

A Scoping Review of Workplace Violence Among Nurses in Indonesia: Implications for Educational and Reporting Models

ARDIA PUTRA, YUSWARDI, MAYANTI MAHDARSARI, ANDARA MAURISSA, HAJJUL KAMIL*

¹Faculty of Nursing, Universitas Syiah Kuala, Banda Aceh, Indonesia

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ABSTRACT

Background: Workplace violence (WPV) is a critical issue in healthcare systems globally, disproportionately affecting nurses due to their frontline role in patient care. The International Council of Nurses recognizes WPV, including verbal abuse, threats, harassment, and physical assault, as a persistent threat to nurses' safety and well-being. In Indonesia, the magnitude of WPV against nurses remains underexplored, and there is limited evidence supporting the development of culturally responsive educational models tailored to local healthcare settings. **Methods:** A scoping review was conducted to analyze current research on workplace violence affecting nurses in Indonesian hospitals. Various electronic databases and gray literature were thoroughly examined using relevant keyword combinations: "Workplace Violence," "Nurse," "Hospital in Indonesia," and "Abuse." Studies were included if they (i) constituted original research, (ii) investigated WPV incidents within hospital environments in Indonesia, (iii) specifically focused on nurses, and (iv) utilized either quantitative or qualitative methodologies. **Results:** The review identified recurring themes related to the high prevalence of WPV among nurses in Indonesian hospitals. Factors contributing to WPV included a lack of institutional support, the absence of standardized reporting systems, and limited awareness and training. While a few studies proposed interventions, none presented a comprehensive or context-specific educational model for WPV prevention and reporting tailored to Indonesia's sociocultural setting. **Conclusions:** There is an urgent need for a structured, culturally adapted workplace violence educational model for nurses in Indonesia. Such a model should integrate reporting mechanisms and preventive strategies to ensure workplace safety and improve healthcare services delivered to the community.

1. INTRODUCTION

Workplace violence (WPV) is a significant global issue in healthcare [1], notably impacting nurses who are on the front lines [2]. The International Council of Nurses (ICN) defines WPV as any incident where an employee is abused, threatened, or assaulted related to their work, including commutes. This violence directly threatens workers' physical and

mental health [3]. Nurses face heightened risk due to their constant interactions with patients, families, and caregivers, often in emotionally charged or high-stress contexts [4].

Numerous empirical studies indicate that nurses report high rates of WPV. For instance, Gacki-Smith et al. and Esmailpour et al. found that over 50% of nurses had encountered some form of WPV, with verbal abuse being the most frequent [5-6].

Likewise, Park et al. documented 12-month prevalence rates of verbal abuse (63.8%), threats (41.6%), physical assault (22.3%), sexual harassment (19.7%), and bullying (9.7%) across various clinical environments [7]. These statistics highlight a widespread global concern, further complicated by varying research methodologies that prevent straightforward comparisons [7]. A global integrative review indicated that nurses in the Anglo, Asian, European, and Middle Eastern regions experienced physical violence (31.8%), non-physical violence (62.8%), bullying (47.6%), and sexual harassment (17.9%) within the past year [8].

In Indonesia, WPV is also prevalent. National statistics reveal that 54.6% of nurses have faced non-physical violence, and 10% have experienced physical violence [9]. Nonetheless, many incidents remain unreported due to the normalization of violence, ignorance of reporting procedures, and the challenges of self-reporting [10–12]. A recent study in Aceh Province, affected by conflict, found that nurses regularly encounter verbal and physical aggression [10], primarily from patients and their families [13]. Despite the frequency of these violent occurrences, most nurses opt not to report, citing fears of retaliation, distrust in institutional responses, and a lack of awareness of reporting options [14]. This situation illustrates the “iceberg phenomenon” regarding WPV, where only a fraction of actual incidents get recorded and addressed [11].

The high rates and normalization of WPV, coupled with institutional inertia, necessitate an immediate and organized response [15]. To meet this challenge, researchers advocate for developing a Workplace Violence Education Model (WPVEM) tailored to the healthcare environment. This model educates healthcare professionals to identify early signs of violence, implement preventive measures, and respond effectively to incidents. According to OSHA, over 7.6 million WPV cases are reported in the United States annually, encompassing physical assaults, threats, intimidation, and verbal harassment, highlighting a critical need for comprehensive preventive measures [16]. Evidence indicates that structured WPV educational programs can substantially lower incident rates. For example, organizations that adopted NIOSH-endorsed WPV

prevention frameworks experienced up to a 50% decline in WPV cases [17].

Various WPVEMs have been developed [16, 18, 19], including:

- a. NOVA (Nurse Occupational Violence Awareness): This model adopts a prevention approach to lower WPV risk by focusing on four areas: physical environment, policies and procedures, employee recruitment and training, and conflict management;
- b. AWAKE (Alert, Warn, and Knowledge for Employees): This model trains employees to recognize signs of violence, take preventive steps, and respond appropriately in violent situations. It emphasizes knowledge, skills, and behavior;
- c. Prevention and Management of Violence in Healthcare: This model was designed to address violence in healthcare settings. It trains staff to identify early signs, understand risk factors, and develop prevention and response strategies.

