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Barriers to reporting workplace violence: a qualitative study of nurses' perceptions in tertiary care settings

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Abstract

Background Workplace violence (WPV) remains a formidable concern among nurses worldwide, with up to 60% in Saudi Arabia reportedly experiencing some form of aggression. In tertiary care hospitals, robust hierarchies and cultural norms intensify underreporting, thwarting evidence-based prevention and obscuring vital data.

Aim This qualitative study investigated the perceived barriers to WPV reporting among nurses in tertiary care settings in the Aljouf region of Saudi Arabia, specifically addressing how organizational and cultural factors converge to discourage formal incident reporting.

Methods A qualitative descriptive design was employed, guided by Ajzen's Theory of Planned Behavior and the Social Ecological Model. Thirty-six registered nurses, purposively sampled from three tertiary hospitals, participated in six semi-structured focus groups conducted in Arabic or English, depending on participant preference. Data were thematically analyzed in NVivo, with methodological rigor ensured through triangulation and inter-coder reliability.

Results Three principal themes emerged: (1) Emotional and Psychological Barriers (78%), encompassing distress, anxiety, and fears of professional blame; (2) Organizational Ineffectiveness (65%), marked by convoluted reporting processes and perceived managerial indifference; and (3) Cultural and Hierarchical Influences (57%), reflecting deference to authority and normalization of violence. These themes illustrate how attitudes, subjective norms, and perceived behavioral control shaped by socio-cultural dynamics collectively contribute to persistent underreporting.

Conclusions Mitigating WPV underreporting in Saudi tertiary care hospitals requires streamlined, user-friendly reporting channels, leadership accountability, and holistic psychosocial support. Implementing interprofessional education aimed at dismantling hierarchical imbalances can foster a zero-tolerance ethos toward violence. Longitudinal and comparative research should further examine evolving reporting behaviors to refine context-specific, culturally attuned strategies for addressing WPV.

Clinical trial number Not applicable.

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Introduction

Workplace violence (WPV) remains a persistent, disheartening reality for healthcare professionals worldwide, encompassing a broad spectrum of aggressive behaviors ranging from verbal abuse and intimidation to physical assault [1–3]. For nurses in tertiary care settings, these occurrences are not merely episodic aberrations but often emerge as recurrent, draining experiences with detrimental consequences for nurse well-being, patient outcomes, and healthcare organizational cultures [4, 5]. Despite targeted policies and training programs implemented globally, workplace violence underreporting remains alarmingly frequent [6]. This underreporting deprives healthcare institutions of the data necessary to implement robust prevention strategies, and it leaves many nurses feeling powerless and unseen [7, 8]. Within the Kingdom of Saudi Arabia, where social norms and organizational hierarchies shape professional conduct in unique ways, understanding the barriers to reporting WPV among nurses holds particular urgency [9, 10].

Within the Kingdom of Saudi Arabia, the legal and policy frameworks addressing workplace violence in healthcare settings have evolved significantly in recent years [11]. The Saudi Commission for Health Specialties, through Directive 39281 (2023), established formal protocols for reporting and addressing violence against healthcare workers, including specific punitive measures for perpetrators [12]. Additionally, Royal Decree No. M/46 outlines legal consequences for workplace violence, including fines of up to 50,000 SAR and potential imprisonment for severe cases [13]. The Ministry of Health further reinforced these protections through Circular 1392/H, mandating all healthcare facilities to implement standardized reporting systems and protective measures [14]. Despite these national-level directives, preliminary evidence suggests significant gaps in policy awareness, implementation, and enforcement at the institutional level [15]. Understanding how these policy-practice gaps influence nurses' reporting behaviors is critical for developing effective interventions that align with existing legal frameworks while addressing the contextual barriers unique to Saudi healthcare environments [16].

Recent statistics illuminate the scope of this complex issue; the World Health Organization (WHO) reports that nearly 50% of healthcare workers worldwide have experienced at least one incident of WPV in their careers [1, 17, 18]. In Saudi Arabia, emerging evidence suggests that the prevalence rate may be equally high, with some studies indicating that up to 60% of nurses have encountered violence in some form [19–21]. These alarming figures place nurses at the forefront of occupational hazard concerns in modern healthcare systems [22–24]. Given that nurses often serve as the frontline interface between patients, families, and the hospital infrastructure, they are especially vulnerable to acts of aggression [25, 26]. While previous studies have devoted attention to the prevalence and incidence of workplace violence among nurses, there remains a considerable gap in exploring the nuanced reasons behind persistent underreporting, particularly in tertiary care settings that typically offer specialized, high-intensity clinical services [27–31].

Workplace violence against healthcare professionals represents a global public health challenge recognized by international bodies, including WHO, the International Labour Organization (ILO), and numerous national health authorities [1]. Research from diverse healthcare systems, including the United States, United Kingdom, Australia, and various Asian countries, demonstrates remarkable similarities in barriers to reporting despite significant cultural and organizational differences [18, 32, 33]. The Joint Commission in the U.S., the National Health Service (NHS) in the U.K., and Australia's healthcare system have each implemented varying approaches to zero-tolerance policies with differing levels of success [34]. Examining Saudi Arabian nurses' experiences within this global context provides an opportunity to identify both culturally specific and universal factors that influence WPV reporting behaviors, potentially informing international best practices for violence prevention in healthcare settings [35].

The significance of investigating barriers to reporting WPV is multifaceted; first, systematic, comprehensive reporting is critical for capturing reliable data on the incidence and types of violence [36, 37]. Without accurate, up–to-date reports, the full extent of workplace violence within a given institution remains unknown, hindering the development and implementation of effective preventive interventions [38, 39]. Second, thorough reporting mechanisms can empower nurses by validating their experiences and providing them with organizational support [40]. Failure to address underreporting not only permits the continuation of violent events but also contributes to a corrosive workplace atmosphere that affects morale, job satisfaction, and retention rates [41, 42]. Given the ongoing shortage of skilled nursing professionals in Saudi Arabia and globally [43–46], nurse attrition driven by a hostile or unsafe work environment threatens healthcare quality and sustainability [47]. Finally, a better understanding of the forces that discourage nurses from

reporting violence can guide targeted policy revisions, organizational reforms, and educational interventions that uphold the rights and well-being of nurses [48].

