Received: 5 May 2021 | Revised: 16 June 2021 | Accepted: 15 July 2021

DOI: 10.1111/jonm.13423

ORIGINAL ARTICLE

WILEY

Workplace violence from the perspective of hospital ward managers in Sweden: A qualitative study

Jenny Jakobsson PhD, Associate Senior Lecturer[1,2] |
Karin Örmon PhD, Associate Professor[1,3] |
Hanne Berthelsen Odont.Dr., Associate Professor[2,4] |
Malin Axelsson PhD, Associate Professor[1]

[1]Department of Care Science, Faculty of Health and Society, Malmö University, Malmö, Sweden

[2]Centre for Work Life and Evaluation Studies (CTA), Malmö University, Malmö, Sweden

[3]The Västra Götaland Region Competence Center on Intimate Partner Violence, Gothenburg, Sweden

[4]Faculty of Odontology, Malmö University, Malmö, Sweden

Correspondence
Jenny Jakobsson, PhD, Department of Care Science, Faculty of Health and Society, Malmö University, Malmö, Sweden.
Email: jenny.jakobsson@mau.se

Funding information
AFA Insurance, Grant/Award Number: 190220

Abstract

Aim: The aims of the study are to explore workplace violence perpetrated by patients or visitors from the perspective of hospital ward managers and to describe how ward managers perceive their leadership role and manage related incidents.

Background: Few studies focus on workplace violence from the perspective of ward managers even though they are the closest managers to the operational staff.

Method: Fifteen semistructured interviews were analysed using qualitative content analysis.

Results: Four categories emerged: the face of workplace violence, a two-fold assignment, strive towards readiness to act, and managing incidents.

Conclusion: While the most common acts of workplace violence are considered less serious and related to patients' medical conditions or dissatisfied visitors, hospital organizations focus on serious but rarely occurring incidents. Consequently, ward managers have limited opportunities to ensure a safe work environment on an everyday basis.

Implications for nursing management: To support ward managers' occupational safety and health management, workplace violence prevention and management should be acknowledged as an important responsibility for senior management in hospitals. It is important to identify incidents that most likely will occur at the wards and to create strategies related to those incidents. Strategies could include risk assessments, prevention, evaluation, education and reflection combined with, for example, scenario training.

KEYWORDS
content analysis, interviews, nurse manager, qualitative methods, workplace violence

1 | BACKGROUND

Workplace violence perpetrated by patients or visitors against health-care professionals is regarded as a global problem (ILO/ICN/WHO/PSI, 2002) and research repeatedly testifies to consequences in terms of reduced well-being, negative impact on family and social life, and on efficiency and skills at work (Ashton et al., 2018; Hassankhani et al., 2018; Nyberg et al., 2021). The management's significance in relation to workplace violence has been underlined before, and ward managers have an important role in ensuring occupational safety (Havaei et al., 2019). Still, few studies have focused on workplace violence from the perspective of ward managers.

Nursing shortages and heavy workloads can contribute to high levels of tension in both nurses and patients resulting in threats and violence (Najafi et al., 2018). Health-care professionals' experience is that preventive strategies at an organizational level are more or less absent or inadequate (Jakobsson et al., 2020) and that a typical managerial attitude is that workplace violence should be accepted as an inherent part of nursing (Ashton et al., 2018; Jakobsson et al., 2020). In contrast, ward managers have described workplace violence as part of nursing, though unacceptable, draining on resources and disrupting care delivery (Heckemann et al., 2017; Morphet et al., 2019). Ward managers' situation has been described as complicated and their leadership role as a loyalty battle between being a part of the management system and advocating for the nurses and assistant nurses at the ward (Ericsson & Augustinsson, 2015). In situations of workplace violence, the battle has been described as an ethical conflict since the responsibility of a ward manager involved the rights of both patients and staff and simultaneously the hospital's standards (Sato et al., 2016).

