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ORIGINAL ARTICLE

Assessing workplace well-being in healthcare: The violence-prevention climate and its relationship with workplace happiness

Ahmet Y. Yesildag MHA, Research Assistant[1,2] | **Ayten Turan Kurtaran PhD, Professor**[1] | **Ferit Sevim MHA, Research Assistant**[1,2]

[1]Faculty of Health Sciences, Health Management Department, Karadeniz Technical University, Trabzon, Turkey

[2]Institute of Health Sciences, Ankara University, Ankara, Turkey

Correspondence
Ayten Turan Kurtaran, Karadeniz Technical University, Farabi Street, Building 88, Office:213 Trabzon, Turkey.
Email: ayturan@ktu.edu.tr

Abstract

Aim: To identify the relationship between the violence-prevention climate and workplace happiness in hospitals. The secondary objective is to adapt a valid and reliable scale to a different culture in healthcare settings.

Background: Healthcare settings are not immune to the harmful effects of violence, which can exacerbate existing challenges such as staff shortages. In the midst of these challenges, organizational efforts to ensure the safety of health workers are critical. These efforts can contribute positively to workers' happiness or well-being.

Method: Using a cross-sectional design with 400 healthcare professionals from five hospitals in Trabzon, Turkey, data collection involved the Violence-Prevention Climate Scale and Workplace Happiness Scale. Confirmatory factor analysis was conducted to test the Turkish validity and reliability of the scale, and the consistency coefficient was calculated.

Results: The findings revealed that, on average, employees exhibited high levels of violence-prevention climate ($\bar{x} = 4.22$) and moderate levels of workplace happiness ($\bar{x} = 3.70$). Subsequently, correlation analysis unveiled a statistically significant association between the dimensions of violence-prevention climate and workplace happiness ($p < 0.05$, $r = 0.392$). It was observed that those who experienced violence and did not feel safe in the workplace had lower levels of happiness.

Discussion: The instances of healthcare workers being exposed to violence identified in the study largely align with previous theories related to both individual and organizational effects.

Conclusion: Violence-prevention climate affects the safety and workplace happiness of workers.

Implications for nursing and/or health policy: Employees expect their managers to seriously consider all reports of violence. In this context, creating a violence-prevention climate would be a good start. According to WHO 2030 targets, in an environment where there is a significant shortage of healthcare personnel, especially nurses, ensuring that existing employees work in a safer and happier environment will make a positive contribution to healthcare systems.

KEYWORDS

Health workers, violence, violence-prevention climate, workplace happiness

INTRODUCTION

Workplace violence is a global phenomenon that manifests as an issue causing adverse effects among both private and public healthcare professionals. This is particularly evident for nurses who play a crucial role, often at the forefront, in any healthcare setting (Salvador et al., 2021). Policy- and decision-makers must prevent, monitor, and manage this violence against health workers (Civilotti et al., 2021).

Globally, workplace violence within the healthcare system has evolved into a substantial occupational and public health concern (Dean et al., 2021). On a global scale, both verbal and physical aggression directed at healthcare professionals has escalated to alarming levels (Vento et al., 2020). A study found that promoting environmental safety within the workplace and implementing policies for the prevention of violence play a crucial role in strengthening the safety-related behaviors of employees (Shea et al., 2017). These measures are pivotal in augmenting both the quality of work and interpersonal interactions (Chang et al., 2019). Preventing and managing this issue is possible only if policymakers and administrators create comprehensive approaches to violence prevention (Jacob et al., 2021).

Pinar et al. (2017) showed that multidimensional, comprehensive, and preventative analytical programs that address the issue of violence from social, cultural, environmental, political, institutional, organizational, and individual perspectives can minimize the frequency of violent incidents.

Intense violence in the health sector, as in other fields, is associated with decreased job performance and job satisfaction, an increased intention to leave (Alzoubi et al., 2021), and mental health problems in health professionals (Yang et al., 2018).

Violence in the healthcare profession is frequently regarded as a cultural norm. It is vital to ensure that this cultural perception of healthcare professionals changes (Hartley et al., 2015). Therefore, creating a climate that supports the prevention of violence becomes increasingly important. Violence-prevention climate is expressed as one of the organizational factors for reducing or preventing violence (Spector et al., 2015). In other words, it is the perceptions that organizations create of their employees regarding their policies, processes, and practices to avoid and regulate workplace violence or aggression (Kessler et al., 2008). In this context, a preventive approach should be adopted, and a well-designed analysis and reporting system should be established to identify risk factors for violence, aiming to prevent violence before healthcare workers are affected (Hassankhani et al., 2018). The climate for the prevention of violence in health includes the actions of staff and patients and organizational and environmental factors that come together to contribute to the prevention of violence at primary and secondary levels (Hallett et al., 2018).