The disconnect between comprehensive national policies and their implementation in healthcare institutions represents another critical dimension of WPV reporting. Although Saudi Arabia has established clear regulatory frameworks for addressing workplace violence, studies indicate low awareness of these policies among frontline healthcare workers [49, 50]. Research by Al-Sayaghi (2023) found that only 34% of nurses were familiar with the formal reporting procedures mandated by national directives [20], while Ayasreh et al. (2021) documented significant variations in how punitive measures against perpetrators were enforced across different healthcare settings [51]. This inconsistency in policy implementation may contribute to nurses' skepticism about the effectiveness of formal reporting, particularly when hospital-level protocols fail to align with national frameworks [52].

In the context of Saudi Arabia, cultural and organizational norms add further dimensions to the issue of WPV [53]. Hierarchical structures within many healthcare institutions may impede open communication, leading some nurses to remain silent about incidents for fear of retribution or negative performance evaluations [54]. Likewise, cultural attributes such as respect for authority figures, physicians, administrators, and senior staff may deter nurses from bringing forward complaints, especially when the perceived aggressor holds a higher position in the organizational hierarchy [55, 56]. In some cases, societal perceptions of the nursing profession itself, particularly those related to the role of women in the workforce, could further exacerbate vulnerability and underreporting [57]. This interplay of cultural expectations, workplace dynamics, and personal coping strategies can create a vicious cycle in which violence becomes normalized as part of the job [58].

The existing literature on WPV reporting among nurses in Saudi Arabia highlights a range of critical barriers [45, 46]. Commonly cited obstacles include a lack of awareness of official reporting protocols, time pressures in fast-paced clinical environments, skepticism toward the usefulness of reporting mechanisms, and fear of blame or punitive actions [59]. Also noteworthy is the concern that reporting violent incidents may reflect poorly on a nurse's competence or conflict management skills [60]. Even when formal channels exist, a lingering perception that administrative follow-up will be either dismissive or slow to enact real change can dissuade nurses from filing reports [61]. The dynamic is further complicated by the emotional toll that violence exacts: post-incident shame, guilt, and anxiety can trap nurses in a cycle of silence [44, 62]. Consequently, the literature points to the need for an in-depth qualitative exploration of how these multiple factors converge to prevent nurses from reporting. This gap in understanding is not just academic: failing to address these barriers undermines the quality of patient care and contributes to a workplace climate of continued vulnerability and distress.

By highlighting the underexplored link between nurses' perceptions of WPV and their decision to withhold formal reports, the current investigation seeks to delineate the complexities of these reporting barriers in tertiary care settings. While surveys can capture the frequency of underreporting, qualitative methodologies can peel back the layers of institutional, social, and psychological constraints. Listening closely to the voices of nurses can illuminate subtleties that remain hidden when guided only by quantitative metrics [63]. Given the demonstrated prevalence of WPV in Saudi Arabia and the dearth of focused inquiries into the underlying, context-specific reasons for nurse underreporting, this study aims to address a critical gap in both scholarship and practice.

Aim of the study

The overarching aim of this qualitative study is to explore the barriers that deter nurses working in tertiary care settings in the Aljouf region of Saudi Arabia from formally reporting incidents of workplace violence. The study endeavors to produce an empirically grounded framework of these barriers that can inform policy interventions and institutional reforms, ultimately fostering safer clinical environments for both healthcare workers and patients.

Research question

What are the perceived barriers to reporting workplace violence among nurses in tertiary care settings in Aljouf region, Saudi Arabia?

Objectives

1. To examine the personal, cultural, and organizational factors that inhibit nurses from reporting incidents of workplace violence in tertiary care institutions.
2. To explore nurses' perceptions of existing reporting mechanisms, including their perceived effectiveness, accessibility, and confidentiality.
3. To delineate how cultural norms and hierarchical organizational structures interact with individual concerns and emotional repercussions to shape underreporting behaviors.
4. To propose policy and practice recommendations rooted in qualitative findings that can support a culture of open reporting and provide better safeguards against workplace violence.

In conclusion, the problem of unreported workplace violence in tertiary care settings must be grasped in all its dimensions if institutions are to devise effective, sustainable strategies. The high prevalence rates of WPV among nurses globally, compounded by the specific contextual factors present in Saudi Arabia's healthcare system, demand a focused exploration of the lived experiences of nurses. By shining a spotlight on the barriers that perpetuate underreporting, this study not only addresses a critical gap in the literature but also seeks to empower nurses and healthcare organizations to foster a safer, more supportive environment, one in which violence is neither tolerated nor hidden.

Theoretical framework

As illustrated in Fig. 1, this study integrates two complementary theoretical frameworks: Ajzen's (1991) Theory of Planned Behavior (TPB) [64] and the Social Ecological Model (SEM) [65] to comprehensively understand barriers to workplace violence reporting among nurses in tertiary care settings. The right side of Fig. 1 depicts TPB's three critical factors driving reporting behavior: attitudes, subjective norms, and perceived behavioral control. Nurses' attitudes about reporting are influenced by their assessment of benefits (e.g., prevention, accountability) versus risks (e.g., blame, professional repercussions). Subjective norms encompass the expectations and influences of colleagues and superiors, which can either support or discourage reporting behaviors, particularly within hierarchical healthcare structures. Perceived behavioral control, shown as the third component, represents nurses' beliefs about their capacity to successfully report incidents, including their access to resources, authority, and institutional support without fear of retaliation.

