Quality of work life and workplace violence of medical employees' experience: a conceptual study

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***Abstract*—The conceptual study is concerned with the (QWL) and workplace violence, which medical employees encounter in their workplaces and establishes a relationship between the variables. Based on the nature of the job and challenges that the health facility faces, the healthcare sector is one of the most vulnerable to workplace violence. The article reviews how workplace violence interacts with the QWL of medical employees, leading to issues involving job satisfaction, mental health, and organisational commitment. The study underscores the importance of developing the best means of reducing workplace violence, so that people in workplaces do not have to go through what these participants have narrated ''the enduring terror. In doing this, the study ensures a contribution to policy formulation and improvement of the welfare of the health care workforce. The QWL of medical employees has a close relationship with the work environment. A healthy working environment reduces employee stress, makes them feel wanted, and also helps them improve their performance. However, being exposed to WPV compromises the coping balance and leads to stress, anxiety and therefore, burnout. Concerning the aspects of job stress, focused on the medical workers, who experience a frequently expressed verbal aggression or even threats, the respondents claim fear, helpless- ness, and decreased job efficacy. Cumulatively, these journeys lead to demotivated employees, higher levels of truancy and employee attrition, thus exerting even greater pressure on an already stretched healthcare sector.**

Keywords: (QWL), Workplace Violence, Healthcare Sector, Medical Employees, Job Satisfaction, Employee Well-Being, Organisational Commitment and Violence Mitigation Strategies.

I. INTRODUCTION

The (QWL) highlights the medical employees' opinions about the tasks they perform and includes the employee satisfaction, amount of time and commitment they invest in work and job safety and health of their employees emotionally. But then, there are constantly emerging problems peculiar to the healthcare industry that affect QWL negatively through stress, shift working and the demanding nature of patient care, among others. Of these challenges, the most prominent is the Workplace violations, thus complicating the quality of work life of Medical employees. Hospitals are not immune to workplace violence; their institutional violence encompasses everything from aggressive words and actions to actual physical contact. This violence has further consequences which have direct impacts on the health of the affected persons, their bodies and minds, and the broader organisational environment. Hospital workers who are victims of violence in the workplace suffer from low worker satisfaction, a high level of burnout out and poor perception of safety, which in turn affects the quality of service delivery to the patients. Finally, acts of violence in the workplace have impacts on turnover, absenteeism and compromised organisational success. In terms of place and time, the overwhelming majority of the publications are dedicated to formal HC settings in industrialised countries, which is another reason why there is a lack of insight into the experiences of medical employees in developing countries, where actual and potential barriers to quality patient care may be quite different. Also, job categories such as the nurses or front-line employees are most often researched, while the rest of the employees in the healthcare field, including those administrative, specialised or support workers, are excluded from the analysis of the trends in WCV and QWL. Chang et al. (2024) employed research work that defines the correlation between the perceived health of nurses, burnout, sleeping quality, workplace violence and organizations culture. The authors stress that nurses are at a higher risk of developing occupational burnout because their work is high stress and can be made worse by such conditions as sleep disorders and violence at work. The study unveiled that the aspects of sleep quality affected health factors that API heralded as directly influencing physical and mental

health and nurses' capacity to deal with stressors at the workplace. Both verbal and physical workplace violence boost the level of burnout by not only contributing to the deterioration of relations in the workplace and reducing job satisfaction. Another variable that is discussed in the context of the presented research is organisational culture as a moderator. Positive organisational culture can also reduce the impacts of workplace violence and poor sleep quality in that staff will be encouraged to work together and be provided with necessary resources, and staff will encourage and support each other emotionally. On the other hand, a bad organisational culture tends to worsen these stressors and outcomes, resulting in more working absenteeism, more turnovers and poor patient care. The results support the pressing need for efforts designed to address such issues as poor sleep quality, possession of weapons at the workplace, and the unfavourable climate to protect nurses from burnout. Recommendations include developing inclusive, multi-faceted violence prevention guidelines, promoting workers' expressions of concerns, and providing access to psychological services.