Nevertheless, the availability of these models in Indonesia is limited. The sole formal legal structure is Law No. 12 of 2022 from the Ministry of Manpower, focusing on sexual violence but lacking comprehensive regulations for WPV in healthcare contexts [20]. Therefore, creating a localized and culturally appropriate WPVEM for Indonesian healthcare facilities is crucial for protecting workers, enhancing safety, and fostering a positive organizational culture.

This review examines WPV prevalence, reporting behaviors, psychological and organizational impacts, and strategies to mitigate WPV among nurses in Indonesia. It highlights the need for a structured educational model suited to the Indonesian healthcare sector. In addition, this review is important for uncovering shortcomings in current policies and reporting systems and for offering evidence-based recommendations to improve future practices, policy development, and research efforts. By reviewing recent literature and incorporating case studies from Aceh Province, this work contributes to growing knowledge on reducing WPV and promoting healthcare workers' well-being.

This scoping review aims to analyze empirical evidence on the incidence of WPV among nurses in Indonesian hospitals. Furthermore, guided by this Population-Concept-Context (PCC) framework, the scoping review addressed the following questions:

- a. What types and prevalence of workplace violence are reported among nurses in Indonesian hospital settings?
- b. What individual, organizational, and contextual factors are associated with workplace violence against nurses?
- c. How do nurses report and respond to workplace violence, and what barriers to reporting are identified?
- d. What institutional strategies, educational interventions, or reporting mechanisms have been described, and what gaps remain for developing a context-specific Workplace Violence Education Model?

2. METHODS

2.1. Study Design

This study employed a scoping review design, conducted in accordance with established methodological guidance for scoping reviews and reported following the PRISMA-ScR reporting framework [21]. The review process was transparently documented using a PRISMA flow diagram (Figure 1) to ensure reproducibility and methodological rigor. To answer the research questions, we formulate this study using the PCC framework, which includes:

- a. Population (P): Registered nurses working in hospital settings;
- b. Concept (C): Workplace violence (WPV), encompassing physical violence, verbal abuse, threats, bullying, harassment, and sexual violence; associated factors; reporting behaviors; and institutional responses, including education and prevention strategies;
- c. Context (C): Hospital settings in Indonesia, including emergency departments, intensive care units, inpatient wards, critical care units, operating rooms, and mental health facilities.

2.2. Search Strategy and Eligibility Criteria

Specific criteria ensured relevance and quality, including original, peer-reviewed articles from 2018 to 2025, in English or Bahasa, addressing WPV incidents among nurses in Indonesian hospitals. Qualitative and quantitative designs were suitable. Exclusions were applied to studies that were not fully available, were not in English or Bahasa, or did not focus on WPV among hospital nurses.

From December 5, 2024, to March 15, 2025, a thorough literature search was conducted across reputable databases (Elsevier, ResearchGate, and Google Scholar), as well as institutional libraries and national repositories [22]. A mix of keywords and Boolean operators helped locate relevant studies, including terms like “Workplace Violence”, “Nurse”, “Hospital in Indonesia” and “Abuse”. The strategy was tailored to each database’s features, as detailed in Supplementary Material S1. Reference lists of all selected articles were also reviewed for qualifying studies (Table 1).

2.3. Study Selection

All search results were imported into a structured spreadsheet for screening. The selection process involved two stages, which were completed by independent reviewers. In the first stage, titles and abstracts were used to eliminate irrelevant studies. In the second stage, full-text versions of eligible articles were reviewed. Reviewer discrepancies were resolved through discussion or a third reviewer. The process followed PRISMA guidelines, detailed in the flow diagram [23] (Figure 1).

2.4. Data Extraction, Quality Appraisal, and Data Synthesis

Both reviewers independently extracted data using a standardized form capturing study characteristics, including authors, year, location, design, sample size, types and frequencies of WPV, perpetrator and victim characteristics, contextual factors, and significant findings. Inconsistencies were discussed and resolved for accuracy.

Table 1. Matrix Review Literature.

Ref	Participant	Aims	Methods	Findings	Conclusions
[9]	The study involved 169 nurses employed in the emergency departments (EDs) of six Jakarta and Bekasi, Indonesia hospitals.	Examine the experiences of violent incidents committed by nurses in the ED in Indonesia.	Quantitative Research with data analyzed using descriptive and multivariate logistic regression.	As per the study findings, 10% of emergency nurses stated that they had experienced physical abuse, mainly perpetrated by patients. More than half of the nurses (54.6%) reported experiencing non-physical violence, with family members being the primary culprits. Most nurses (55.6%) were not encouraged to report WPV incidents, and only a tiny fraction (10.1%) had received any information or training on handling WPV situations.	The study's outcomes brought attention to the gravity of violence in the EDs of Indonesia. The findings suggest that management backing, support, and motivation to report violence, and the availability of WPV training could help reduce and control the abuse that nurses face while working in EDs.
[25]	The sample of this study comprised ten nurses who had been working in the ED for a minimum of six months and were not currently on maternity leave, as the nurse manager/head of the room.	To understand the psychological trauma experienced by ED nurses in the face of verbal abuse in the workplace.	Qualitative research using a phenomenological approach.	The themes found in this study are (i) knowledge, with sub-themes: types of verbal violence and forms of verbal violence; (ii) sources of verbal violence with sub-themes of perpetrators and causes of verbal violence; (iii) the influence of verbal violence with sub-themes of response when experiencing verbal violence, the effects of verbal violence, and coping in the face of verbal violence.	Verbal abuse in the workplace impacts the psychological performance of nurses. By understanding the psychological trauma of nurses, efforts are expected to arise to protect nurses from providing nursing care and improve the quality of service.