The left side of Fig. 1 illustrates the Social Ecological Model (SEM), which provides a multilayered contextual framework for understanding reporting behaviors. As shown, SEM progresses from societal to individual levels, each influencing reporting decisions. At the societal level, cultural norms and healthcare policies shape the broader context. The organizational level encompasses institutional policies and reporting systems, while the interpersonal level addresses relationships with peers and supervisors. At the individual level, personal experiences and professional identity influence reporting decisions. The connecting arrow between the two frameworks in Fig. 1 demonstrates how these ecological factors directly influence the TPB components, creating an integrated understanding of how personal, social, and institutional factors interact to affect workplace violence reporting in tertiary care settings. As visually represented, this dual-theoretical approach provides a comprehensive framework for examining the complex interplay of factors affecting nurses' reporting behaviors.

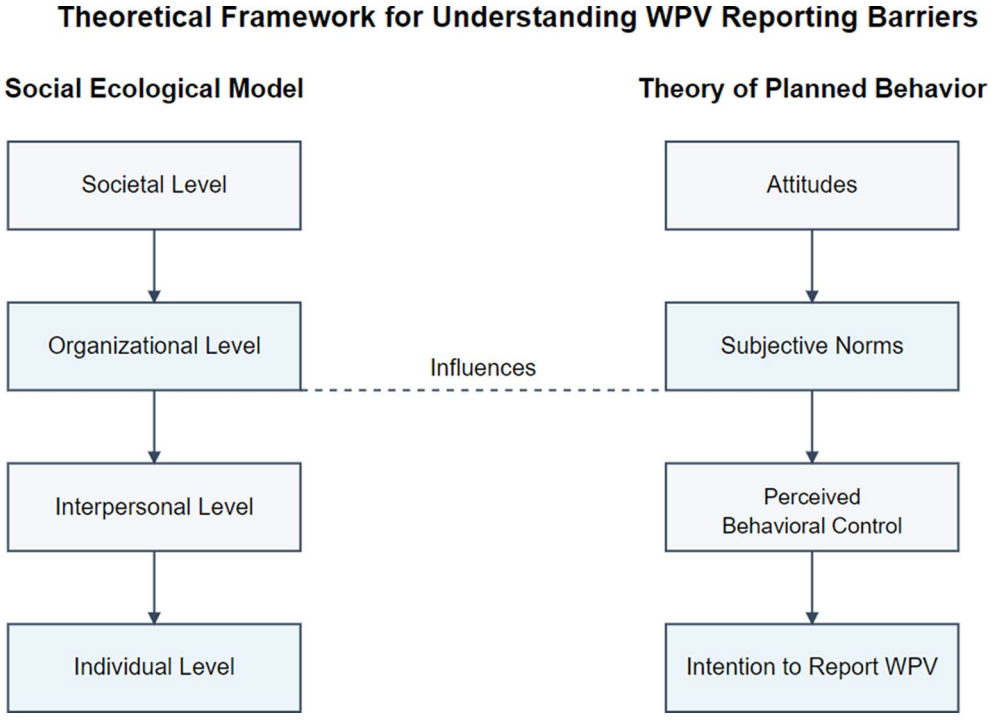

Fig. 1 Theoretical framework: Integration of TPB and SEM for understanding workplace violence reporting barriers in nursing practice

Materials and methods

Research design

Guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) [66], this study employed a qualitative descriptive design to explore the barriers to reporting workplace violence among nurses in tertiary care settings [67]. Data were collected through focus groups, each comprising 6–8 participants, using a semi-structured discussion guide informed by the study's theoretical frameworks. Focus groups were conducted in private, neutral settings to encourage open dialogue while ensuring confidentiality and psychological safety [68]. Audio recordings of the discussions were transcribed verbatim, with all identifying information removed to safeguard participants' privacy. Data triangulation was achieved by integrating transcriptions, field notes, and reflective memos, allowing for cross-validation of findings and minimizing bias [69]. Thematic analysis was performed iteratively, identifying patterns and themes that provide actionable insights for addressing the cultural, organizational, and interpersonal barriers influencing nurses' reporting behaviors [70]. This methodological approach ensures rigor and relevance, contributing to the development of evidence-based strategies for improving workplace safety and reporting practices.

Sampling and settings

This qualitative study was conducted in three tertiary care hospitals situated in both urban and semi-urban cities within the northern region of Saudi Arabia. These hospitals were deliberately chosen for their high patient volume, specialized clinical services, and diverse nursing workforce, factors deemed likely to yield a broad range of experiences in workplace violence. A purposive sampling strategy was employed to recruit registered nurses with at least six months of clinical experience [71], ensuring they had sufficient familiarity with hospital workflows and potential exposure to violent incidents. Exclusion criteria encompassed temporary or agency nurses, those under ongoing workplace violence investigations, individuals on extended leave, and nurses lacking proficiency in Arabic or English, as these languages were essential for meaningful participation in focus group discussions. Initially, 48 nurses were approached; of these, 36 provided informed consent, resulting in a 75% response rate. The final sample was equally distributed across the three hospitals (12 participants per site) and organized into six focus groups consisting of six participants each. This sample size was determined using two convergent criteria: (1) data saturation, wherein recruitment ceased once no new themes emerged, and (2) balanced representation across clinical shifts (day, evening, and night) and departments (e.g., emergency, intensive care, medical-surgical units). Recruitment spanned from August to November 2023 via departmental announcements and nurse manager referrals. Most sessions were conducted immediately after nurses' shifts to accommodate their availability while avoiding fatigue associated with long clinical hours. Each focus group convened once for approximately 60–90 minutes in private meeting rooms within the hospitals' education departments, settings selected to ensure neutrality and confidentiality. These methods and settings provided a robust framework for eliciting diverse, context-specific insights into the barriers that deter nurses from reporting workplace violence.