II. LITERATURE REVIEW

Hu et al. (2024) examine the correlation of workplace violence to job satisfaction and burnout of healthcare workers in the mobile cabin hospitals in China, with the focus on perceived work environment stress as the mediator variable. In light of the pandemic, facilities such as mobile cabin hospitals used in Uganda upset students due to the elevated pressure environments and lack of resources. These results show that workplace violence plays a large role in influencing perceived stress among healthcare workers and, by extension, the levels of job satisfaction and burnout. The study described verbal attack and physical aggression by patients or their families as frequent occurrences in these settings and believed that they cause increased intensity of personal distress and depersonalization among the staff. Furthermore, lacking facilities, nonsense, and an ambiguous hierarchy in the mobile cabin hospitals results in higher stress and lower work involvement. In this study, we find that perceived stress moderates the effects of workplace violence on burnout, and these results should be taken into consideration to address both personal and structural aspects. This study determined that perceived stress and workplace violence can be reduced by creating a favourable organisational culture by implementing an organisational communication system, sufficient resources, and managers' support. On the other hand, wrong environment management aggravates all these vices, resulting in a cycle of dissatisfaction, truancy, and compromised quality of healthcare delivery. According to the study, it is suggested that the specific measures should be put into practice as follows: the establishment and support of sound programs for preventing workplace violence, stress management training, in addition to the enhancement of the structural design and the provision of mobile hospitals. Lastly, promotion of wellness at the workplace can easily be achieved through encouraging leadership and organisation-wide formation of groups and companies that would help such healthcare workers feel more encouraged and less stressed after performing their duties in such challenging facilities. Pariona-Cabrera (2024) seeks to establish how workplace violence affects the job stress of HCWs and the mediating function of well-being-centred HRM practices. The authors draw everyone's attention to the fact that care employees report an increased level of workplace violence in the form of verbal harassment and physical aggression, leading to higher levels of perceived job stress. In some cases, psychological detachment from this type of violence results in unfavourable consequences: reduced job satisfaction and emotional burnout, the ability to make decisions is also affected, which affects both patients' and workers' health. The study establishes 'Well-being-oriented Human Resource Management' practices as an essential protective mechanism against the vice of Workplace Violence. Measures including employee assistance, psychological testing and treatment, training in conflict solving and fostering a polite working environment were discovered to lower job stress levels considerably. Such initiatives support the healthcare workers in managing the vicissitudes of WPV, through offering them tools and means and creating a climate of safety and organisational support. In addition, the study supports leadership as a critical factor in the execution of sound HRM practices. If managers attend to employees' needs, proactively foster non-violent and receptive organisational cultures, workplace violence incidence and severity would be deterred. The research findings suggest that workplace violence, which can be treated by effective HRM practices, not only positively affects each employee but also is critical for organisational recovery and productivity.

To safeguard organisational staff from the negative impacts of workplace violence, the authors recommend the mainstreaming of well-being HRM interventions into the healthcare systems. To that end, they suggest that effective implementation of these practices should be accompanied by targeted modifications and ongoing evaluation for healthcare workers in various settings.

III. RESEARCH BACKGROUND

Abuhasheesh (2024) looked at the relationship between workplace violence and healthcare professionals' QoL and the moderating effect of social support. The authors stress that workplace violence is a prevalent issue and an issue of the health care personnel's exposure to physical, psychological and verbal aggression and threats, which has a serious influence on individuals' mental, emotional, and physical health. Such violence results in stress levels, anxiety and burnout, finally reducing their QoL. Another research finding proved that social support helps to minimise or moderate the effects of workplace violence and aggression. Support from colleagues, supervisors, or even family plays the role of a moderator by offering comfort or help. HCPs with higher levels of perceived social support are likely to demonstrate better coping ability and hence the ability to do more than just survive workplace violence. It also describes policies and practices that might improve social support within organisations: development of team and group work, establishment of organisational policies against violence, and promotion of peer support programs. All these developments afford the workers a secure environment that any quest to enhance their QoL ought to address. The authors suggest that healthcare organisations should allocate resources to purchase training on this topic, as well as stress management and team building, to promote improved social support. When one tries to address workplace violence in a full spectrum, the outcome is better health of the employees, better job satisfaction, and overall improved quality of care for the patients. Charati et al. (2021) described the correlation between occupational violence and quality of working life (QWL) among the nurses working in the Intensive Care Unit (ICU) of educational-medical centres. The study shows that nurses working in ICUs are most vulnerable to workplace violence because of their short temper due to working on the lives of critically ill patients, as well as handling distressed families. The study establishes that OV in the form of verbal aggression, threats and physical conduct reduces nurses' QWL because it raises their stress, emotional fatigue and job discontentment. Primes of all these outcomes are not only detrimental to the health and well-being of the nurses involved but are also catastrophic to the level of care that can be offered to patients. The study establishment signifies that WVE disrupts the work environment, thus devising nurses' morale and organisational commitment even lower. Also, with the help of the research, it is clear that institutional initiatives are required to tackle occupational violence and enhance QWL. Some of the recommended interventions are staff awareness campaigns on ways of preventing and combating violence, clear policies and procedures on reporting violent actions and defining how to support inculpated workers. The authors also stress that creating a positive organisational culture, which would call for the promotion of safety measures among employees, is very crucial. The study established that cuts in OV and improvements in QWL are instrumental to the maintenance of high-quality staff care givers in nursing institutions, hence quality care for the patients. It asks healthcare organisations to develop preventive measures to design a safer and more favourable environment for ICU nurses. Mosadeghrad (2011) examined the links between job stress and quality of work life and the turnover intentions of the hospital staff were examined. The authors underscore that organisational stress factors impacting on employees' QWL include HI workload, time pressure, and resource scarcity prevalent in hospitals, which enhance TO intentions. Stress on the job is defined to be a key predictor of QWL, with high stress associated with signs of EE, job dissatisfaction, and reduced work engagement. These negative outcomes are lowering the employees' perception of the environment, which reduces their organisational commitment. The study also indicates that when people have poor QWL, they are likely to request for transfer, early promotion or resignation to join other organisations that do not stress them out. This article recognises certain indicators that make work-related stress worse for employees in the hospital; these are staff shortage, lack of managerial support, and low recognition. Also, this study establishes that turnover intention not only has an impact on individual employees but also undermines organisational stability, and thereby incurs the costs of recruitment, training, and constrains productivity. To this end, the authors call

for good organisational climates that will enhance the quality of work-life balance of employees. Increased QWL as a result of these strategies relieves job stress, improves satisfaction, and standards of living, and stems turnover. It is therefore recommended that solutions to the interaction of job stress, QWL and turnover intention are pinpointed as paramount in supporting a strong commitment of a hospital-based workforce. Employers have to apply comprehensive strategies to make the workers realise that they are valued in their highly taxing jobs.