In interviews with experts, there is a relationship between violence and happiness in organizations (Sarkar, 2021). Workplace happiness relates to how content individuals are with their jobs and lives. Workplace happiness is critical to increase productivity in any organization. As a result, it is essential to comprehend what factors influence workplace happiness (Wesarat et al., 2014). A study conducted in China suggests that exposure to workplace violence negatively affects innovative work behavior, with employee happiness playing a mediating role in this relationship (Zhou et al., 2020).

Healthcare institutions have a significant risk of experiencing both internal (Type III) and external (Type II) violence (Byon et al., 2022; Hamblin et al., 2016). According to the National Institute for Occupational Safety and Health (NIOSH), workplace violence is typically categorized into four main types, yet in healthcare settings, Types II and III are most commonly witnessed (NIOSH, 2020). Type II involves violence from a customer, client, or patient, where an individual while receiving services exhibits aggression despite having a relationship with the business. Type III encompasses worker-on-worker violence, where an employee attacks or threatens another employee (American Nurses Association, 2023). People working in many different disciplines in the health sector work in a common ecosystem. The connection between the healthcare sector and violence is strong due to employees recognizing those subjected to violence, providing services to those resorting to violence, and the reasons for employees being exposed to violence (Ali, 2018). Specifically, nurses emerge as the most susceptible professionals to violence, encountering verbal abuse at least once throughout their professional careers (Alzoubi et al., 2021; Byon et al., 2022). Although nurses are commonly identified as the most vulnerable group to workplace violence in different regions worldwide, in Turkey, physicians and dentists have been documented as the most vulnerable groups to workplace violence within the healthcare sector (Pinar et al., 2017). However, findings from subsequent studies suggest that nurses in Turkey are exposed to violence more than other professionals (Bingöl & İnce, 2021; Demirci & Ugurluoglu, 2020). Note that violence is a very common and undesirable experience for healthcare workers. The repercussions of workplace violence are pertinent to the healthcare system as it detrimentally impacts the quality of care, long-term financial costs, and the retention of healthcare workers (Dean et al., 2021). Workplace violence experiences, the establishment of a violence-prevention climate, and positive emotions related to work excitement play pivotal roles in influencing the intricate pathways through which professional commitment affects nurses' intentions to leave their position (Chang et al., 2019).

In Turkey, several studies conducted to investigate the causes and types of violence in healthcare institutions found high incidence rates and resulted in specific recommendations (Çevik et al., 2020; Hamzaoglu & Türk, 2019). The majority of these studies have focused on the frequency and types of

violence, with very few delving into the examination and analysis of policies aimed at violence prevention (Sevim & Akbulut, 2024). Although monitoring and reporting the number of violent incidents in healthcare services are important, additional and complementary data sources are needed for a comprehensive examination of the workplace violence environment (Brunero et al., 2021). The examination of the atmosphere or climate of violence within healthcare settings is recommended by the World Health Organization and at the local health service level, as it is believed to significantly impact treatment efficacy (WHO, 1953).

It is important to measure the climate for preventing violence to which healthcare personnel are exposed. Therefore, this study sought to answer the following research questions: Is there a difference between violence-prevention climate and workplace happiness according to sociodemographic characteristics? What is the relationship between organizational climate and workplace happiness in health institutions where the potential of being exposed to and experiencing violence among health personnel is high? To achieve this primary objective, we aim to develop a measurement tool specific to healthcare workers in Turkey. Through this, we aim to provide a more comprehensive understanding of the organizational factors affecting workplace happiness and incidents of violence and to contribute to the body of knowledge.

METHODS

Participant

This correlational study sample included 400 healthcare professionals currently working in hospitals in Trabzon, a city that holds significance as one of the major urban centers in the Black Sea Region of Turkey. A total of 6593 health personnel work in hospitals in Trabzon city center. Using Calculator.net, the required sample size was calculated to be 364. The calculation was made with a 95% confidence interval and a 5% margin of error. The research data were collected from a university hospital, a public education and research hospital, a general hospital, and two branch hospitals operating in the provincial center. The study was conducted only in hospitals located in the provincial center due to financial and time constraints. Among these hospitals, data were collected from five institutions that gave official consent to the study. The participants were included in the study through accidental sampling (Kumar, 2018). Physicians, nurses, paramedics, medical secretaries, and individuals working in administrative offices participated in the study.