<p>[26] The 105 participating nurses came from the ED and ICU at four hospitals: Bitung, Budi Mulia Bitung, Hermana Lembean, and Maria W Maramis Airmadidi.</p>	<p>To analyze the relationship between violence and work stress in nurses in several EDs and ICUs of hospitals in Bitung City and North Minahasa.</p>	<p>Type of quantitative survey analytics research using a cross-sectional design. This study used the chi-square, Fisher's exact, and logistic regression tests.</p>	<p>As per the study findings, the most frequently encountered form of violence reported by the participants was verbal abuse (54.3%), followed by bullying (28.6%), physical violence and threats (19%), sexual harassment (11.4%), and harassment (8.6%). Perpetrators of violence are most often committed by the patient's family (63.5%). Furthermore, there is a meaningful association between all WPV, including physical, verbal, bullying, harassment, sexual harassment, threats, and work stress. Multivariate analysis showed that verbal abuse was the most dominant factor associated with job stress in nurses.</p>	<p>For hospital institutions, it is recommended to develop orientation and introduction programs for staff, design the environment, and work in a clear organizational structure, placement, training in WPV, clear job descriptions, and good conflict communication to prevent WPV from triggering work stress.</p>
<p>[27] The respondents were 60 nurses who work in the public hospital in Luwuk.</p>	<p>Determine emergency response and wait times for outpatients with violence against nurses in the Luwuk Banggai General Hospital district.</p>	<p>Quantitative Analytical Surveys. The collected data were subjected to univariate and bivariate analysis, which included the Chi-Square Test.</p>	<p>The most dominant violence is committed by the patient's family against nurses in the form of verbal violence (85%), followed by physical violence (8.33%) and psychological violence (6.67%). Verbal violence is closely related to ridicule, cursing, innuendo, insults, and even being laughed at if the nurse is doing the wrong task. The root of the problem is triggered by the status or profession of a nurse who is considered low, and many indirectly get complaints about the issue of doctor services to nurses.</p>	<p>The relationship between emergency response time and aggressive behavior among nurses is to maximize the treatment of response time through ABCD procedures. Facilities, human resources infrastructure, and ED management improvements are also possible. The relationship between outpatient wait times and the quality of service includes specific dimensions. Namely, I will determine duty time, ease of meeting a patient's needs, convenience and hospitality, human resource aspects, paying attention, and others.</p>

Table 1 (Continued)

Ref	Participant	Aims	Methods	Findings	Conclusions
[28]	The researcher used a total sampling technique involving 196 nurses from the Regional General Hospital of Meuraxa.	Determine factors associated with workplace intimidation among nurses in Banda Aceh City.	Cross-sectional quantitative research. Data were analyzed using univariate analysis, bivariate analysis (chi-square test), and multivariate analysis (multiple logistic regression).	Factors associated with the impact of bullying in the workplace include age = 0.001, year of service = 0.000, position = 0.001, and organizational climate = 0.000. Results of the multivariate analysis indicated that organizational climate was the most crucial factor for this issue, with an OR value of 3.483.	Bullying in the workplace is linked with age, seniority, position, and organizational climate. However, the most related factor is the organizational climate, where a poor environment versus a good one leads to workplace bullying. Leaders and decision-makers look forward to creating a supportive organizational climate and anti-bullying policies, creating a pleasant and reassuring workplace.
[29]	Respondents were nurses from the Aceh General Hospital; 391 out of 410 nurses participated (95%). Respondents were nurses from patient rooms, critical care units, EDs, and operating rooms.	To identify factors influencing verbal abuse among nurses in Aceh's government hospitals.	A quantitative design using a cross-cutting approach. The data gathered are then processed and analyzed using univariate, bivariate, and multivariate analysis.	This study revealed that the factors influencing nurse verbal abuse were (0.014), occupational status (0.021), work unit (0.188), shift (0.007), work stress (0.000), and organizational climate (0.012). The value of a Nagelkerke R-squared is 0.212. Indicates that each variable is most associated with verbal abuse has a 21.2% probability of influencing verbal abuse, and that 79.8% is another factor apart from these factors.	Addressing the issue of verbal abuse among nurses in the workplace requires assigning assignments based on a nurse's career path. Adopt a strong workplace attitude and improve the factors that can cause verbal violence in the workplace.