IV. STATEMENT OF THE PROBLEM

Despite the aforementioned malady, workplace violence against medical employees is usually unreported or poorly handled, and this can be as a result of several factors: danger of being retaliated against, the violence is considered ordinary in the workplace or healthcare facility, or no proper measures have been put in place. In addition, there is little research about how the experience of violence at the workplace is associated with QWL, particularly as to concerns about long-term effects on affective well-being, job commitment and retention age of the worker. These factors not only make medical employees predisposed to violence on the job, but also these very factors make handling the ramifications of the violence virtually impossible. Thus, it is high time to reveal the ways to enhance the QWL of medical employees by combating WLV appropriately. Through identifying major effects and recommending practical recommendations, the study will increase healthcare staff's safety and satisfaction, as well as their health and productivity. Sundram et al.'s (2024) systematic review synthesises the multifaceted organisation of occupational stress for nurses when considering the antecedents, effects, and protective behaviours. Having reviewed the literature from around the world, the authors noted that occupational stress in nursing results from organisational, individual, and patient factors. Stress areas consist of job demands, shortage of staffing, shift working, and emotional demands put forward by the patients. It said the current practice exposes the nurses to role ambiguity, lack of autonomy, and restricted decision-making authority, factors that heighten stress levels. Some of the factors that make the problem worse include conflict with colleagues, supervisors, and the families of the patients. This article highlights the impact of job stress on the nurses' health, drains them of their energy and health both mentally and physically through burnout, anxiety, depression and dissatisfaction at work. Another way that stress affects the quality of care includes imparting the realm of safety more errors mean. Measures which have been suggested entail the hiring of more human resources, some form of flexible working, and providing a working stress line. Training related to stress, communication and emotional intelligence is also suggested to be provided. Finally, the authors suggest that combating occupational stress in nurses must necessarily involve both systemic solutions and personal supply mechanisms.

V. RESEARCH GAP

With much focus on workplace characteristics and occupational stress in the health care industry, more specifically in this study, the quality of work life (QWL) and workplace aggression among medical employees are still areas of investigation. Reestablished research mostly investigates more universal facets of QWL, including job satisfaction, work-life balance and career advancement. Although these factors are recognised as important, little consideration has been paid to the negative impact of workplace violence, from verbal harassment to actual physical attacks, on the QWL of medical employees. Additionally, most studies focus on the short-term effects of experiencing violent behaviours at work, within the workplace stress and burnout, but not on the more extensive, employer and employee personality qualities, the cumulative damaging impact on the long-term well-being of the individual performer and organisational culture. There is a particularly important gap in knowledge of the contingency variables that tend to increase or decrease workplace violence in healthcare organisations and systems. While research identifies potential enablers such as staff deficit, patient-to-staff ratio, and the pressured regime of clinical practice, there is a lack of investigation into how these factors are related to the organisational safety climate standards and work-related attitudes among employees. Furthermore, while some literature focuses on the rate of workplace violence, there is a dearth of literature on the extent and effectiveness of the anti-violence policies, training, and intervention programs endorsed by organisations. Such a lack of research highlights the ongoing need and necessity for studies that examine antecedents and effects of QWL and WVI from the psychological,

organisational, and systemic perspectives. Another imperative that cannot be overlooked in the current literature is a lack of research focusing on summing up the efficiency of existing interventions and the development of research-based interventions for various contexts of healthcare system delivery. This article can help to fill this research gap and offer a better understanding of the antecedents of Medical employees' work experiences will also serve to assist in designing specific measures to promote not only the quality of work life, but also the safety of Medical employees at their workplace as well.