Collection of data

The questionnaire consisted of three sections. In the first part, demographic characteristics such as gender, age, marital status, occupation, institution, duration of work in the profession and institution, and previous exposure to violence were explored. The second part contained the Violence-Prevention Climate Scale, which was adapted from English to Turkish. The adaptation process of the scale followed the adaptation guidelines prepared by the International Test Commission (ITC, 2017). The translation back into English was approved by the scale's developer.

The scale consists of practice, policy, and pressure dimensions and 12 statements. The adapted scale was developed by Kessler et al. (2008) and contained 18 statements in a 6-point Likert-type scale. However, in this study, the authors adapted the validated version of the scale with 12 statements (Yang et al., 2012) into Turkish. In the third part, the Workplace Happiness Scale developed by the World Health Organization and adapted into Turkish by Alparslan (2016) was used to measure employees' workplace happiness. Both scales provided valid and reliable measurements in their original forms. The measurements were conducted on a 6-point Likert scale, where respondents could score a minimum of 1 and a maximum of 6 points for a single item.

The inclusion criteria consisted of individuals who (a) were actively employed in a hospital in Trabzon and (b) voluntarily agreed to participate in the questionnaire survey without predisposition. Exclusion criteria included employees currently on sick leave, maternity leave, annual leave, or absent during the data collection period, who were not considered for inclusion in the study.

The data were collected by visiting hospitals during working hours and on-call hours between January and April 2022. Participants were invited to participate in the study by visiting outpatient clinics, clinics, emergency departments, and administrative offices at different times without any discrimination. Although some employees responded face to face instantly, some forms were collected later. Ethical approval was granted by the Karadeniz Technical University Faculty of Medicine Scientific Research Ethics Board (number 24237859-783). The board thoroughly assessed and approved the study's adherence to all pertinent ethical standards. Participants were selected based on inclusion and exclusion criteria.

Analysis of data

The SPSS 23.0 program was used to calculate the distribution frequencies based on the demographic characteristics of the participants, to assess the normal distribution assumptions, and to assess the scale's internal consistency. In addition, the mean and standard deviation values of the scores obtained from the measurements were determined. These differences were then compared between the groups in the research variables. In this context, the data were analyzed with *t* test and ANOVA test. As the scale has an original theoretical factorial structure, confirmatory factor analysis was performed to test the compatibility of the Turkish measurement with the existing structure (Brown, 2015). The confirmatory factor analysis

is conducted to determine whether a previously designed scale operates with its original structure in multiple languages and cultures (Karagöz, 2019). Analysis was done through the SPSS AMOS 24.0 program to test the scale in terms of structure. The STROBE checklist was followed during the research and reporting process (von Elm et al., 2007).

RESULTS

Over half the sample (53%) was female; of the participants, 49.5% were aged between 36 and 55. When the participants are examined in terms of profession, 35% are nurses, 21.8% are medical secretaries, 18% are administrative staff, and 17% are physicians. The participants in the other group work in various departments as pharmacists, physiotherapists, psychologists, audiologists, and health technicians. In the study, 35% of the participants stated that they did not feel safe in the institution they worked in, and 48.9% were exposed to violence at least once. The type of violence experienced is mostly verbal violence (82.5%). Finally, 24.2% of the participants think that they may be exposed to violence by the staff in the institution they work for.

Table 1 shows the kurtosis skewness values, standardized regression coefficients (SRW), and Cronbach's alpha reliability coefficients of the scale. The SRW of the items in the Violence-Prevention Climate Scale vary between 0.53 and 0.93. The Cronbach's alpha coefficients of the total Violence-Prevention Climate Scale and its subdimensions were estimated as 0.876 (total), 0.921 (practices), 0.909 (policies), and 0.756 (pressure). When the kurtosis and skewness values for the items and dimensions of the scale are examined, all the values in the table are sufficient for the assumption of normal distribution (Tabachnick & Fidell, 2013). Figure 1 shows the confirmatory factor analysis goodness-of-fit values.

Figure 1 shows the path diagram and summary of the model. Data obtained from the research sample are compatible with the original structure of the scale. Model-fit values that are frequently checked in structural equation models and confirmatory factor analysis are x^2/df (relative chi-square index), goodness-of-fit index, comparative fit index, RMSEA, and normed fit index values (Karagöz, 2019). According to Karagöz (2019), these values are in perfect harmony with the original structure of the scale.

Table 2 provides an overview of the differences in participants' perceptions of the violence-prevention climate and workplace happiness concerning sociodemographic variables. In light of these findings, it was observed that physicians had lower perceptions of the violence-prevention climate compared with other professional groups. Regarding workplace happiness, individuals working in administrative roles were found to have a higher level of workplace happiness compared with other groups. When the measurements were evaluated based on participants' feelings of safety at work, the group who did not feel safe exhibited a lower level of both violence-prevention climate and workplace happiness.