<p>[30] A study sample of 50 nurses from two hospitals (X & Y) was obtained.</p>	<p>To analyze WPV among nurses in an accredited hospital in Pekanbaru.</p>	<p>The type of research used for the present study is descriptive, quantitative, and analytical.</p>	<p>Finding a Hospital X: 100% of respondents stated “no evaluation of the effectiveness of the impact of violence at work policies” and “violence training in the workplace is not provided”; 92% of respondents said, “they did not know about policy changes based on evaluations of violence prevention programs in the workplace”. Finding at the Hospital Y: 40% of respondents stated “the availability of verbal violence policies from patients or visitors”; 48% of respondents stated that “the policy of preventing violence in the workplace was needed related to incident reporting”; 36% of respondents said that “appropriate technical training is needed to reduce conflict”; 72% of respondents stated “the availability of follow-up support such as counseling for nurses who experience verbal/physical violence”.</p>	<p>Hospital managers must demonstrate and document their commitment to the prevention of WPV. They should also prioritize preventing WPV, setting goals, targets, and effectiveness, providing adequate resources and support, and appointing leaders with the authority and knowledge to facilitate change and provide leadership. Ideally, employees with a different understanding of the workplace should be engaged in all aspects of the program. Employees are invited to communicate openly with management and to raise concerns without fear of reprisal.</p>
<p>[11] Eight ED nurses were purposely sampled. The data gathered were analyzed by theme using the Miles and Huberman technique.</p>	<p>To explore WPV as a function of the internal situation of ED nurses.</p>	<p>A descriptive phenomenological approach was carried out utilizing in-depth interviews.</p>	<p>Three themes emerged from the study: (i) the nurse reporting dilemma, (ii) “ready or not,” and (iii) the iceberg phenomenon. The conclusion demonstrates the internal factors that influenced nurses in reporting WPV.</p>	<p>The study highlighted that hospitals should remove the “normalization” of violence to reduce incidents and move from the “culture of blame” to the “culture of learning” to create a “culture of reporting.” Furthermore, an educational and training program should be reinforced for all forms of unacceptable violence. Senior managers must also adequately protect and support staff who have experienced violence.</p>

Table 1 (Continued)

Ref	Participant	Aims	Methods	Findings	Conclusions
[31]	Out of the total sample size of 161 individuals, 127 participants (78.9% response rate) from the Aceh Provincial Hospital participated in this study.	To explore the correlation between overtime and physical and emotional violence experienced by nurses working at the Aceh Provincial Hospital.	Quantitative approach with transversal study design. Data analysis used Univariate analysis (descriptive statistical tests) for time analysis. The bivariate analysis (chi-square test) revealed the relationship between the two variables.	The study found a significant association between overtime and the psychological abuse of nurses working at the Aceh Provincial Hospital (p=0.000). However, no such correlation was observed for physical abuse among the nurses at the hospital (p=0.290).	Overtime and psychological/non-physical violence are linked to verbal harassment and bullying/crowding. Nurses are tired of working overtime, thereby reducing their concentration at work. It will also affect the quality of service, which will affect the satisfaction of service recipients, which may lead to WPV.
[32]	Data were obtained from 120 RNs employed in a mental health hospital in West Java.	Examine the violence and related factors experienced by Indonesian nurses.	A descriptive transversal design was used in the present study.	46.7% of nurses reported verbal abuse, 29.2% physical assault, and 24.2% verbal and physical abuse. Of those who experienced both verbal and physical abuse, 27.6% were victims of acute care, and 32.1% were victims of routine treatment and unit rounds. Nurses with degrees were more likely to be physically assaulted and to experience physical and verbal abuse than those with an undergraduate degree. Nurses working in the ICU tended to experience more physical and verbal abuse than in other units.	Developing an electronic system is essential to assist nurses in requesting assistance from the safety team when patients are unruly, agitated, out of control, destructive, aggressive, life-threatening, and environmental. It is also essential to give nurses legal immunity from litigation and to create an ethics team that can protect the interests of nurses and patients.
[33]	The sample size in this study was 172 nurses using the snowball sampling approach in the Banda Aceh district.	Describe incidents of physical violence by nurses in Banda Aceh's district.	The present study uses a descriptive method and a transversal study approach.	Nurses had never been subjected to physical violence in the past 12 months. However, up to 7% of nurses witnessed physical abuse, and 2.9% reported incidents of physical abuse.	Implementing a reporting mechanism is vital to ensuring that nurses are adequately protected in a safe workplace so that quality health services can meet the community's interests.