Impact of Workplace Violence on the Quality of Work Life among Medical Employees

WPV has sensationally become an issue within the healthcare workplace that has impacted the QWL of medical staff members. Nurses and other caregivers are at a higher risk of experiencing violence given the nature of the workplaces they find themselves in, especially in patient care settings. Clients, families or even colleagues may use foul language, or even physically or psychologically attack them limited or completely remove their access to workplace facilities or equipment. This appears to not only affect the welfare of the health care professionals but also affect the quality of service that is rendered to the patients. WPV also has effects on medical employees' physical and mental health. Stress reveals that the healthcare employees who get exposed to such violence are likely to develop the symptoms of PTSD, depression and other related psychological diseases. Also, the culture of 'predominant recurrent violence' results in continually heightened anxiety levels, which interfere with their capacity to focus or to reason and act accurately in high-pressure situations. These effects are not only on the individual employee levels, but also impact team-level processes, patient care, and overall organisation performance. The effects of WPV on the organisation are also not good. If medical employees are on the receiving end of violence, they begin to develop job dynamics and disconnect from the organisational job, which results in reduced performance levels. In addition, for institutions that do not address strategically, the workplace violence will end up having some adverse effects, such as damaging reputation, high turnover of personnel, especially of the skilled personnel, and more legal risks. Therefore, promoting organisational safety, which is creating favourable conditions at the workplace that support the victim and punish the perpetrator, becomes an ethical and maybe even a strategic necessity for healthcare organisations. The challenge of managing WPV to enable enhanced QWL is therefore best tackled through an integrated perspective. Alzoubi (2024) measures the QNWL among critical care nurses while also identifying the factors explaining the variability of these parameters. This study reveals the strenuous nature of the critical care setting, which affects the professional and QoL of the nurse. Based on the Findings, it is established that workload, organisational support and emotional resilience are the key drivers of QNWL. Long hours of work, staff shortage and heavy workload cause physical exhaustion, stress and, thus, deterioration of QNWL. On the other hand that nursing care structures, education, sufficient and appropriate equipment, and positive rewards positively predict the experiences of the nurses. The paper also discusses the concept of emotional intelligence as an aspect of preparedness or a coping mechanism with the job demands of the critical care setting. Findings of research indicate that healthcare workers with higher resilience levels provide optimal stress coping mechanisms and greater organisational contentment. Secondly, human relationships in the workplace play a crucial role in QNWL since entities that work in collaboration and with respect for each other have a strong desire to belong to QNWL. The authors recommend staff-to-patient ratio policies and against an excessive number of hours worked to address critical care nurses' burnout and to provide them with personalised mental health care. Other structural levers for improving QNWL include professional development, Training recognition and Rewards programs. When these factors are duly considered, the conceptual framework illustrates that HC organisations can effectively support nurses and also improve patient care in the important areas.

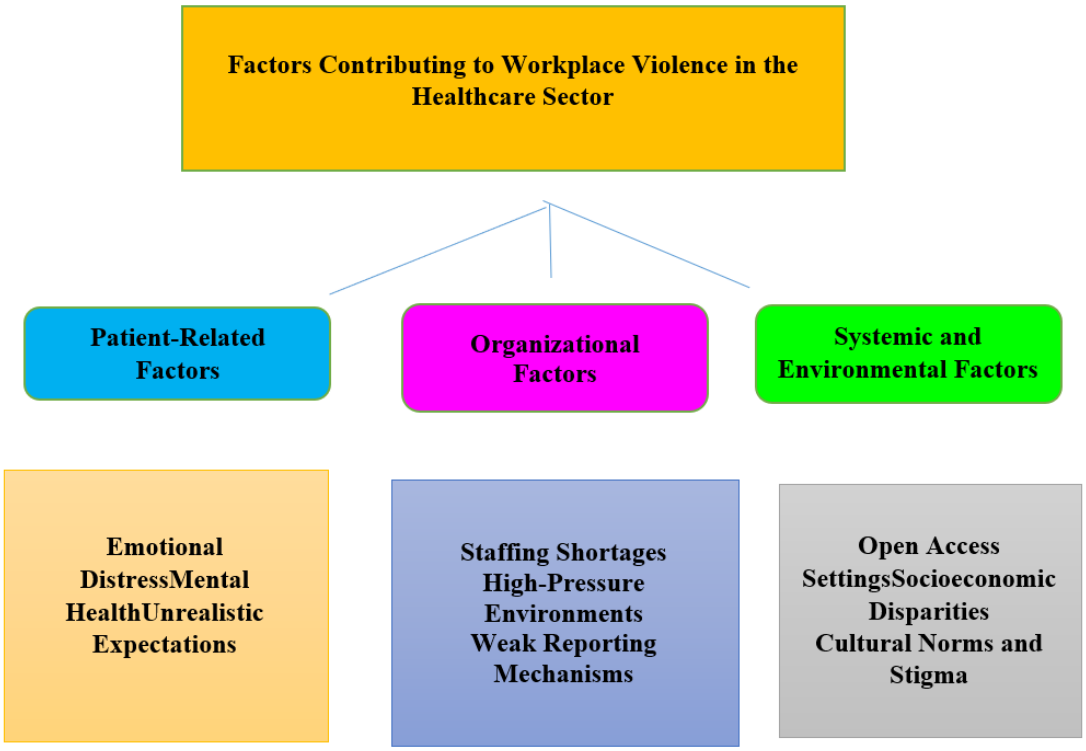
Objectives

1. To sketch the Key Factors contributing to workplace Violence in the Healthcare Sector among medical employees.
2. To present some recommendations for measures and approaches to controlling (QWL) and preventing workplace violence.
3. To propose interventions and strategies to improve (QWL) and Reduce Workplace Violence

Key Factors Contributing to Workplace Violence in the Healthcare Sector

Workplace violence (WPV) in the healthcare sector arises from a complex interplay of factors rooted in the unique nature of the industry and its operational challenges. These factors can be broadly categorised into patient-related, organisational, and systemic causes.