TABLE 1 Kurtosis, skewness values, and Cronbach's alpha (a) coefficients of the violence-prevention climate.

Scale items and dimensions	SRW	Skewness	Kurtosis	(a)
Practices1. Management in this organization quickly responds to episodes of violence.	0.85	−0.763	−0.216	**0.921**
Practices2. Management encourages employees to report physical violence.	0.88	−0.863	−0.245	
Practices3. Management encourages employees to report verbal violence.	0.84	−0.715	−0.384	
Practices4. Reports of violence from other employees are taken seriously by management.	0.87	−0.955	0.191	
Practices (mean)		**−0.735**	**−0.181**	
Policies 1. My employer provides adequate assault/violence-prevention training.	0.93	−0.625	−0.449	**0.909**
Policies 2. In my unit, violence-prevention procedures are detailed.	0.83	−0.401	−0.865	
Policies 3. In my unit, there is training on violence-prevention policies and procedures.	0.70	−0.347	−0.966	
Policies 4. In my unit, employees are informed about potential violence hazards.	0.75	−0.401	−0.871	
Policies (mean)		**−0.391**	**−0.583**	
Pressure 1. In my unit in order to get the work done, one must ignore some violence-prevention policies.	0.89	−0.889	0.441	**0.759**
Pressure 2. In my unit, whenever pressure builds up, the preference is to do the job as fast as possible, even if that means compromising violence prevention.	0.69	−0.787	0.239	
Pressure 3. In my unit, human resource shortage undermines violence-prevention standards.	0.53	−0.695	−0.608	
Pressure 4. In my unit, violence-prevention policies and procedures are ignored.	0.57	−0.729	0.259	
Pressure (mean)		**−0.709**	**0.199**	
Total (Violence-Prevention Climate Scale)		**−0.161**	**−0.304**	**0.876**

Table 2 also includes the mean and standard deviation values of the Violence-Prevention Climate Scale, its dimensions, and the Workplace Happiness Scale, which are measured in a 6-point Likert-type scale. The employees' perceptions of the violence-prevention climate were at the level of $\bar{x} = 4.22$.