Data collection tools

Data were obtained through a semi-structured discussion guide [72] constructed in alignment with Ajzen's Theory of Planned Behavior (TPB) [64] and the Social Ecological Model (SEM) [65] to capture the personal, organizational, and cultural barriers to reporting workplace violence (WPV). The guide was organized into four core domains: (1) individual perceptions and attitudes, (2) organizational policies and support, (3) hierarchical and interpersonal dynamics, and (4) cultural norms, each formulated with open-ended and probing questions that encouraged rich, context-specific responses. Example prompts included: "What personal factors influence your decision to report a WPV incident?" and "How do hierarchical or cultural factors shape your comfort in speaking out?" Initially written in English, the guide underwent a forward-backward translation into Arabic to ensure conceptual equivalence in the bilingual study setting.

To validate and refine this tool, a pilot test was conducted with three nurses who were not included in the main study. Feedback from this pilot informed minor adjustments, such as clarifying certain terms and adding additional probes on organizational reporting procedures. All focus group discussions, typically lasting 60–90 minutes, were facilitated by a trained moderator with qualitative research expertise in healthcare contexts. An independent observer experienced in qualitative methods documented non-verbal cues and group dynamics via field notes. Sessions were audio-recorded with backup devices in place to prevent data loss. Immediately following each session, reflective memos were completed to capture emergent insights and guide iterative adjustments to the discussion approach. The instruments underwent bidirectional translation (English-Arabic) with cultural and contextual validation specific to Saudi Arabian group dynamics [73]. This thorough, bilingual, and pilot-tested data collection protocol ensured methodological rigor and maximized the depth and validity of the findings.

Ethical approval

This study received ethical approval from the Bioethics Institutional Review Board (IRB) at Jouf University (Approval No. 6852–2024). The research adhered to the ethical principles of the Declaration of Helsinki, protecting participants' rights, privacy, and well-being. Written informed consent was obtained from all participants before their inclusion in the study, with assurances of confidentiality and the voluntary nature of participation. Participants were informed of their right to withdraw from the study without penalty. All data were anonymized during transcription and securely stored to safeguard privacy. Additionally, measures were taken to minimize any psychological distress, given the sensitive nature of discussing workplace violence, by providing participants with access to counseling resources if needed. This ethical framework ensured that the study upheld the highest research integrity and participant care standards.

Procedure

Data collection was conducted from August to November 2023 and organized into three phases (Phase I, Phase II, and Phase III), each governed by memoranda of understanding and confidentiality agreements established with nursing directors and hospital administrators. Upon obtaining ethical clearance from the Bioethics Institutional Review Board at Jouf University (Approval No. 6852–2024), the research team finalized formal protocols that detailed data handling procedures, participant anonymity safeguards, and contingency plans for addressing potential technical failures (e.g., backup digital recorders). Department heads distributed recruitment flyers to eligible nurses, who were given a two-week deliberation period and provided a secure institutional email for inquiries to preserve autonomy and confidentiality.

Phase II involved six focus groups, with six nurses each, proportionally representing different shifts (day, evening, and night) and clinical units (emergency, ICU, and medical-surgical). Each session lasted 60–90 minutes and encompassed a structured format: a 5-minute orientation and consent verification, a 10-minute rapport-building segment, a 45–60-minute moderated discussion, and a 10-minute closing reflection. The moderator was a doctoral-level nurse researcher skilled in qualitative facilitation, supported by a master's-prepared nurse educator who meticulously documented non-verbal cues and contextual nuances. To address language barriers, sessions were conducted in Arabic or English according to participant preference, supplemented by a trained bilingual translator to ensure conceptual fidelity. Translational accuracy was further validated through iterative forward-backward checks. All focus group discussions were held in the hospitals' education departments, neutral settings chosen to promote confidentiality and candid exchanges.

Quality assurance and data saturation, covered in Phase III, incorporated immediate post-session transcription and cross-verification with observer field notes and reflective memos to strengthen data triangulation. Member checking occurred at the conclusion of each session, allowing participants to review and validate the preliminary thematic highlights. Four weekly peer debriefing sessions followed, where the research team cross-verified emergent themes and documented any methodological adjustments in an audit trail. Data saturation was defined as the point at which two consecutive focus groups yielded no novel themes or codes, indicating comprehensive coverage of reporting barriers. All transcripts were encrypted and assigned coded identifiers, and physical documents were stored in locked cabinets to maintain the highest standards of confidentiality and methodological rigor.

Data analysis

The focus group data were analyzed following Braun and Clarke's six-phase thematic analysis framework, employing an integrated inductive-deductive approach [74]. First, the audio recordings were transcribed verbatim, and the transcripts were read multiple times to achieve data immersion. Using NVivo 12 software, two independent researchers performed line-by-line coding, guided by the Theory of Planned Behavior (TPB) and the Social Ecological Model (SEM), while remaining receptive to emergent codes.

Coding and reliability

Inter-coder reliability was ensured through regularly scheduled consensus meetings, during which discrepancies in coding were discussed until at least 90% agreement was achieved. Potential codes were iteratively grouped into preliminary themes, followed by researcher triangulation: a third researcher separately evaluated both the coding structure and the developing thematic framework for consistency and robustness.

Trustworthiness and validation strategies

Multiple strategies were employed to strengthen analytic credibility and overall trustworthiness:

1. *Member Checking:* Preliminary themes were presented to a subset of participants (n = 12) for verification and refinement.
2. *Negative Case Analysis:* Contradictory or outlier data were scrutinized to challenge emerging patterns and ensure comprehensive theme development.

3. *Thick Description:* Contextual information and verbatim quotations were systematically integrated to substantiate interpretations.
4. *Audit Trail:* A meticulous record of all analytical decisions, including code definitions, thematic development, and theoretical mapping, was maintained.