Even though ward managers are part of the management system, they have described themselves as excluded from important decision making and without support from higher management (Ericsson & Augustinsson, 2015; Hedsköld et al., 2021). It has also been explained that available policies and guidance are difficult to apply in various situations and contexts (Morphet et al., 2019). As an example, official policies on how to prevent and manage delirium in patients have been insufficiently implemented and unknown among physicians, resulting in incidents (Heckemann et al., 2017). Considering their own leadership role in relation to workplace violence, ward managers have identified a need to be able to increase the staffing, especially during night shifts, as well as to educate health-care professionals in managing incidents (Morphet et al., 2019). However, it may be difficult to justify initiatives to higher management if this will result in financial costs (Heckemann et al., 2017).

A high frequency of workplace violence has been reported by health-care professionals internationally (Babiarczyk et al., 2019; Spector et al., 2014) and in Sweden, a recent report made by the Swedish Association of Health Professionals show that nurses experience a higher risk to be exposed now compared with 3–4 years ago. Acknowledging workplace violence should therefore be an important issue for ward managers. The aim of this study was to explore workplace violence perpetrated by patients or visitors from the perspective of hospital ward managers and to describe how ward managers perceive their leadership role and manage related incidents.

2 | METHOD

2.1 | Participants

A purposeful recruitment was made with the intention of including ward managers in public hospitals located in different parts across Sweden. Ward managers in surgical wards were included in this specific study because it has been described that patients admitted to surgical wards can be threatening or violent when they are cognitively affected due to age, disease, trauma, surgery or opioid analgesics (Jakobsson et al., 2020).

In total, 42 ward managers from 15 hospitals were contacted by an e-mail containing written information about the study and a request for an answer by replying the e-mail in case of an interest in participating. Those who answered were contacted either by telephone or by e-mail to decide the time and locations for the interviews.

2.2 | Data collection

Data were collected between March 2020 and January 2021 using semistructured interviews based on an interview guide (see Appendix). The applicability of the interview guide was discussed after the three first interviews, but no major changes were needed. Four interviews were made face-to-face in a secluded room at the university or at the ward managers' offices and the remaining ($n = 11$) by telephone or videotelephony software programme. The mean duration of interviews was 49 min, ranging from 28 to 67 min. All interviews were audio-recorded and transcribed verbatim.

2.3 | Data analysis

Data was analysed using manifest, content analysis (Elo & Kyngäs, 2008). Accordingly, all transcripts were initially read to obtain a sense of the whole. Thereafter, transcripts were re-read, during which open coding was carried out by each author individually. After three transcripts, all authors met to discuss conformity of coding. Subsequently, coding was continued by all authors individually until nine transcripts had been completed. At this stage, a distinct pattern had emerged from the data, and therefore, the codes were transferred and grouped into preliminary categories. To verify the preliminary categorization, the first and last authors continued coding the rest of the transcripts, but no changes were made and the abstraction process continued. This process was led by the first and last authors with frequent reconciliations with all the authors jointly to maintain consensus.

2.4 | Ethical considerations

The study was approved by the Regional Ethics Review Board and followed ethical standards expressed in the Declaration of Helsinki. Participants were informed verbally and in writing about the study, voluntary participation and the right to withdraw without explanation. Written consent was collected prior to the interviews.

3 | FINDINGS

Fifteen ward managers from 11 different hospitals participated in the study (Table 1). Four categories emerged from the analysis: *the face of workplace violence*, *a two-fold assignment*, *strive towards readiness to act* and *managing incidents*.

3.1 | The face of workplace violence

Workplace violence was a rare phenomenon according to some of the ward managers while others experienced it as recurring. Incidents were regarded as commonly related to crisis reactions and to patients' medical conditions in connection with trauma, substance abuse, cognitive disorders and particularly in patients with dementia. Workplace violence typically occurred when patients were unprepared for care activities.

> After all, it is not gang members who are threatening and violent, mostly, but rather elderly persons who are confused and fight to defend themselves (7).

TABLE 1 Participants' characteristics ($n = 15$)

Age (years)	
Mean	46
Min–max	27–60
Gender (*n*)	
Male	2
Female	13
Basic profession (*n*)	
Registered nurse	14
Assistant nurse	1
Education in leadership (*n*)	
Yes	6
No	9
Experience as ward manager (years)	
Mean	7
Min–max	1 month–35 years
Type of hospital (*n*)	
University hospital	7
County hospital	7
Smaller county hospital	1

Note: n = number.