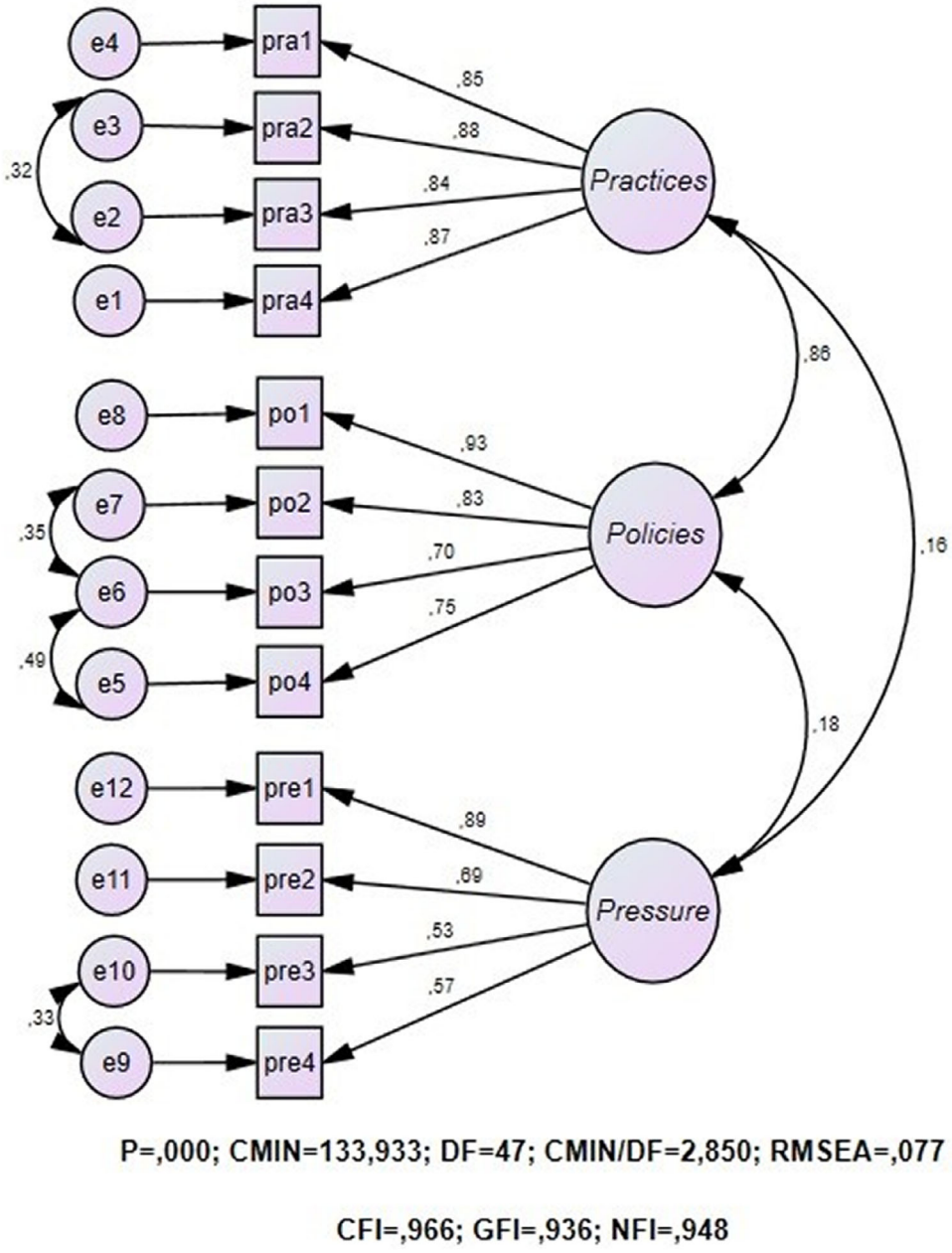

FIGURE 1 Confirmatory factor analysis model.

When considered at the level of dimensions, the dimension with the highest score was pressure ($\bar{x} = 4.48$). The dimension with the lowest perception was policies ($\bar{x} = 3.90$). The employees' workplace happiness level was at $\bar{x} = 3.70$ on average.

Table 3 shows the correlation values between Violence-Prevention Climate Scale and its dimensions. The results of the correlation test showed a high level of positive correlation at the $p = 0.001$ significance level. Accordingly, the dimensions that have a significant positive relationship with the total are, respectively, practices ($r = 0.871$), policies ($r = 0.864$), and pressure ($r = 0.505$). Positive correlation levels of the dimensions with each other are similar to the original scale (Chang et al., 2012). In this study, the correlation level between the practices dimension and the policies dimension was determined as 0.718, whereas the correlation value in the original version of the scale was 0.690. The practices dimension is partially correlated with the other two dimensions ($r = 0.175$–$r = 0.140$). This low-level relationship is also similar to the correlation levels of the original scale ($r = 0.230$–$r = 0.160$).

Table 3 also includes the correlation values between violence-prevention climate and workplace happiness. The result shows that perceptions of violence-prevention climate and employees' happiness levels have a significant positive relationship ($r = 0.392$). Additionally, the dimension most strongly associated with happiness is the practices dimension.

TABLE 2 Differences between means by sociodemographic variables.

Variables		Practices x̄\s	Policies x̄\s	Pressure x̄\s	Total VPCS x̄\s	Workplace happiness x̄\s
Mean scores	***N* = 400**	**4.28\1.26**	**3.90\1.29**	**4.48\0.97**	**4.22\0.90**	**3.70\0.87**
Profession						
Physician	68	3.78\1.27	3.30\1.34	3.88\1.00	3.66\0.93	3.49\0.78
Nurse	142	4.33\1.17	4.00/1.16	4.45\0.94	4.26\0.78	3.57\0.82
Med. secretary	87	4.48\1.17	4.26\1.26	4.73\0.88	4.49\0.84	3.71\0.94
Admin. staff	72	4.38\1.41	3.73\1.40	4.73\0.97	4.28\0.99	4.19\0.64
Others	31	4.30\1.26	4.16\1.21	4.56\0.76	4.34\0.78	3.63\1.09
ANOVA test (*p*)		0.009	0.001	0.001	0.001	0.001
Post hoc (Tukey)		(1–2, 3, 4)	(1–2, 3, 5)	(1–2, 3, 4, 5)	(1–2, 3, 4, 5)	(4–1, 2, 3, 5)
Feeling safe at work						
Yes	260	4.59\1.13	4.13\1.26	4.58\0.95	4.43\0.85	3.91\0.82
No	140	3.69\1.28	3.49\1.25	4.27\0.98	3.82\0.84	3.32\0.83
t test (*p*)		0.001	0.001	0.002	0.001	0.001

TABLE 3 Correlation analysis results (*r*).