Figure: 01



Patient-Related Factors

1. Emotional Distress of Patients and Families: Daily struggle with various aspects of emotional distress is hugely affecting patients' quality of care and quality of life. Emotions are invariably high among patients and families due to the many unknown factors that surround medical situations, chronic disease, or impaired functioning as a result of a disease diagnosis. Such distress may lead to anxiety, anger or frustration, which interferes with the patient-healthcare Providers' relationship. Also, family members may feel compromised for care responsibility, especially when dealing with chronic diseases or end-stage illness. Medical practitioners have to be aware of this distress and necessarily respond to it through words of encouragement and by appealing to the necessary resources. Being safe in itself reduces the stress level of the patient, thus increasing the level of satisfaction of the patients.

2. Mental Health: Common psychological disorders are depression, anxiety or PTSD that make patient management and recovery even more challenging. Although these conditions are common, they are often unaddressed or poorly managed within the healthcare system, and failure to adhere to treatment regimes and reduced health status is frequently the sequel. It is crucial that mental disorders are diagnosed as early as possible in the attitude of healthcare providers, and that the psychological component of the treatment is included in a set of interventions. Such measures as the provision of mental health check-ups, counselling and bringing in of psychiatric care in first-line health care services are crucial, geared towards patients' health optimisation.

3. Unrealistic Expectations: Perceived indispensable expectations are also capable of generating disappointment and unfavourable interactions. Entire procedures can be misunderstood, the course of healing times, or possible complications which are obtained from health-related information from the wrong sources. This is why achieving these expectations has to do with clear communication that can be described as honest and thorough. It is expected that physicians should clearly justify the available medical opportunities and restrictions, and also the realistic objectives should be achieved through mutual decision. Education of patients and involving them in decision making of personalised medical treatment is

expected to result in their care should always be managed well, thus enhancing satisfaction.

Organizational Factors

1. Staffing Shortages: Deficient in human health care means that the quality of health care is reduced due to a shortage of staff in health facilities, overworking, and burnout of the health care workers. Reduced staffing means that patients will experience long waiting times, less focused care, ineffective information sharing and therefore a lower level of satisfaction. Smoothing workforce deficiency hence calls for proper employment and employee retention measures, better remuneration package and health worker Work-life balance. In addition, new technologies, for example, telemedicine or automatic systems, can relieve the current employee overload while providing the same level of quality.
2. High-Pressure Environments: The healthcare delivery systems practice in conditions that involve a high level of pressure, more so during emergencies or actualisation of disasters. It can result in mistakes, missed information exchange, and demoralised personnel in the provider facilities. Employees of the health care sector are always under pressure due to the rapidity of work, teamwork and the general stress. Organisations must focus on promoting a healthy culture, providing access to mental health services for employees, and mandatory and routine training to be held about stress. Promoting or building a competent and strong staff as a valuable asset leads to development in choosing and the well-being of patients, which are very challenging in their environment.
3. Weak Reporting Mechanisms: Component consistency of reporting systems limits the possibility of identifying and addressing existing system problems, including medical mistakes and adverse situations, limited. Basically, due to a lack of appropriate structures in reporting, information about patient safety risks that can be exploited to enhance patient care quality gets lost in the system and this results in repeated mishaps. Enhancing these mechanisms needs reporting systems which are effective to use, staff that has a complete understanding of the process being followed and employers who do not punish subordinates for reporting. The last is to operate feedback and response mechanisms that enhance trust and act on all the reported matters to improve the flow of healthcare.