Threatening and violent situations also happened as an expression of dissatisfaction among patients or relatives regarding provided care or limited visiting hours. These situations gave rise to verbal threats directed against the health-care professionals regarding their competence, their privacy or that their professional license would be revoked.

Some ward managers argued that registered nurses and nurse assistants were more exposed to workplace violence because they performed nursing care close to the patients. Others stated that all professional categories were at risk of being exposed, but more likely those who were less confident in their professional role. It was also perceived that situations sometimes arose due to the health-care professionals' approach towards the patient or to personal chemistry. In addition, some ward managers explained that females or health-care professionals with minority ethnical backgrounds were especially exposed, but this was not acknowledged by all.

> Many of our colleagues who come from other countries are mocked and harassed because of the colour of their skin and their headscarves, there is lot of that stuff, verbal violence (12).

3.2 | A two-fold assignment

Ward managers' role and responsibility was perceived as a two-fold assignment, requiring them to ensure both high-quality care and occupational safety. On the one hand, they were responsible for the care of patients, and their leadership included ensuring that patients were cared for in the best possible way. A basic attitude was that patients are entitled to equal care regardless of their personal background or behaviour.

> … everyone is entitled to the same healthcare. We work according to that principle and you can think what you like but it must never affect the patients (3).

On the other hand, they were responsible for the safety of employees. Workplace violence was considered somewhat inevitable in a human care profession, but the goal was to avoid it as far as possible. Ward managers aimed to build structures to prevent and deal with incidents and the managerial assignment was perceived to run 24/7. Most ward managers accepted to be contacted during their free time if necessary. However, workplace violence was described as challenging the ward managers' leadership role and responsibility. A low tolerance for unacceptable behaviour among patients or patients' visitors was expressed, but despite this, there were situations when it was necessary to care for a potentially threatening or violent patient. In such cases, it could be difficult to balance the provision of high-quality care against maintaining workplace safety.

> You cannot decide not to take care of a threatening patient, the patient has to be cared for somehow, in

> these cases it can be challenging to be responsible for both patient security and the work environment… (14).

Regarding threatening or violent patients who did not have any cognitive disorder or patients' visitors, it can be hard to set a limit for what should be tolerated. The ward managers felt responsible for the ward, but with limited decision-making authority. For example, they might confront patients or patients' visitors to indicate that their behaviour was unacceptable, but it was not in their mandate to refuse provision of care or visits. In situations where it became necessary to set an ultimatum for patients or visitors, this had to be in consultation with a chief physician or the senior manager.

Registered nurses were regarded as responsible for and coordinating the immediate patient care and also to signal to the ward manager if something was perceived as problematic. However, it was sometimes a challenge to get information about minor incidents because the employees handled it themselves. In wards where workplace violence occurred regularly, ward managers reflected that registered nurses and assistant nurses might become used to it and therefore not pay so much attention to it. All this could jeopardize the ward managers' ability to maintain their two-fold assignment as the patients received good care but potentially at the expense of work environment.

> A lot might be happening that I do not even know about or have any possibility of knowing. So this is a challenge, that the employees have to tell me about it or I might intercept it up if I am there (1).

By contrast, in wards where threatening or violent incidents were rare, it was a challenge for everyone to know how to act in a situation. Here, it was described as even more important to regularly discuss workplace violence, and to educate.

Lack of resources was another problem that was described as a challenge for both quality in care and workplace safety. A high staff-turnover led to frequent staff shortages and inexperience among many of the employees, due to both youth and little work experience. Therefore, they needed more support in different situations. At times when a threatening or violent patient was cared for, ward managers tried to increase the staffing level; however, this was solved internally in the wards, which could lead to a risk that the employees became worn out.

> It's difficult to strike a balance between what is beneficial or what… in the long run. It's hard to be at work, but if I cannot rest then I am not going to feel well in the longer term. This is a difficult balance (4).