<p>[13]</p> <p>The research applied the snowball sampling technique to gather information from 433 participants. The criteria for inclusion were nurses working at a single hospital with at least two years of experience.</p>	<p>This study aimed to collect information on both physical and non-physical violence against nurses in hospitals throughout Aceh Province while also pinpointing the individuals responsible for these acts.</p>	<p>This research employs a cross-sectional design and utilizes a quantitative, descriptive approach. Data was collected through web-based questionnaires distributed to selected respondents via Google Forms.</p>	<p>Nurses in hospitals across Aceh Province reported experiencing workplace violence, which included physical assault (15%) and sexual abuse (5.5%), significantly affecting their well-being. A significant number (64.4%) dealt with emotional abuse, 37.9% faced verbal threats, and 10.4% were subjected to verbal sexual harassment. In 60.3% of the incidents, relatives and patients' families were identified as the primary perpetrators.</p>	<p>Nursing associations are vital in providing guidance, regulatory frameworks, and educational materials regarding workplace violence. Their support is essential for identifying and addressing potentially violent behaviors swiftly, which significantly contributes to reducing violent incidents at work.</p>
<p>[14]</p> <p>The study involved experienced nurses from public hospitals, including seven key informants. These participants were chosen through purposive sampling, where individuals were selected intentionally based on defined criteria for study inclusion.</p>	<p>This study seeks to comprehensively examine, analyze, and document workplace violence incidents and related experiences nurses face in hospitals in Aceh, Indonesia.</p>	<p>This qualitative research initiative aims to carefully identify the types of WPV nurses face, analyze the factors that contribute to these incidents, and thoroughly investigate current reporting procedures through detailed interviews.</p>	<p>Three key themes emerge from the analysis. The first theme addresses the nature and frequency of incidents, shedding light on their prevalence and defining characteristics. The second theme investigates the various forms of workplace violence faced by nurses, such as physical assault, emotional abuse, threats, verbal sexual harassment, and sexual abuse. Lastly, the third theme focuses on the difficulties of reporting incidents of workplace violence in the healthcare environment, highlighting the existing barriers and complexities.</p>	<p>Apparent and standardized regulations for reporting incidents of workplace violence, along with the essential support and infrastructure, are vital for managing these situations effectively. The ultimate goal is to encourage and assist nurses in reporting violent acts and managing them more effectively.</p>

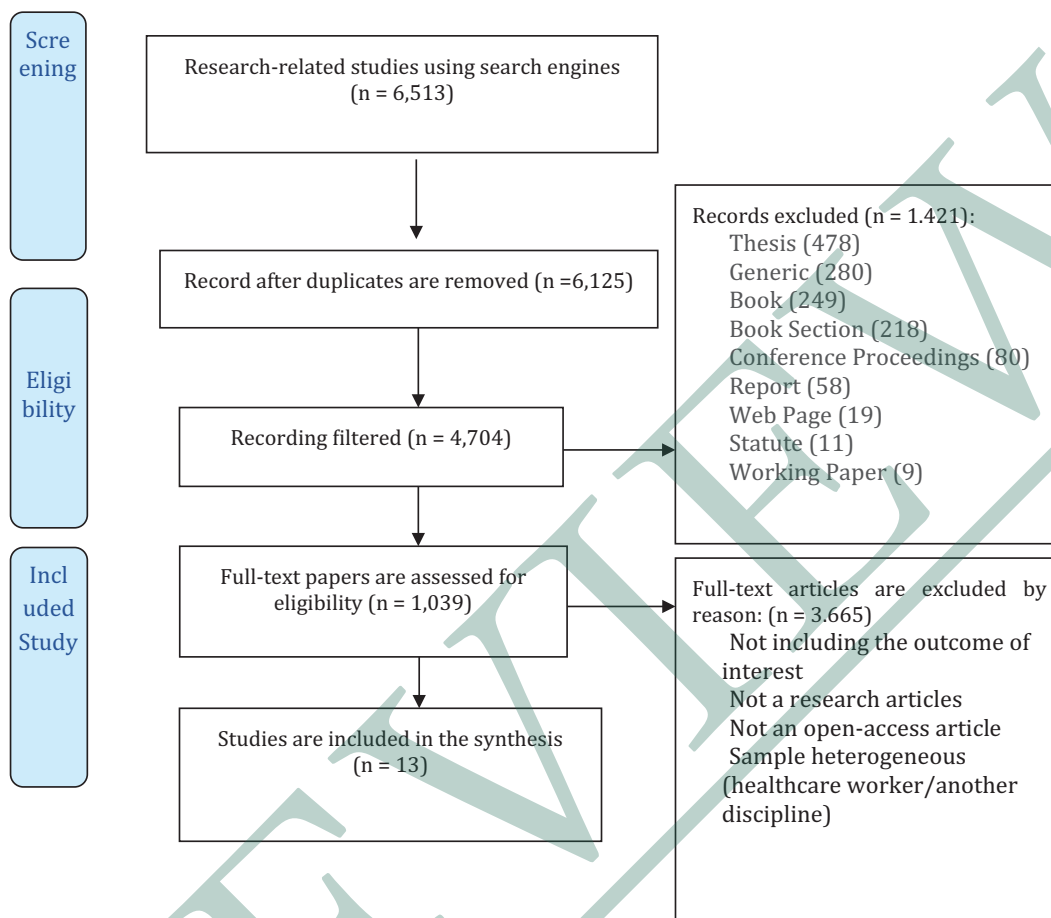


Figure 1. PRISMA flow diagram.