Pearson correlation ***N* = 400**	**1**	**2**	**3**	**4**	**5**
1. Practices	1				
2. Policies	0.718	1			
3. Pressure	0.175	0.140	1		
4. VPCS (high is positive)	0.871	0.864	0.505	1	
5. Workplace happiness (high is positive)	0.404	0.267	0.207	0.392	1

Note: Correlation is significant at the 0.01 level (two-tailed). All *p*-values not indicated in the table are significant ($p < 0.05$).
Abbreviation: VPCS, Violence-Prevention Climate Scale.

DISCUSSION

In this study, perceptions of violence-prevention climate and workplace happiness were measured among health workers, who are a group with a high potential to be exposed to workplace violence. The measurements were analyzed with a focus on the sociodemographic variables of the employees and the their answers to some questions about violence. In addition, the interrelationship of variables such as violence-prevention climate and workplace happiness was analyzed.

Although there are organizational and managerial risk factors for workplace violence, there are suggestions for organizational processes at the solution point (OSHA, 2016). This study examined the relationship between violence-prevention climate and workplace happiness. However, it also serves a secondary purpose of adapting a scale as there is no validated short scale for the health sector in the Turkish literature. As there is no research on violence-prevention climate directly in the sample of health workers in the Turkish literature, this study was designed to adapt a scale for violence-prevention climate and to determine its relationship with workplace happiness. After obtaining permission from the scale owner, the adaptation study of Kessler et al.'s (2008) 18-item Violence-Prevention Climate Scale with a sample of employees in the service sector was published by Dursun et al. (2020). As the scale adopted in the study consisted of 18 expressions and was not measured directly in the sample of health workers, the study we designed continued when the conditions of the COVID-19 pandemic were appropriate. Goodness-of-fit values of the scale we adapted in the study are similar to the values of Dursun et al. (2020). According to Karagöz (2019), the goodness-of-fit values in this study's scale are at a better level. In line with the correlation analysis findings in the study, the relations between dimensions and the general level are also proportionally similar to the correlation levels of the original scale (Chang et al., 2012) and the study by Dursun et al. (2020).

When the values for the violence-prevention climate are examined, the means between the dimensions are similar to the study of Dursun et al. (2020), although the study group is from different sectors. Although the mean value for the practices dimension was $x = 4.28$ ($s = 1.26$) in this study, it was measured as $x = 4.14$ ($s = 1.30$) in Dursun et al. (2020). In the policies dimension, the mean value was measured as 3.90 ($n = 1.29$) in this study, whereas it was 3.88 ($n = 1.28$) in Dursun et al. (2020). Although the mean value of the pressure dimension was 4.48 (s = 0.97) in this study, it was 4.30 ($n = 1.86$) in Dursun et al. (2020). Although the sectors and provinces where the two studies were conducted are different, similar scores indicate a high cultural harmony in the management of the institutions. After the completion of this research, a 12-item scale was utilized during the publication revision phases (Reyhanoğlu & Akın, 2020). However, in that study, the original expression was excluded from the structural analyses. Therefore, this study retains its originality.

In this study, perceptions of violence-prevention climate and levels of workplace happiness among participants were compared based on their professions. Additionally, measurements were also compared based on whether individuals feel safe or not in the workplace. As a result, it was observed that

physicians have significantly lower perceptions of violence-prevention climate, and their levels of workplace happiness are also lower compared with others. Furthermore, it was found that employees who feel safe in the workplace have positive thoughts regarding violence-prevention climate and are happier in the workplace. From this perspective, feeling safe at work is considered crucial for employees' happiness. Establishing a violence-prevention climate can play a significant role in providing this sense of safety. Other authors also confirm the relationship between violence-prevention and safety climate in healthcare organizations (Rajakrishnan et al., 2022).

We observed that physicians have the lowest perception of violence prevention, whereas medical secretaries have the most positive perception of violence-prevention climate. This intriguing finding opens up new avenues for understanding the relationship between violence and staff dynamics.

The relationship between the well-being of healthcare workers and violence-prevention climate has also been addressed in another study (Reyhanoğlu & Akın, 2020). Reyhanoğlu and Akın (2020) found that the perception of violence prevention in their research was much more negative than the findings of this study. However, the existence of relationships between prevention climate and employees' job-related well-being is a common aspect of the studies.

Chang et al. (2024) emphasize that perceived health and sleep quality in healthcare workers are intricately associated with happiness. They examined the impact of these variables on burnout and noted that workplace violence significantly moderates this relationship. Our study also contributes to strengthening theories regarding happiness and violence by identifying the positive effects of feeling safe and perceptions of violence prevention on happiness. However, although Chang et al. (2024) included various professions, no differences were reported among occupational groups. In contrast, our study observed some differences among occupational groups. In another study, Sarıçoban and Ulusoy (2020) reported that perceptions of violence risk and associated intentions to leave employment did not differ among occupational groups.