3.3 | Strive towards readiness to act

Considering that workplace violence could not be completely avoided, most ward managers strived for a general readiness to act. This involved preparing the employees with education and reflection. Many of the ward managers stated that the health-care organization provided on-line training about how threatening and violent situations should be prevented and tackled. Some ward managers expected their employees to take part in this training and repeat it yearly, others stated that they were not aware of any training addressing this topic. However, training or lectures offered by the health-care organization were rarely mentioned by the ward managers as mandatory or offered on a regular basis. Many ward managers arranged lectures themselves held by experts in, for example, geriatric or psychiatric care to learn how to prevent or handle different states of confusion.

> Training is very important, because the more knowledge you have the more you can do to prevent that they [threatening and violent situations] arise (12).

With knowledge and clinical experience, it was perceived that it was possible to identify patients with a risk of aggressive behaviour due to cognitive disorders. Patients with substance-induced delirium, for example, could receive medication at an early stage to relieve their abstinence and consequently prevent aggression. For patients with dementia, care could be adapted to approach the patients according to their conditions. Furthermore, communication was highlighted as an important factor in the prevention of workplace violence. Much irritation and misunderstanding could be avoided, and ward managers aimed to coordinate the interprofessional team and to promote good communication.

3.4 | Managing incidents

Ward managers' actions in a threatening or violent situation differed depending on the incident's severity and also on whether or not the patient was considered of sound mind. From the interviews, it could be understood that the hospital organizations had the same approach, which mainly focused on serious incidents. Many ward managers trusted their employees' competence to handle less serious incidents themselves, for instance threats and violence perpetrated by patients with cognitive disorders or crisis reactions. Still, they felt that they had to be responsive and talk with the employees if needed.

> I would assume that they talk with each other and get that support from a colleague rather than from me. In case they do not do so, and they do not feel well, then this will become visible quite quickly and then it is necessary to be attentive and notice this (1).

A few hospitals had general 'house rules' that were available to the public and such documents were regarded as helpful in situations when the ward manager had to, for example, confront bad-mannered patients or visitors. General guidelines formulated by the hospital organization were mentioned by most of the ward managers and contained information and routines about how to act in more serious

situations. In such cases, security guards could be called in for protection, to create a feeling of security and if necessary or to evict visitors. For an employee who had been exposed to a more serious incident, it was possible to put the person off duty and to offer paid sick leave. If needed, occupational health care could be contacted to provide support with processing the experience. There was also the human resources department, although some ward managers were satisfied with their support while others expressed dissatisfaction.

In the ward managers' safety work, general hospital guidelines had to be adapted to fit the specific ward, and routines concerning less serious incidents seemed to depend on the ward managers' own interest and was generally not automatically encouraged or facilitated by the hospital organizations. In the absence of organizational support, other ward managers or operational managers, to whom they could turn for advice, were a source of support that was highlighted as particularly valuable.

> We cooperate a lot and support each other a great deal. And our operational manager, if there is an issue, then he is there for us, he really is. And then there is occupational healthcare and things like that who are available to support if there is a need, or external guidance or anything. So there is support, but mostly we support each other, us managers (11).

When a more serious incident had taken place, it was regarded as important that everyone reflect on the incident. This was achieved in different ways, by a debriefing together with the interprofessional team, by writing reports to start an event analysis or by discussing it with the security department. Although workplace violence was considered somewhat inevitable, learning from experience was considered a significant part of the safety work.

> As long as we reflect on what we do and kind of deposit it in our knowledge bank for the future, then perhaps sometimes we have to accept that this is the way it is (5).

4 | DISCUSSION

This study aimed to explore workplace violence from the perspective of hospital ward managers and to describe how they perceived their leadership role and managed related incidents. According to the ward managers, serious incidents were rare. Serious incidents have been described in earlier research as physical attacks by confused or delirious patients, including breaking things in acts of aggression or confusion. It could also take the form of personally directed, verbal threats (Jakobsson et al., 2020). In the current study however, workplace violence was described as consisting mostly of less serious incidents, that is, incidents that occurred due to the patients' health status, crisis reactions or to lack of communication. It was also expressed that incidents commonly took place in connection with caring for patients with cognitive disorders. Such incidents have been described in hospital ward contexts earlier and involve patients throwing items such as shoes or medicine cups at the professionals, hitting them with a fist or cane, pushing or biting (Ferri et al., 2016; Hahn et al., 2008; Jakobsson et al., 2020).