Critical appraisal tools evaluated methodological quality and risk of bias based on study design. The CASP checklist was used for qualitative studies, while the JBI checklist was used for quantitative analyses, categorizing risk as low, moderate, or high. Effect measures varied due to qualitative and quantitative designs. Quantitative studies reported prevalence rates, odds ratios (ORs), and confidence intervals (CIs), while qualitative studies employed thematic analysis to derive insights [24].

A narrative synthesis grouped and interpreted findings thematically to identify commonalities, differences, and contextual factors influencing WPV among nurses in Indonesian hospitals. Potential reporting biases were considered during quality appraisal. The certainty of the evidence from quantitative studies was assessed using the GRADE

approach, evaluating study limitations, consistency, directness, precision, and publication bias, resulting in high, moderate, low, or very low overall ratings.

3. RESULTS

A total of 13 studies were included in this scoping review, comprising quantitative cross-sectional surveys, qualitative phenomenological studies, and descriptive analyses. The studies were conducted across diverse hospital settings in Indonesia, including emergency departments, intensive care units, inpatient wards, operating rooms, and mental health hospitals. Most participants were registered nurses providing direct patient care, with several studies focusing specifically on high-risk units such as emergency and critical care departments. This diversity

of settings allowed for a comprehensive mapping of workplace violence experiences across clinical contexts.

3.1. Incidence of WPV Among Nurses in Indonesia

Empirical studies reveal the widespread and complex nature of WPV against nurses in Indonesian hospitals [10]. Findings show that 10% of emergency nurses face physical violence, mainly from patients, while 54.6% experience non-physical violence, mostly from patients' families. Alarming, 55.6% are discouraged from reporting incidents, and only 10.1% have received WPV management training [9]. Verbal abuse is the most common form (54.3%), followed by bullying (28.6%), physical violence and threats (19%), sexual harassment (11.4%), and harassment (8.6%). Most acts are committed by patients' families (63.5%) and are linked to nurses' job stress, with verbal abuse being the most significant factor [26].

Verbal violence is the dominant type (85%), involving ridicule, cursing, and insults, often rooted in societal perceptions of nurses' lower professional status [27]. Another study revealed that 46.7% of nurses experienced verbal abuse, 29.2% physical assault, and 24.2% both forms. These incidents were more frequent in acute care (27.6%) and routine units (32.1%), particularly among nurses with advanced degrees and those in ICU settings [32]. More recent data indicated that while no nurses reported being physically abused in the prior year, 7% witnessed physical violence, and 2.9% formally reported it, reflecting ongoing underreporting and normalization [10, 33].

Regarding contributing factors, an earlier study identified age, years of service, job position, and organizational climate as significant, with the environment being the most influential (OR = 3.483) [28]. Zulfan et al. also reported that verbal abuse was significantly influenced by occupational status, shift work, work unit, job stress, and organizational climate, accounting for 21.2% of the variance [29]. Institutional evaluations further revealed systemic gaps. In one accredited hospital, 100% of respondents reported no policy evaluations or violence

prevention training, and 92% were unaware of any policy revisions. Another hospital showed partial policy implementation, with 40% acknowledging verbal violence policies and 48% indicating a need for reporting mechanisms and conflict-resolution training [30]. Reinforcing this point, it is noted that institutional support remains limited, while cultural stigma hinders reporting [10]. They called for policy reforms, improved communication, and the development of a culture of accountability to reduce WPV in Indonesian healthcare environments [14].

3.2 Implication of WPVEM for Nurses in Indonesia

This review identifies critical challenges in addressing WPV among nurses in Indonesia, emphasizing the urgency of context-specific strategies that promote awareness, improve reporting, and facilitate effective educational interventions. A significant barrier is the persistent underreporting of WPV, often likened to an iceberg phenomenon in which many incidents go unreported due to internal and systemic constraints. These include fear of retaliation, normalization of violence in healthcare settings, limited managerial support, and a prevailing culture of silence within institutions [11].

WPV is especially prevalent in regions such as Aceh Province, where a history of armed conflict has intensified aggression toward healthcare workers. A previous study highlighted frequent occurrences of verbal and physical violence by patients and their families in Aceh [13]. A subsequent investigation revealed that many nurses avoid reporting such incidents due to a lack of trust in institutional processes, fear of repercussions, and limited knowledge of support mechanisms [14]. The seriousness of WPV in Indonesia is further underscored by data from the International Committee of the Red Cross, which recorded over 600 WPV incidents targeting healthcare workers during the COVID-19 pandemic, including events across Kalimantan, Java, and Sumatra involving both civilians and state actors [31, 34].

A qualitative study adds depth to these findings, which identified key themes from nurses' experiences, including their understanding of WPV, its verbal forms, the triggers of abuse, and coping

strategies [25]. Similarly, recurrent concerns were the reluctance to report incidents, lack of preparedness, and continuation of the iceberg effect [11]. These results suggest the need for a comprehensive WPVEM tailored to address personal and institutional barriers.