Systemic and Environmental Factors

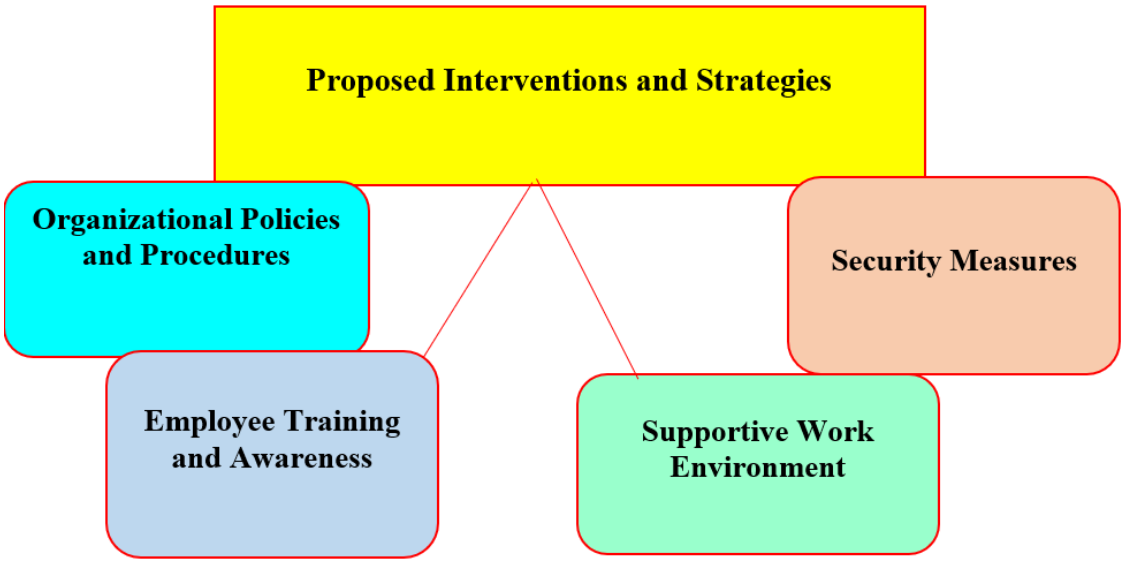
1. Emergency practice areas Emergency practice areas, including walk-in clinics and emergency rooms, may experience overcrowding of patients and resources. Such environments are not suitable for patients to deliver individual or patient-centred care, which results in dissatisfied patients. As a result of opening access, the number of users is greatly increased, and so proper screening procedures that form triage to ensure that congestion is not rife must be present, coupled with adequate allocation of resources needed in handling cases from open access.
2. Socioeconomic Disparities: The studies reveal that SES highly influences healthcare access and utilisation. The existing gaps include: low income, lack of adequate health insurance and poor access to primary care services. This results in neglected treatments, hence worsened health situations. It has long been recognised that these disparities will not be resolved without wider systems changes that involve affordable healthcare policies, community-based health programmes and outreach initiatives. Greater public health spending alongside decreased reliance on direct personal expenses are both important steps toward greater equality and superior quality of care for the uninsured individuals.
3. Cultural Norms and Stigma: Such topics are cultural norms and stigma, as well as the roles that they play in health-seeking conduct, utilisation of treatments, and communication with doctors. Taboos in terms of mental health, reproductive issues or chronic diseases make patients delay their visits to a doctor. Culture becomes another area where providers have to practice cultural sensitivity in an attempt to address the client. Outreach programmes starting with cultural elders, which encompass taboo areas in the community, can greatly decrease such obstacles and promote patient-centred health care.

Proposed Interventions and Strategies to Improve (QWL) and Reduce Workplace Violence

Improving the quality of work life (QWL) and reducing workplace violence (WPV) in the healthcare sector requires a multifaceted approach that addresses organisational policies, employee well-being, and systemic challenges. Abdul Abrar& Malik, A. (2024) provide a qualitative study that focuses on the problems and unpleasant sentiment of ASHA workers in India, as well as investigates the experiences of ASHA workers in implementing the community health programs. The research, thus, applied both qualitative and quantitative research

approaches to establish that the dissatisfied employees have the following discontent factors: meagre wages, congested work schedule and job acknowledgement. The quantitative data reveal that hours of work irregularity is the major cause of dissatisfaction due to the low pay scale of ASHAs. They also experience delays in receiving incentives, and any delays in the payments dent their financial status. Other non-intrinsic factors include workload due to unattainable production rates, lack of workforce, and insufficient training, all cause stress and burnout at the workplace. The work conditions that are revealed in the course of the qualitative analysis indicate that the civil servant system neglects the workers or employees, for there are no healthcare benefits that are offered to the employees, poor working conditions and few chances for career advancement. ASHAs complain of a lack of recognition of their work because they feel ignored by both their superiors and the population that they serve. Interpersonal conflicts with higher authorities and an inadequate and limited number of communication networks also hamper their performance. The research finds out that to enhance ASHAs' job satisfaction, the main issues are areas of monetary and non-monetary compensation. An important part of solving the problem is to develop measures such as changing remuneration systems, prompt payment of bonuses, improving the effectiveness of training activities proposed, and offering options for social security to employees. Appreciation of their efforts can go a long way in encouraging ASHAs towards improved commitment, adding value to the attainment of community health goals.

Figure: 02



Source: Researcher contribution

1. Strengthen Organisational Policies and Procedures

1. Develop and Implement Zero-Tolerance Policies: Policies of zero tolerance must be regarded as the foundation of safe and positive behaviour at work. These policies specify areas of prohibited behaviour, including, but not limited to, harassment, discrimination, and violence in the workplace, and what will happen if prohibited behaviour is engaged in. Creation of such policies requires engagement of lawyers and personnel from the Human Resources departments to ensure compliance with the legal requirements as well as industry standards. It is best disseminated through policy manuals, recognising that work may also be done through initial training and in subsequent refresher training where necessary. Any zero tolerance policies called for must be applied equally at all organisational levels irrespective of one's rank or the length of time they have served the company. The other aspect of transparency is well observed in investigation protocols enhancing employee's confidence that their grievances will be addressed fairly. A proper revision of these policies appears every time the organisation has legal compliance issues to ease the organisation into getting a new legal standard and expectation.