One challenge in ward managers' leadership role was to combine the responsibility for ensuring high-quality care while caring for a threatening or violent patient. This challenge was also described in the study by Sato et al. (2016) where ward managers struggled with an internal ethical conflict between keeping staff safe, advocating for the patient and maintaining organizational functioning. Ward managers in this current study had many years of managerial experience. Even though less than half had any leadership training, they seemed confident in their leadership roles. Their leadership style can be described as both task-oriented, dealing with practical matters, and relation-oriented, communicating and reflecting with the employees as a means to prevent and manage workplace violence. Challenges were described as mostly of practical nature and concerning allocation of resources. However, it has been shown that task-focused leadership styles are not associated with any positive outcomes in relation to work environment but rather with significant lower job satisfaction among nurses (Cummings et al., 2018). Practical matters, such as the need to increase staffing, or to lead and coordinate professionals when dealing with workplace violence have been highlighted also in other studies (Heckemann et al., 2017, 2019; Morphet et al., 2019) indicating that a task-focused leadership is predominant for hospital ward managers.

Although other studies have described ward managers as excluded from important decision making and lacking support (Ericsson & Augustinsson, 2015; Hedsköld et al., 2021), ward managers in the current study appeared independent and relatively unconcerned about support provided from the hospital organization. When needed, security guards could be called in and occupational services could support victimized professionals. Less serious incidents were managed with joint efforts in the wards, and for ward managers, support was found in colleagues rather than the hospital organization. This might be yet another example of the distance between ward management and the senior hospital management as seen in previous research (Ericsson & Augustinsson, 2015; Heckemann et al., 2017, 2019; Hedsköld et al., 2021; Morphet et al., 2019). Importantly, there were occasions when the voice of the hospital organization strengthened the authority of the ward manager, for instance when printed 'house rules' were used in a confrontation with threatening or violent patients or visitors.

In the current study, it became apparent that there was an organizational discrepancy in the management of workplace violence depending on the severity of incidents. For serious incidents, the hospital organization could provide support measures. Less serious incidents were solved ad hoc by the staff involved and consequently, responsibility rested on the ward managers. Whereas occupational safety and health management concerning those commonly occurring events more or less depended on the ward managers' own interest, many ward managers trusted the nurses and assistant nurses to

handle the situation. This approach was also reported by Heckemann et al. (2019) where health-care professionals coped with situations themselves without managerial involvement. Corresponding results were described in this current study as ward managers found it challenging to be informed of minor incidents. The findings point towards an acceptance within health-care in general that threats and violence by persons who are not fully of sound mind is unintentional and therefore excused. Such mitigating circumstances have been described by nurses in studies before (Hahn et al., 2008; Hogarth et al., 2016; Luck et al., 2008; Pich et al., 2011) and might also explain the absence of guidelines addressing this sort of workplace violence—simply put, no one asks for it. However, earlier research has shown that physical violence is commonly performed by patients affected by psychiatric disease, cognitive disorder or under the influence by drugs (Ferri et al., 2016). It could therefore be argued that even if threatening or violent actions are unintentional, they can be harmful. Furthermore, it is likely that patients in hospitals with cognitive disorders will become more common due to an ageing population in several parts of the world, leading to an increased risk of incidents.

4.1 | Study limitations

This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) to enhance rigour (Tong et al., 2007). Although, some limitations should be considered. We approached 42 ward managers, but only 15 responded and agreed to participate. According to Malterud et al. (2016), sample size in qualitative research is guided by information power. Sufficient information power can be obtained with fewer participants if the aim of the research is narrow, including a specific target group, supported by established theory, conducted by experienced researchers and, including in-depth exploration of narratives. Hence, 15 participants could be considered as a sufficient sample size.

Due to the Covid-19 pandemic, the majority of interviews were conducted by telephone. By tradition, qualitative interviews are made face-to-face in order to capture nonverbal aspects, which are assumed to provide richer data. However, it has been argued that face-to face interviews have some disadvantages (Burnard, 1994). For example, nonverbal communication can be difficult to interpret. Further, the 'exposure' during interview can inhibit sharing of experiences regarding sensitive topics. Telephone interviews are easier to arrange, allowing researchers to collect data effectively and with more comfort for participants. Research has shown that people are comfortable using the telephone in daily life and therefore perceive telephone interviews as convenient (Ward et al., 2015). Thus, telephone interviews can be regarded as an adequate data collection method.