Milet (2016) reports that 66% of healthcare workers are exposed to violence, the rate of verbal violence is higher, and the majority of workers continue to work without responding in case of verbal violence. In this study, 48.9% of the employees reported that they were exposed to violence. The fact that verbal violence is the most frequently exposed type is similar to Milet's (2016) study.

Some studies have investigated the violence-prevention climate and work-related attitudes in health institutions. Chang et al. (2018) stated, in their study with 973 nurses working in three hospitals in Taiwan, that the violence-prevention climate significantly affects the intention to leave and increases the perception of job frustration. Similarly, they found a linear and positive relationship between the perceptions of the violence-prevention climate and the level of workplace happiness. Vrablik et al. (2019) conducted qualitative interviews with 23 healthcare professionals working in an emergency room in the United States and reported that burnout might increase if employees are exposed to violence and actions to prevent violence are not taken. However, measures to prevent violence can increase employee welfare, but more research is needed. As in this research, violence-prevention activities have been associated with concepts such as burnout, well-being, happiness, and trust in studies in the literature.

In a review of research focusing on violence against nurses, Pagnucci et al. (2022) proposed that various environmental and organizational factors play a role in preventing horizontal and vertical violence. They found that management attitudes, organizational structure, misuse of procedures, workload, and staff shortages are triggering factors for violence. This study found that there was not excessive workload, staffing shortages, or undue pressure to complete tasks. Simultaneously, this circumstance positively affected the climate of violence prevention.

Zhang et al. (2021) emphasize that managers in healthcare institutions tend to overlook the effects of violence when distanced from the field and instead advocate for the development of policies and procedures. They advocate for exercise of zero tolerance toward violence. Our findings substantiate this perspective. Specifically, practices such as combating violence and encouraging employees to report incidents of violence have a more significant impact on the overall violence-prevention climate and workplace happiness compared with other factors. This underscores the pivotal role of violence-related policies and procedures in shaping workplace culture and the happiness of employees.

Chang et al. (2012) found that the experience of being exposed to violence increased tension and decreased motivation. However, clear policies, quick response of management to violence cases, and acceptance of employee safety as a priority increase motivation by reducing pressure on employees. Similarly, this study found a significant relationship between violence prevention and positive work attitudes.

A study conducted with 358 nurses working in three hospitals in Korea (Choi & Lee, 2017) found that 95.5% of nurses were exposed to violence in the last one year. Choi and Lee (2017) also reported that exposure to workplace violence negatively affects the quality of professional life and intention to leave. Ramacciati et al. (2018) state, referring to the study of Choi and Lee (2017), that significant relationships exist between violence and intention to leave work and the quality of work life in Italy as well. Similarly, this study found that exposure to violence and perceptions of violence-prevention climate negatively affect workplace happiness.

Han et al. (2022) report that 81% of 14,264 psychiatrists and psychiatric nurses working in 41 hospitals in China have been exposed to violence in the last one year. In addition, exposure to violence causes a lower quality of life, increased intention to leave, and decreased satisfaction. The results of this study are similar to those of Han et al. (2022).

In a study conducted with 696 nurses to determine the relationship between exposure to violence and the quality of nursing care (Chang et al., 2019), a significant relationship was found between professional commitment, intention to leave, job excitement, and violence. The violence-prevention climate

plays a moderating role in the interaction between exposure to violence and professional commitment, and this situation has a positive effect on the intention to leave in general. This study found that employees who perceive a high violence-prevention climate feel safe and happy in their workplace. Although these variables were not measured, the violence-prevention climate may also positively affect commitment and intention to leave the job.

Bayram et al. (2023) emphasize the impact of violence on the quality of care nurses provide. In this phenomenological study, the authors argue that incidents of violence lead to missed nursing care. They emphasize the necessity of organizational and educational policy actions in addressing this issue. In this regard, an organizational climate aimed at preventing violence will inevitably positively impact missed nursing care and the well-being of the staff. Similarly, the nurses who participated in Alshammari et al. (2023)'s study complained that there is a lack of information on violence management during formal education, on-the-job training, and orientation processes. Therefore, institutional education, policies, and procedures will contribute to the organizational climate of violence prevention and help minimize its effects.