2. Legal and Regulatory Compliance: Legal and regulatory compliance goes beyond the mantle of observing laws; it is an ethical stance of the

organisation to operate fairly. Employment laws, safety rules, and guidelines for various industries are fast changing and management cannot afford to be in the dark. This needs an assignment of a compliance officer or a team that will monitor the adherence and then conduct analysis on the same. This approach of management training makes sure that the employees have insight on what the laws require of them and what they should not do. They also need to have ways of how they will update themselves with relative changes in laws and be able to incorporate them into the organizations' practices instantly. Furthermore neglect of these regulation attracts severe penalties, loss of reputation and erosion of employee trust. That way one guarantees that the legal requirements specified for an organisation would be met which in turn yields operational stability while at the same time shaping a credible organisational persona.

VI. DISCUSSION

Del P Quinones (2024) explores the mediating variables that exist at the individual, team, and environmental level that define QWL in stressful healthcare setting. Observed indicators includes workload, both inter and intra personal interactions, organisational support, and emotions. CCU employees receive limited work breaks, extended work schedules, physically and emotionally demanding work resulting in poor QWL. Lack of staffing, no management support, and little or no chance of professional advancement at work also adds to these difficulties. The study points out that relationships with people at workplace particularly bosses are instrumental in improving QWL. The positive communication strengthens unity and pulls together the team, relieves pressure, and leads to job satisfaction. On the other hand, when the relationships are tense, the employees are burnt out and dissatisfied. Second main prepared consequence is that the presence of positive physiological personality variables and emotional well-being predicts the level of QWL. It showed that workers with positive ways of coping, and those with access to mental health services have higher QWL. According to the authors, healthcare management should strive to introduce concept-specific measures in order to enhance QWL: stress-.preventive activities, team-orientation practices, and appropriate staffing regulation. It is therefore the conclusion of the study that improving QWL in CCU needs to factor in the complex individual and organizational factors. Caring for the HCSA's QWL benefits them but also the overall patient care. Kochuvilayil& Varma (2024) focus on caregiver burden and QoL, and use both qualitative and quantitative methods to investigate the views of both primary caregivers and medical staff of the primary palliative care program in Kerala. In the want generation study, the difficulties of the caregivers who are attending to the terminal ill patients with physical, emotional and financial stresses are discussed. All of these factors impact their QoL in a way that sometimes they experience stress, anxiety and burnout. Numerical data show that caregivers experience a substantial load because of extensive caregiving, lack of opportunities for a temporary break, and poor mental health resources available to them. Furthermore, there are no professional support systems in place by healthcare systems that make these issues even worse. Qualitative data for providers concentrate on system inequalities, which include inadequate preparation of childcare givers, poor communication, and better father or mother care resources. Providers also appreciate the intervention acuity that comprehensively targets caregiver outcomes and the longer-term stability of the palliative care service delivery. The study suggests combined strategies for decreasing the burden for caregivers that include the creation of support groups, financial assistance, and better education of caregivers. Promoting good relationships between providers and the caregivers is also important, as this will lead to understanding each other well to improve the patient outcome. Thus, with the ability to fill these gaps, the primary palliative care program of Kerala can achieve better distribution of load and quality care amongst caregivers. Pourshaikhian (2016) applied grounded theory to explicate the phenomenon of WPV affecting EMS staff members. EMS is considered one of the most at-risk groups in WPV simply because of what they do – dealing with pressure-stimulating incidents, future traumas, and emotionally charged events. From the interview and the analysis of the qualitative data, the research establishes the dynamic, cause-and-effect perspective of WPV. The findings portray procedural violence starting with aggression stimuli that include dissatisfied patients, expectations that are not met, and delayed service. This commonly degenerates into the use of words, physical assaults, and personal threats, mostly from the patients or their relatives. Hazardous organisational factors which increase the probability of the development of violence include inadequacy of staff, lack of training,

and insufficient safety measures. WPV has enormous impacts on the EMS staff through making them emotionally stressed, exhausted, and unsatisfied with their jobs. Another psychological feeling mentioned by many participants was fear and feeling insecure, which had reflected in personal and professional attainments and interpersonal relations. These outcomes resonate with a clarion call for substantive reforms for the elimination of WPV because it points to the system. The conclusion of the study reiterates possible solutions, including the training of violence prevention programs, increased staffing, and the provision of conflict-solving solutions to protect EMS professionals. Organisational leadership must also ensure adequate reporting and support systems that can be of help during WPV incidents are well developed.