Organizational responses must be proactive and inclusive. Meri and Mayenti advocated that hospital leaders set clear objectives, allocate appropriate resources, and appoint competent leaders, while ensuring broad employee engagement in anti-violence initiatives [24]. Cultivating a culture of open communication, shifting from blame to learning, is vital to fostering trust and reporting [11]. From technological and ethical perspectives, integrating electronic alert systems was proposed to enable rapid staff access to security during violent episodes [32]. Legal protections should also be established to shield staff who report violence in good faith, with ethics committees supporting both patient and healthcare provider rights [32, 33].

4. DISCUSSION

Workplace violence against nurses remains a significant global concern, with international evidence indicating that up to 90% of nurses experience at least one form of violence during their careers [35]. Consistent with this global pattern, studies in Indonesia report a high prevalence of WPV in hospital settings. Zahra and Feng documented that 54.6% of nurses experienced non-physical violence and 10% reported physical violence, most often perpetrated by patients or their family members [9]. However, these figures likely underestimate the true magnitude of the problem because WPV is widely underreported. This phenomenon, often described as the “iceberg phenomenon”, reflects systemic and institutional barriers that prevent incidents from being formally recorded or addressed [11].

Evidence from Aceh Province further illustrates the depth and complexity of this issue, showing that nurses in post-conflict settings are particularly vulnerable to verbal and physical violence, largely driven by interactions with patients and their families [13]. Follow-up findings showed consistently low reporting rates, caused by limited trust

in institutional procedures, fear of retaliation, and a lack of awareness about available support systems [14]. These patterns are not exclusive to Indonesia and are consistent with wider national and global literature, suggesting that nurses often see violence as a normal part of their job and thus tend to avoid using formal reporting systems [11, 36].

The consequences of WPV extend beyond immediate physical harm to include substantial psychological and professional impacts. Repeated exposure to violence has been linked to reduced job satisfaction, emotional exhaustion, anxiety, depressive symptoms, and somatic complaints such as sleep disturbances and headaches [37-42]. At the organizational level, WPV leads to increased staff turnover, lower workforce morale, and reduced patient safety, impacting overall healthcare quality and system performance [39, 41].

Despite the severity of the issue, institutional efforts to address WPV in Indonesian hospitals are still insufficient. Data show that organizational support structures, such as formal reporting systems and post-incident counseling, are often inconsistently available or missing [14]. Studies show that many hospitals lack structured policies or educational interventions to prevent WPV [30]. Additionally, the absence of clear definitions of WPV, inconsistent enforcement of rules, and a culture of silence contribute to the normalization of violence [9, 43].

At the policy level, Indonesia has yet to establish a comprehensive framework to prevent and manage WPV in healthcare settings. Current legal instruments, including Law No. 12 of 2022, primarily address sexual violence and do not encompass the broader spectrum of physical, verbal, and psychological violence that nurses encounter [20]. This policy gap highlights the urgent need for a structured WPVEM. International frameworks like NOVA, AWAKE, and the Prevention and Management of Violence in Health Care model provide valuable insights by focusing on preventive education, early risk detection, de-escalation strategies, and organizational readiness [14, 15, 17, 18]. However, these models require contextual adaptation to align with Indonesia's sociocultural and institutional realities.

Successfully implementing a WPVEM in Indonesia relies heavily on strong institutional

commitment. Hospital leadership is crucial for emphasizing violence prevention by setting clear goals, allocating sufficient resources, and appointing capable leaders to oversee policy enforcement [28, 30]. A positive organizational climate backed by strong anti-bullying policies is crucial for encouraging nurses to report incidents without fear of blame or retaliation. Additionally, technological tools such as electronic alert systems that enable quick access to security support during violent situations can further enhance protections for frontline staff [44]. Moreover, healthcare workers who report WPV in good faith should be protected by law, and ethics committees ought to be established to defend the rights of both staff and patients [32, 33].

Additionally, occupational medicine is a potentially useful yet underutilized component of WPV prevention in Indonesia [45]. It usually involves risk prevention, hazard detection, post-incident health assessments, and fostering safe work environments. However, its role in addressing WPV is limited because there are no specific rules, institutional mandates, or standardized clinical procedures concerning violence in healthcare [46]. Consequently, responses to WPV tend to be reactive and inconsistent, relying primarily on local managers' judgment rather than coordinated occupational health strategies [11]. Integrating occupational medicine into the WPVEM framework may enhance systematic risk assessments, health monitoring for nurses, documentation of violence outcomes, and cooperation with hospital management on prevention efforts [47]. This integration would help shift the focus from individual blame to a preventive, system-oriented approach that prioritizes worker safety and organizational accountability.

This study acknowledges certain limitations, such as the fact that most included studies are observational, which limits causal inference. Additionally, reliance on published research may have omitted relevant grey literature, and regional variations in reporting suggest that findings may not be universally applicable across Indonesia. Despite these issues, the practical, policy, and research implications are evident. Indonesian healthcare facilities should adopt structured, context-specific WPVEM systems; policymakers need to strengthen legal and

reporting frameworks; and future research should evaluate the long-term effects of educational and occupational health initiatives aimed at reducing workplace violence. These measures will help build a safer, more adaptable healthcare system that protects both healthcare workers and patients.