5 | CONCLUSION

In relation to workplace violence, occupational safety and health management by ward managers and hospital organizations seem to focus on incidents that are dramatic, out of control and require the intervention of security guards. However, such events are rare. Instead, the majority of incidents are caused by patients with impaired cognitive function or persons with crisis reactions. The findings from this study indicate signs of unreflected and misdirected efforts for occupational safety within hospital organizations. Efforts related to workplace violence need to focus on commonly occurring incidents to support ward managers in balancing the responsibilities for high-quality care and for occupational safety.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

This study provides insights that can inspire a more reflective and relational leadership among ward managers as well as hospital organizations internationally. It is important that ward managers and hospital organizations not only focus on serious incidents but on all forms of workplace violence as those most likely will increase. Hence, it is time for everyone to stop seeing workplace violence as part of the job. The occupational safety and health management at hospital wards should focus on risk assessments, prevention, evaluation, education and reflection combined with, for example, scenario training. It is necessary to identify incidents that are likely to occur and to create strategies for those incidents. This can help avoid escalation of some events that otherwise would require greater resources with the presence of guards and in worst case result in injured professionals. However, this work should not depend on ward managers' own interest but needs to be mandatory and included in a systematic, hospital-wide occupational safety and health management initiated and directed by the hospital organizations. Otherwise, there is a risk that these important issues will be forgotten and deprioritised because of the ward managers' other work.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

FUNDING INFORMATION

This research was conducted with grants from AFA Insurance, Stockholm, Sweden (No: 190220).

ETHICAL APPROVAL

The Regional Ethics Review Board in Lund, Sweden (no 2018/800).

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions (Appendix S1).

ORCID

Jenny Jakobsson https://orcid.org/0000-0002-1735-9437
Karin Örmon https://orcid.org/0000-0002-0228-1358
Hanne Berthelsen https://orcid.org/0000-0002-4573-4548
Malin Axelsson https://orcid.org/0000-0001-5493-8334

REFERENCES

Ashton, R. A., Morris, L., & Smith, I. (2018). A qualitative meta-synthesis of emergency department staff experiences of violence and aggression. *International Emergency Nursing*, *39*, 13–19. https://doi.org/10.1016/j.ienj.2017.12.004

Babiarczyk, B., Turbiarz, A., Tomagova, M., Zelenikova, R., Onler, E., & Cantus, D. S. (2019). Violence against nurses working in the health sector in five European countries—Pilot study. *International Journal of Nursing Practice*, *25*(4), e12744. https://doi.org/10.1111/ijn.12744

Burnard, P. (1994). The telephone interview as a data collection method. *Nurse Education Today*, *14*, 72. https://doi.org/10.1016/0260-6917(94)90060-4

Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., Micaroni, S. P. M., & Chatterjee, G. E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, *85*, 19–60. https://doi.org/10.1016/j.ijnurstu.2018.04.016

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Ericsson, U., & Augustinsson, S. (2015). The role of first line managers in healthcare organisations: A qualitative study on the work life experience of ward managers. *Journal of Research in Nursing*, *20*(4), 280–295. https://doi.org/10.1177/1744987114564258

Ferri, P., Silvestri, M., Artoni, C., & Di Lorenzo, R. (2016). Workplace violence in different settings and among various health professionals in an Italian general hospital: A cross-sectional study. *Psychology Research and Behavior Management*, *9*, 263–275. https://doi.org/10.2147/PRBM.S114870

Hahn, S., Zeller, A., Needham, I., Kok, G., Dassen, T., & Halfens, R. J. G. (2008). Patient and visitor violence in general hospitals: A systematic review of the literature. *Aggression and Violent Behavior*, *13*(6), 431–441. https://doi.org/10.1016/j.avb.2008.07.001

Hassankhani, H., Parizad, N., Gacki-Smith, J., Rahmani, A., & Mohammadi, E. (2018). The consequences of violence against nurses working in the emergency department: A qualitative study. *International Emergency Nursing*, *39*, 20–25. https://doi.org/10.1016/j.ienj.2017.07.007