VII. CONCLUSION

Workplace aggression significantly Mars employee QWL, working satisfaction, employee mental health and performance among medical employees. The evaluation of the means allows identifying that workplace violence in the healthcare sector occurs because of high-stress working conditions, shortage of staff, absence of security measures, and staff and patients or their families poor communication. Most of these challenges affect the medical employees adversely and also affect the efficiency of the organisation's performance, thus leading to higher turnover, lower retention, and lower employee satisfaction. Solving these problems is a multicare approach that will involve more of a predictive and proactive and reconstructive approach. Measures which can be suggested include promulgation of strict workplace policies; upgrading the security measures, providing psychosocial support, and creating a workplace culture that doesn't tolerate violence in healthcare institutions may go a long way in preventing workplace violence. Furthermore, to reinforce QWL, the steps needed to address workloads in medical organisations, provide Continued Professional Development for the medical personnel and eliminate unfair practices in remunerations will elicit better encouragement of medical employees. Moreover, QWL in combination with critical organisational results of the employees, including employee turnover, satisfaction, and performance, call for serious attention to and focus on employees. By having a higher QWL, it reduces violence at the workplace and also improves productivity, morale and the service delivery of health care. These results support the encouragement of effective measures that healthcare organisations should implement to address issues in the workplace comprehensively, thereby creating a safer workplace for medical employees. As with WPV, it should be noted that the promotion of QWL and the prevention of violence necessitates intervention at multiple levels with numerous, integrated support structures. These strategies not only have positive impacts on the employee health-wise, financially and socially, but also on organisational productivity and even patient care. In this way, healthcare organizations can guarantee a constant and effective staff as results of prioritized interventions. The measures towards preventing workplace violence in the healthcare setting, these root causes should therefore be addressed by discretionary strategies of security, staff education, effective implementation of respect in the workplace and comprehensive line of action on reporting and managing violent incidences. In this way, organisations can control the major risk factors and ensure the development of proper conditions for the personnel of healthcare facilities.

REFERENCE

[1] Abrar, D., & Malik, A. (2025). Assessing Challenges and Sources of Dissatisfaction among Accredited Social Health Activists Employees. International Review of Management and Marketing, 15(1), 91-98.

[2] Abuhasheesh, S., Al-Hussami, M., Shehadeh, J., &DarwishElhajji, F. (2024). The impact of workplace violence on healthcare professionals' quality of life: the mediating role of social support. Discover Social Science and Health, 4(1), 1-12.

[3] Alzoubi, M. M., Al-Momani, S., Al-Mugheed, K., Owiedat, I., Shosha, G. M. A., Alabdullah, A. A. S., ... &Abdelaliem, S. M. F. (2024). Assessment of the quality of nursing work life and its related factors among critical care nurses. Frontiers in Public Health, 12, 1305686.

[4] Chakkunny, M. J., & Raj, T. S. (2024). Abysmal Afflictions and Everyday Life Challenges of Transgender Older Adults in Kerala. Indian Journal of Gerontology, 38(4), 441-467.

[5] Chang, Y. P., Lee, D. C., Lee, Y. H., & Chiu, M. H. (2024). Nurses' perceived health and

occupational burnout: a focus on sleep quality, workplace violence, and organizational culture. *International nursing review*.

[6] Charati, F. G., Esmaeili, R., Nasab, N. M., &Jafari, H. (2021). Occupational violence and its association with the quality of working life of nurses in intensive care units of educational-medical centers in 2019. Iranian Journal of Psychiatry and Behavioral Sciences, 15(4).

[7] Del P Quinones-Rozo, L., Canaval-Erazo, G. E., & Sandoval-Moreno, L. M. (2024). Predictors of quality of work Life in health care workers at adult critical care units: A Cross-sectional study. Indian Journal of Critical Care Medicine: Peer-reviewed, Official Publication of Indian Society of Critical Care Medicine, 28(4), 355.

[8] Hu, Y., Zhang, S., Zhai, J., Wang, D., Gan, X., Wang, F., ...& Yi, H. (2024). Relationship between workplace violence, job satisfaction, and burnout among healthcare workers in mobile cabin hospitals in China: Effects of perceived stress and work environment. Preventive medicine reports, 40, 102667.

[9] Kochuvilayil, A., & Varma, R. P. (2024). Understanding caregiver burden and quality of life in Kerala's primary palliative care program: a mixed methods study from caregivers and providers' perspectives. International Journal for Equity in Health, 23(1), 92.

[10] Mishra, R., Singh, V. J., Jain, J., Singh, J., &Thakral, S. (2024). Battered doctor syndrome: Legal & policy perspectives of violence against doctors in India.

[11] Mosadeghrad, A. M., Ferlie, E., & Rosenberg, D. (2011). A study of relationship between job stress, quality of working life and turnover intention among hospital employees. Health services management research, 24(4), 170-181.

[12] Oweidat, I., Omari, A., ALBashtawy, M., Alrahbeni, T., Al-Mugheed, K., &Alsheikh, A. D. I. (2024). Factors affecting the quality of working life among nurses caring for Syrian refugee camps in Jordan. Human Resources for Health, 22(1), 1.

[13] Pariona-Cabrera, P., Bartram, T., Cavanagh, J., Halvorsen, B., Shao, B., & Yang, F. (2024). The effects of workplace violence on the job stress of health care workers: buffering effects of wellbeing HRM practices. The International Journal of Human Resource Management, 35(9), 1654-1680.

[14] Pourshaikhian, M., Khorasani-Zavareh, D., Gorji, H. A., Aryankhesal, A., &Barati, A. (2016). Workplace violence process against emergency medical services staffs: A grounded theory. Global journal of health science, 8(12), 213.

[15] Sundram, B. M., Vallasamy, S. K., &Muhadi, U. (2024). Exploring the Multifaceted Nature of Occupational Stress Among Nurses: A Systematic Review. Kesmas, 19(2), 121-128.