5. CONCLUSION

WPV in hospitals is not new in healthcare, especially in nursing. The violence occurred regardless of age, gender, position, and other factors. WPV can affect psychological performance during hospital work. There needs to be facilities and institutions to channel and convey problems, especially violence against nurses, be it physical, psychological, sexual, or/racial violence, so that these incidents can be followed up and receive the appropriate punishment according to the level and severity of violence committed against nurses.

Policymakers and stakeholders should prioritize WPV prevention by creating education programs, encouraging incident reporting, and providing access to enhanced OSH training to help reduce violence against health workers. Additionally, facilities and infrastructure must be designed with policies that minimize violence against nurses and foster a safe, supportive work environment. Ultimately, adopting a culturally appropriate WPVEM supported by legal frameworks, digital technologies, and strong leadership is essential to reducing WPV and promoting safe, rights-based healthcare settings in Indonesia.

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AUTHOR CONTRIBUTION STATEMENT: AP conceptualized the study and drafted the manuscript. HK critically reviewed the research concept and contributed to manuscript editing. YY, MM, and AM were responsible for identifying relevant themes and conducting data extraction. All authors reviewed and approved the final version of the manuscript.

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PREVIEW



MATTIOLI 1885

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APPENDIX

SUPPLEMENTARY MATERIAL: S1

COMPLETE SEARCH STRATEGY FOR SCOPING REVIEW

1. Overview

This supplementary material includes the full and reproducible search strategy for this scoping review. It aims to thoroughly identify studies on workplace violence (WPV) among nurses in Indonesian hospital settings, following scoping review methodology and PRISMA-ScR guidelines.

2. Databases and Sources

The literature search was conducted between December 5, 2024, and March 15, 2025, across the following sources:

- Elsevier (ScienceDirect)
- Google Scholar
- ResearchGate
- National & Institutional repositories (e.g., Garuda, Neliti)

Additionally, manual searches of the reference lists of included studies were conducted to identify additional relevant articles.

3. Search Keywords and Boolean Strategy

The search strategy was developed using a combination of keywords and Boolean operators based on the Population–Concept–Context (PCC) framework:

- Population: Nurse, Nurses, Nursing staff.
- Concept: Workplace violence, Occupational violence, Abuse, Aggression, Harassment, Bullying.
- Context: Hospital, Healthcare setting, Indonesia.

4. Full Search Strings (Examples per Database)

4.1 Elsevier (ScienceDirect)

("workplace violence" OR "occupational violence" OR abuse OR aggression OR harassment OR bullying)
AND (nurse OR nurses OR "nursing staff")
AND (hospital OR "healthcare setting")
AND (Indonesia)

4.2 Google Scholar

("workplace violence" AND nurse AND hospital AND Indonesia)
OR ("kekerasan di tempat kerja" AND perawat AND rumah sakit AND Indonesia)

Additional filters applied:

- Year: 2018–2025
- Language: English OR Bahasa Indonesia

4.3 ResearchGate

("workplace violence" OR abuse OR harassment)
AND (nurse)
AND (Indonesia hospital)

4.1 National & Institutional Repositories

("kekerasan" OR "kekerasan di tempat kerja")
AND (perawat)
AND (rumah sakit)
AND (Indonesia)

5. Search Limits and Filters

The following inclusion filters were applied:

- Publication years: 2018–2025.
- Language: English and Bahasa Indonesia.
- Study type: Original research (quantitative, qualitative, or mixed-methods).
- Setting: Hospital settings in Indonesia.
- Population: Registered nurses.

6. Eligibility Criteria

6.1 Inclusion Criteria

Studies were included if they met the following criteria:

- Original empirical research.
- Focused on workplace violence.
- Conducted in hospital settings in Indonesia.
- Included nurses as the primary population.
- Used quantitative, qualitative, or mixed-methods designs.
- Available in full-text.

6.2 Exclusion Criteria

Studies were excluded if:

- a. The review does not focus specifically on nurses; for example, it considers mixed healthcare workers without separate analysis.
- b. It was not conducted in hospital settings and excludes reviews, editorials, theses, conference abstracts, or reports.
- c. Full-text versions are not available, and the publications are not written in English or Bahasa Indonesia.

7. Study Selection Process

All retrieved records were exported into a structured spreadsheet for screening. The selection process involved two stages: firstly, screening titles and abstracts to exclude irrelevant studies, and secondly, conducting a full-text review to determine eligibility.

This process was carried out independently by two reviewers, with any disagreements

resolved through discussion or by involving a third reviewer. The selection process is illustrated in the PRISMA flow diagram included in the main manuscript.

8. Additional Search Procedures

- a. Backward citation tracking involved screening the reference lists of included studies.
- b. Manual search included reviewing key journals and relevant Indonesian publications.
- c. Grey literature was considered only in accessible institutional repositories.

9. Notes on Search Adaptation

The search strategy was adapted to each database's functionality, including:

- a. Simplified keywords are used in Google Scholar, while Boolean operators and phrase searches are employed in ScienceDirect.
- b. Repositories feature broader keyword combinations due to limited indexing.