K6 Fear of being assaulted again, be alter, anxious K7 Adjusted ways of interacting with patients K8 Not fulfil patients' needs. K9 Negatively influenced building and maintaining trust relationships and caring for patients. K10 Maintained a safe distance from patients.	K