Havaei, F., MacPhee, M., & Lee, S. E. (2019). The effect of violence prevention strategies on perceptions of workplace safety: A study of medical-surgical and mental health nurses. *Journal of Advanced Nursing*, *75*(8), 1657–1666. https://doi.org/10.1111/jan.13950

Heckemann, B., Hahn, S., Halfens, R. J. G., Richter, D., & Schols, J. (2019). Patient and visitor aggression in healthcare: A survey exploring organisational safety culture and team efficacy. *Journal of Nursing Management*, *27*(5), 1039–1046. https://doi.org/10.1111/jonm.12772

Heckemann, B., Peter, K. A., Halfens, R. J., Schols, J. M., Kok, G., & Hahn, S. (2017). Nurse managers: Determinants and behaviours in relation to patient and visitor aggression in general hospitals. A qualitative study. *Journal of Advanced Nursing*, *73*(12), 3050–3060. https://doi.org/10.1111/jan.13366

Hedsköld, M., Sachs, M. A., Rosander, T., von Knorring, M., & Pukk Härenstam, K. (2021). Acting between guidelines and reality- an interview study exploring the strategies of first line managers in patient safety work. *BMC Health Services Research*, *21*(1), 1–10. https://doi.org/10.1186/s12913-020-06042-3

Hogarth, K. M., Beattie, J., & Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. *Australasian Emergency Nursing Journal*, *19*, 75–81. https://doi.org/10.1016/j.aenj.2015.03.006

ILO/ICN/WHO/PSI. (2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector. https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf?ua=1

Jakobsson, J., Axelsson, M., & Örmon, K. (2020). The face of workplace violence: Experiences of healthcare professionals in surgical hospital wards. *Nursing Research and Practice*, *2020*, 1–10. https://doi.org/10.1155/2020/1854387

Luck, L., Jackson, D., & Usher, K. (2008). Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. *Journal of Clinical Nursing*, *17*(8), 1071–1078. https://doi.org/10.1111/j.1365-2702.2006.01870.x

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Morphet, J., Griffiths, D., Beattie, J., & Innes, K. (2019). Managers' experiences of prevention and management of workplace violence against health care staff: A descriptive exploratory study. *Journal of Nursing Management*, *27*(4), 781–791. https://doi.org/10.1111/jonm.12761

Najafi, F., Fallahi-Khoshknab, M., Ahmadi, F., Dalvandi, A., & Rahgozar, M. (2018). Antecedents and consequences of workplace violence against nurses: A qualitative study. *Journal of Clinical Nursing*, *27*(1–2), e116–e128. https://doi.org/10.1111/jocn.13884

Nyberg, A., Kecklund, G., Hanson, L. M., & Rajaleid, K. (2021). Workplace violence and health in human service industries: A systematic review of prospective and longitudinal studies. *Occupational and Environmental Medicine*, *78*(2), 69–81. https://doi.org/10.1136/oemed-2020-106450

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2011). Patient-related violence at triage: A qualitative descriptive study. *International Emergency Nursing*, *19*(1), 12–19. https://doi.org/10.1016/j.ienj.2009.11.007

Sato, K., Yumoto, Y., & Fukahori, H. (2016). How nurse managers in Japanese hospital wards manage patient violence toward their staff. *Journal of Nursing Management*, *24*(2), 164–173. https://doi.org/10.1111/jonm.12281

Spector, P. E., Zhou, Z. E., & Xin Xuan, C. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, *51*(1), 72–84. https://doi.org/10.1016/j.ijnurstu.2013.01.010

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Ward, K., Gott, M., & Hoare, K. (2015). Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing*, *71*(12), 2775–2785. https://doi.org/10.1111/jan.12748

SUPPORTING INFORMATION

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

How to cite this article: Jakobsson, J., Örmon, K., Berthelsen, H., & Axelsson, M. (2021). Workplace violence from the perspective of hospital ward managers in Sweden: A qualitative study. *Journal of Nursing Management*, 1–7. https://doi.org/10.1111/jonm.13423