Theme emergence and theoretical alignment

The final analysis produced three primary themes, each comprising two subthemes, assessed for internal homogeneity and external heterogeneity. Continuous comparative analysis further examined how the themes aligned with TPB constructs (attitudes, subjective norms, perceived behavioral control) and the multi-level structure of SEM (individual, organizational, and societal). This theoretical mapping highlighted how emotional, organizational, and cultural factors collectively influence WPV reporting behaviors.

Data saturation and rigorous evaluation

Data saturation was deemed reached after the final two focus groups offered no additional codes or thematic insights. Trustworthiness was further reinforced by:

- *Credibility:* Prolonged data engagement and methodological triangulation.
- *Transferability:* Detailed presentation of participant demographics and the research context.
- *Dependability:* Systematic documentation of analytical processes.
- *Confirmability*: Ongoing researcher reflexivity and peer debriefing sessions.

This rigorous approach yielded a robust framework that illuminates the interplay of personal, organizational, and socio-cultural determinants shaping workplace violence (WPV) reporting practices among nurses.

Table 1 Demographic and professional characteristics of nurses in tertiary care settings (n = 36)

Characteristic	Frequency (n = 36)	Percentage (%)
Gender		
- Female	25	70
- Male	11	30
Age Group		
- 25–30 years	10	28
- 31–40 years	24	67
- > 40 years	2	5
Clinical Experience		
- 1–4 years	6	17
- 5–10 years	22	60
- > 10 years	8	23
Clinical Shift		
- Day	12	33
- Evening	12	33
- Night	12	33
Department		
- Emergency	10	28
- ICU	8	22
- Medical-Surgical	12	33
- Obstetrics	6	17

Results

This section presents the study's findings derived from six focus groups (n = 36) conducted among registered nurses in three tertiary care hospitals in the Aljouf region. Data triangulation (transcripts, field notes, reflective memos) and iterative thematic analysis were employed to ensure rigor and alignment with the aim, research question, and objectives. Each theme is situated within Ajzen's Theory of Planned Behavior (TPB) and the Social Ecological Model (SEM), highlighting how attitudes, subjective norms, perceived behavioral control, and multi-level ecological factors converge to inhibit workplace violence (WPV) reporting. Although Objective 4 (policy and practice recommendations) is addressed in the discussion, the themes below lay the empirical groundwork for those recommendations.

Overview of the participants

Table 1 summarizes participant demographics and professional backgrounds. The sample (70% female; mean age = 32.8 ± 4.6 years) represented a wide range of clinical experience, with most having 5–10 years on the job (60%). Day, evening, and night shifts were evenly distributed (33% each), ensuring broad coverage of possible WPV encounters. Departmental representation across emergency, ICU, medical-surgical, and obstetrics units provided insight into varying clinical contexts. These characteristics positioned the sample to capture nuanced perspectives on WPV underreporting.

Integrating demographics with qualitative insights

- Younger nurses (25–30 years) expressed greater emotional vulnerability (Theme 1), describing heightened anxiety and fear in response to WPV incidents.
- Nurses with more than 10 years of experience highlighted frustrations with organizational barriers (Theme 2), citing repeated encounters with ineffective reporting mechanisms.
- Participants from high-acuity settings like emergency and ICU contributed extensively to discussions on hierarchical dynamics (Theme 3), underscoring power imbalances with senior staff or physicians.

Key themes identified

Three major themes emerged from the data analysis, reflecting the personal, cultural, and organizational factors influencing nurses' reporting of workplace violence (WPV), their perceptions of reporting mechanisms, and the impact of cultural norms, hierarchy, and emotional repercussions. These themes are summarized in Table 2 and further elaborated below with illustrative quotations. While the findings provide the groundwork for policy and practice recommendations, those are addressed in the discussion rather than as a separate theme in the results.

Theme 1: Emotional and psychological barriers

This theme captures the profound emotional and psychological challenges that deter nurses from reporting workplace violence (WPV). It aligns with the Attitudes and Subjective Norms constructs of Ajzen's Theory of Planned Behavior (TPB), demonstrating how emotional trauma and apprehension about blame shape nurses' reluctance to engage with formal reporting mechanisms. Emotional responses to violence, such as anxiety and distress, coupled with fears of professional judgment, emerged as significant barriers influencing reporting behavior.

Subtheme 1a: Emotional distress from violence

Nearly 78% of participants recounted acute and lingering emotional strain after experiencing WPV. Nurses described anxiety, insomnia, and self-doubt, which often escalated to the point of deterring them from reporting.

- *I had nightmares for a week after a patient's family threatened me. Every time I considered reporting, the anxiety came back. It's like reliving the trauma.* (FG2-P4)
- *I felt numb and didn't want to talk about it. I thought if I reported, I'd have to discuss it over and over. That terrified me more than the incident.* (FG3-P2)

These statements demonstrate how unresolved emotional distress erodes confidence and underscores the interplay of personal resilience and organizational support. Participants frequently mentioned a lack of psychosocial resources post-incident, intensifying their reluctance to report.

Subtheme 1b: Fear of negative professional consequences

Linked to Subjective Norms (TPB), this subtheme highlights concerns about blame, career stagnation, and peer judgment. Nurses feared being perceived as incompetent or "weak" if they reported WPV.

- *It always comes back to, 'Why couldn't you handle it?' Like maybe I provoked the aggression by not being skilled enough. (FG1-P5)*
- *Once you start the paperwork, you feel you're inviting an investigation that puts your competence on trial. (FG5-P1)*

Such apprehensions reflect deeply rooted cultural beliefs about professional competence. Nurses emphasized that persistent fear of blame or being labeled "unfit" perpetuated silence, even when they recognized the severity of WPV incidents. These fears, rooted in workplace norms and perceptions of professional inadequacy, further exacerbated the reluctance to report.