Nart (2014), who studied with 213 healthcare workers from different occupational groups working in four public hospitals in the Southern Marmara Region, found no significant relationship between exposure to violence and emotional exhaustion, depersonalization and personal achievement variables ($p > 0.05$). However, Nart (2014) found that the job satisfaction levels of the employees who are exposed to violence are statistically lower. Our findings are similar to those of Çabuk (2020) and Nart (2014) in terms of positive attitudes toward work such as happiness, satisfaction, dedication, and performance.

de Barbieri et al. (2022) conducted a study on violence-prevention policies among nurses who were proficient in English and had smartphone access during the European Renal Care Association Conference in 2019. Half of the nurse participants from 23 different countries reported the absence of violence-prevention policies and procedures in their institutions, as well as a lack of training or courses dedicated to preventing violence. This study reported that within the dimension of policies containing statements about the presence of educational activities and violence-prevention procedures, the prevention climate was lower compared with other dimensions. Training for violence prevention is crucial for enhancing employees' skills and abilities to manage such situations. In fact, Havaei et al. (2019) emphasized that practical training and exercises remarkably influence employees' perceptions of safety in a positive manner.

Education, policy development, procedure establishment, and their comprehensive implementation play a significant role in preventing violence and impacting employee happiness. However, elements such as education and reporting impose responsibilities on the employees. Although this is not incorrect, as Spelten et al. (2020) suggested, these practices hold health workers who already experience heavy workloads accountable and further burden them. At this point we emphasize the value of attempting to prevent violence well before its occurrence and holding the perpetrator accountable rather than solely burdening the healthcare workers, who are already under substantial pressure.

Limitations and directions for future research

Study findings are limited to the sample of the study. However, the sample's high potential to reflect the universe and the opinions of various occupations working in different hospitals are significant strengths. Because the perceptions of healthcare professionals were measured in the study, the experience, expectations and evaluations of the violence-prevention climate in similar environments may differ among individuals. As a limitation, the analyses were carried out with the data obtained with a single measurement in a short period of time. Provided that it is cited, the use of the scale developed in the study does not require any permission from the authors. Testing the violence-prevention climate and rich structural models using different variables in future studies will contribute to the knowledge. Another limitation is the regional nature of the findings. Forms of interpersonal violence are subject to interpretation based on cultural contexts. Consequently, participants' interpretations of the phenomenon may exhibit variations according to the region, influencing the generalizability of the study findings.

Implications for nursing and health policy

This study underscores the significance of assessing the violence-prevention climate within healthcare settings, particularly for nurses. The findings indicate that healthcare workers, including nurses, who perceive a higher level of violence-prevention climate, tend to experience greater workplace happiness. This may include enhancing training on violence prevention and conflict resolution, providing support mechanisms for workers who have experienced violence, and fostering a safety culture. Evidence for the positive effects of employee happiness on the quality of healthcare is increasing (Caraballo-Arias et al., 2024; Gonçalves & Curado, 2023). Therefore, violence-prevention climate and employee happiness are integral not only for their professional satisfaction but also for the quality of care they deliver to patients. In addition, this research reinforces the importance of broader health and social policies that support the well-being of healthcare workers across various occupational groups. These policies should not only aim to reduce workplace violence but also emphasize the pivotal role of healthcare professionals in the healthcare system and society as a whole. By addressing these implications, nursing policy, health policy, and social policy can collectively contribute to enhancing the overall well-being of healthcare workers, improving patient care, and fostering a safer and more satisfying work environment in the healthcare sector.

CONCLUSION

This study found a significantly positive relationship between the violence-prevention climate in health institutions and the workplace happiness levels of employees. As a result of the study, a valid and reliable scale that can measure 12 items has been translated into Turkish.

Type II and III violence is seen most intensely in health institutions. The best prevention policy that organizations can make for their employees is to never compromise on violence prevention. The idea that violence is a part of the health profession should be rejected. Institutions should give importance to organizational factors, including significant risk factors and prevention methods for violence. In this way, it will be possible to obtain more information, better monitor the phenomenon, and implement more effective prevention and intervention protocols. At this point, creating and protecting a violence-prevention climate is essential for health institutions.

AUTHOR CONTRIBUTIONS

Study design: Ahmet Y. Yesildag and Ayten Turan Kurtaran. *Data collection*: Ahmet Y. Yesildag and Ferit Sevim. *Data analysis*: Ahmet Y. Yesildag. *Study supervision*: Ayten Turan Kurtaran. *Manuscript writing*: Ahmet Y. Yesildag, Ayten Turan Kurtaran, and Ferit Sevim. *Critical revisions for important intellectual content*: Ahmet Y. Yesildag, Ayten Turan Kurtaran, and Ferit Sevim.

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The authors declare no conflict of interest.

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ORCID

Ahmet Y. Yesildag MHA https://orcid.org/0000-0003-3116-4051

Ayten Turan Kurtaran PhD https://orcid.org/0000-0001-6116-6467

Ferit Sevim MHA https://orcid.org/0000-0001-6935-9650

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