Theme 2: Organizational ineffectiveness

This theme highlights the structural and systemic challenges within healthcare organizations that discourage nurses from formally reporting incidents of workplace violence (WPV). It reflects barriers such as cumbersome reporting processes and perceived management apathy, which collectively diminish nurses' motivation and confidence to report. These issues are closely linked to the Perceived Behavioral Control construct of Ajzen's Theory of Planned Behavior (TPB) and the organizational level of the Social Ecological Model (SEM), underscoring how institutional inefficiencies and lack of follow-through hinder reporting behaviors.

Table 2 Emergent themes and subthemes reflecting barriers to workplace violence reporting among nurses

Theme	Subthemes	TPB/SEM constructs	Frequency of theme (%)	Gender distribution
1. Emotional and Psychological Barriers	1a. Emotional distress from violence. 1b. Fear of negative professional consequences	-Attitudes (TPB) -Subjective norms (TPB)	78	Female: 82% Male: 73%
2. Organizational Ineffectiveness	2a. Complexity and inefficiency of reporting systems 2b. Perceived organizational inaction	-Perceived behavioral control (TPB) -Organizational level (SEM)	65	Female: 59% Male: 70%
3. Cultural and Hierarchical Influences	3a. Deference to authority and hierarchical dynamics 3b. Normalization of workplace violence	-Subjective norms (TPB) -Societal level (SEM)	57	Female: 68% Male: 42%

Note Frequency (%) indicates the proportion of participants who explicitly referenced each theme during focus groups (with overlapping mentions possible). Gender distribution shows the percentage of female (n = 25) and male (n = 11) participants who identified each barrier

Subtheme 2a: Complexity and inefficiency of reporting systems

Nurses consistently described the reporting mechanisms as overly complex and time-consuming, making the process feel burdensome and impractical. Many participants expressed frustration with the required paperwork and unclear report filing instructions. One nurse explained,

- *The reporting system feels like it's designed to make you give up. By the time you figure out what form to fill out, you've wasted hours that could have been spent with patients.* (FG2-P1)

Another added,

- *We work in high-pressure environments where every minute counts. Reporting shouldn't feel like an extra shift of administrative work.* (FG4-P3).

Participants also highlighted how systemic inefficiencies, such as delays in accessing reporting platforms or confusion about whom to report incidents to, further discouraged engagement. As one nurse noted,

- *I had to ask multiple colleagues just to figure out where to submit my report. By the end of it, I felt more frustrated than supported.* (FG6-P35)

When describing current reporting mechanisms across the three hospitals, participants identified specific procedural obstacles that undermined effectiveness.

In Hospital A, nurses described a paper-based system requiring multiple signatures:

> *The form goes through five different people before any action occurs. By then, everyone had forgotten about the incident. (FG1-P6)*

Hospital B reportedly had an electronic system that was frequently offline:

> *I tried to log in three times to report an incident, but the system was down. I eventually gave up. (FG3-P4).*

In Hospital C, participants noted unclear categorization guidelines:

> *There's confusion about what qualifies as reportable violence versus 'difficult patient behavior,' so many incidents go undocumented. (FG5-P2)*

Subtheme 2b: Perceived organizational inaction

Even when nurses successfully navigated the reporting process, many described a pervasive sense of futility stemming from management's lack of meaningful follow-up. Participants recounted instances where reports were acknowledged, but no concrete actions were taken, leaving them feeling unsupported and disillusioned. One participant shared,

- *When I reported violence, my manager said they'd 'look into it,' but I never heard anything after that. It felt like my concerns didn't matter.*(FG5-P13)
- Another added, *There's no accountability. Even when someone reports violence, it gets swept under the rug, and nothing changes.*(FG1-P22)

Participants elaborated on the types of institutional responses they had witnessed following WPV reports. The most common outcome (mentioned by 68% of participants) was acknowledgment without action, where incidents were documented but no visible changes were implemented. Less frequently (23% of participants), reports led to team discussions but rarely to policy changes. As one nurse explained:

> *In my five years here, I've filed three serious incident reports. Only once did I see any response to a one-hour staff meeting about de-escalation techniques that changed nothing in practice. (FG4-P5)*

This perceived lack of institutional commitment to addressing reported violence directly undermined nurses' willingness to engage with formal reporting systems.

This lack of response from management discouraged nurses from reporting future incidents and reinforced a culture of complacency within the organization. As one nurse explained,

- *You start to wonder why you should bother reporting if no one's going to do anything about it. It's like shouting into a void.* (FG2-P7)

The absence of tangible outcomes following reports eroded trust in the system, further perpetuating silence and underreporting. This subtheme aligns with the organizational level of SEM, highlighting how systemic apathy and lack of accountability perpetuate an unsafe work environment.

Our findings regarding organizational ineffectiveness must be considered within the broader context of national policy implementation. Despite the existence of comprehensive legal frameworks in Saudi Arabia that mandate standardized reporting systems and specify consequences for workplace violence, participants

described significant variations in how these policies were operationalized across the three hospitals studied. This inconsistency mirrors the findings [20, 51, 52], who documented similar gaps between policy formulation and implementation. The absence of visible enforcement of punitive measures against perpetrators, as noted by 68% of our participants, further undermines nurses' confidence in the reporting system. As one nurse explained,

> *Even when someone reports violence, there's no evidence that the penalties in the national policy are ever applied. (FG1-P22)*

This perceived lack of policy enforcement represents a critical barrier that extends beyond mere procedural inefficiencies to encompass broader governance challenges in translating national directives into institutional practice.

Theme 3: Cultural and hierarchical influences

This theme delves into how socio-cultural norms, hierarchical structures, and institutional power imbalances reinforce underreporting behaviors. Rooted in Subjective Norms (TPB) and the societal level of the Social Ecological Model (SEM), the findings reveal how deference to authority and the normalization of violence perpetuate a climate of silence around workplace violence (WPV).

Subtheme 3a: Deference to authority and hierarchical dynamics

Participants emphasized the powerful influence of authority figures, particularly physicians, administrators, and senior nurses, on their willingness to report WPV. Respect for authority is deeply ingrained, discouraging nurses from raising concerns or lodging formal complaints.

- *We're taught not to challenge senior staff. Reporting a doctor is unthinkable; the blame often falls on the nurse."* (FG2-P2)
- *Hierarchy is so strong here. If someone from higher up yells at you, you just accept it because complaining might ruin your career.* (FG5-P3)

These statements highlight how hierarchy and fear of reputational damage function as powerful disincentives. Participants described a workplace culture where challenging superiors is perceived as risking their job security and career advancement. Consequently, even legitimate complaints of violence or aggression may go unreported, perpetuating a harmful cycle of silence.

Subtheme 3b: Normalization of workplace violence

More than half of the participants (57%) characterized WPV as an expected or inevitable part of nursing practice. This perception reduces the sense of urgency to report incidents, as nurses internalize violence as an ordinary occupational hazard.

- *It's sad, but we tell new nurses, 'This will happen to you sooner or later just cope.* (FG1-P4)
- *It's normalized to the point that people think we're overreacting if we complain about yelling or threats.* (FG4-P1)

Such normalization erodes the impetus to initiate formal reporting. Nurses often feel that filing a complaint is unnecessary if violence is viewed as routine. This perspective aligns with the societal-level influences of SEM, where deeply rooted cultural attitudes and beliefs sustain an environment in which workplace violence remains largely unchallenged and systematically underreported.

Foundations for policy and practice recommendations

The findings underscore the need for targeted interventions that address the structural and cultural barriers impeding workplace violence (WPV) reporting among nurses. Streamlined, user-friendly reporting systems can alleviate administrative burdens and foster transparency. However, robust institutional follow-up protocols, including prompt investigations and readily available psychosocial support, can help rebuild trust in organizational processes. Equally critical is the dismantling of hierarchical norms and the normalization of aggression, achieved through leadership training, interprofessional education, and workplace awareness campaigns that validate nurses' experiences and reinforce a collective intolerance toward violence. Together, these strategies offer a comprehensive framework for fostering a culture of accountability and respect in which nurses are empowered to report incidents without fear of reprisal or stigma. Grounded in the study's findings, such efforts prioritize nurse safety, ensure visibility of managerial commitment, and champion a healthier, more equitable work environment that mitigates the pervasive issue of WPV in healthcare settings.

Overview of key themes

Three interrelated themes emerged from the data, each grounded in Ajzen's Theory of Planned Behavior (TPB) and the Social Ecological Model (SEM) (Fig. 2). Theme 1, Emotional and Psychological Barriers, reveals how unresolved distress and fear of judgment deter nurses from filing formal reports. Participants described anxiety, insomnia, and apprehensions about being perceived as incompetent, demonstrating how both Attitudes and Subjective Norms (TPB) converge to silence potential reports. Theme 2, Organizational Ineffectiveness, underscores systemic barriers within healthcare settings,

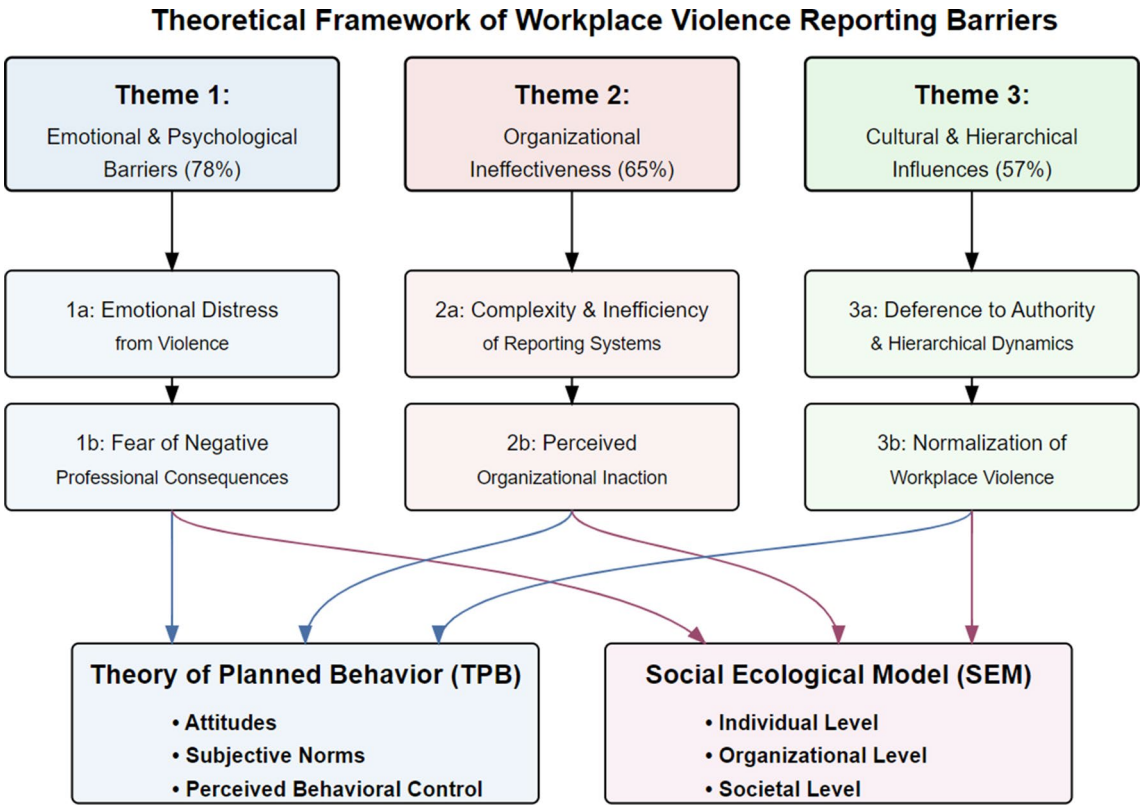

Fig. 2 Theoretical integration of Workplace Violence (WPV) reporting barriers among nurses: A thematic analysis framework

including convoluted paperwork and minimal follow-up from management. These conditions reduce nurses' Perceived Behavioral Control (TPB) and erode trust, highlighting the organizational-level (SEM) factors that compound underreporting. Theme 3, Cultural and Hierarchical Influences, focuses on deference to authority figures and normalizing workplace violence. Nurses frequently cited fear of repercussion when challenging superiors and acceptance of aggression as "part of the job," reflecting Subjective Norms (TPB) and societal-level (SEM) forces that perpetuate a culture of silence around WPV.

Figure 2 provides a visual synthesis of the three emergent themes, mapping each theme and its subthemes onto Ajzen's Theory of Planned Behavior (TPB) and the Social Ecological Model (SEM). This framework underscores how attitudes, subjective norms, perceived behavioral control, and multilevel ecological factors collectively shape nurses' decisions to report or not report workplace violence.

Discussion

The findings of this study bring into sharp relief the myriad social, organizational, and psychological forces that conspire to keep workplace violence (WPV) underreported in tertiary care hospitals in Saudi Arabia. Aligning with Ajzen's (1991) Theory of Planned Behavior (TPB) [48] and the Social Ecological Model (SEM) [49], our results illuminate how personal distress, institutional failings, and deeply rooted cultural norms shape nurses' decisions to remain silent in the face of violence. These findings are consistent with a body of international research indicating that healthcare professionals often perceive violence as part of the job and, consequently, are hesitant to report such incidents [39, 75–79]. Yet, our qualitative exploration offers granularity on how these perceptions interact specifically within the Saudi Arabian context, which is characterized by hierarchical healthcare structures and traditional cultural reverence for authority figures [49, 50, 80–82]. Below, we unpack the interplay between the three emergent themes and situate them against existing literature, exploring both convergent and divergent viewpoints to craft a nuanced analysis of WPV underreporting.

Gender and reporting barriers in the Saudi context

Our analysis revealed notable gender-based differences in WPV reporting behaviors. Female nurses (70% of our sample) described distinct barriers when incidents involved male physicians or administrators. During focus groups, female participants reported 26% higher rates of hesitation to formally document incidents perpetrated by male authority figures compared to their male counterparts. This finding aligns with Almansour (2024), who

documented similar gender-specific reporting barriers in Saudi healthcare settings [83]. When disaggregating our thematic data by gender, female nurses more frequently cited hierarchical barriers (68% vs. 42% among males), while male nurses emphasized organizational ineffectiveness (70% vs. 59% among females). These differences likely reflect broader gender norms in Saudi society, where traditional expectations of female deference may compound professional hierarchies, creating multilayered barriers for female nurses [84, 85].

Emotional and psychological barriers

Theme 1 (Emotional and Psychological Barriers) underscores how personal distress and fear of professional repercussions often overwhelm nurses to the point of silence. Participants detailed anxiety, insomnia, and long-lasting emotional trauma findings that resonate with prior studies that highlight the psychological toll of WPV on nurses [59, 86–90]. Research across various cultural settings has shown that the emotional aftershock from violent episodes can be more potent than the physical harm itself, as nurses grapple with persistent stress and job dissatisfaction [91–93]. Here, our participants described the dread of having to relive the event through formal reporting processes and potential investigations. The synergy of these emotional burdens effectively erodes a sense of empowerment: Under TPB, such experiences negatively shape nurses' attitudes toward reporting while simultaneously impacting subjective norms if peers or superiors dismiss or trivialize these emotional responses.

Fear of negative professional consequences emerged as an equally potent factor. The concern that reporting will be interpreted as incompetence or a display of personal weakness has been highlighted in multiple cross-cultural studies [94–96]. In some healthcare contexts, especially those steeped in strong hierarchical traditions, nurses' perceived professional standing may hinge on their ability to handle aggression without complaint [97–101]. Our data confirm that these anxieties induce a paralyzing effect: nurses often accept emotional abuse or intimidation rather than risk being labeled as unfit for high-pressure clinical settings. This perpetual state of fear is further nurtured by a general lack of institutional assurances that nurses who report violence will be protected or supported. Despite the introduction of staff counseling and debriefing sessions in some institutions [102], many of our participants noted the absence of consistent psychosocial support. Such voids compound the sense of vulnerability and heighten the reluctance to report.

Although fear and emotional distress are cited as near-universal reactions to WPV, the specific interplay with cultural expectations in Saudi Arabia, where hierarchical structures remain deeply embedded, intensifies these barriers. For instance, previous work has shown that in conservative cultural contexts, nurses may feel inhibited from reporting incidents involving male physicians or male family members of patients, fearing not just professional backlash but also cultural disapproval [43–46]. This study further confirms that intangible cultural norms and deference to authority magnify these anxieties, shaping nurses' attitudes (TPB) and reinforcing subjective norms that stifle reporting behaviors.

Organizational ineffectiveness

Theme 2 (Organizational Ineffectiveness) reveals an institutional environment that inadvertently fosters underreporting via cumbersome bureaucracy, unclear reporting channels, and a perceived lack of managerial follow-up. These organizational-level factors (SEM) interact strongly with perceived behavioral control (TPB), a component critical in determining whether nurses feel capable of initiating a formal report. Congruent with studies from other nations, including high-resource countries, our participants lamented that the complexity of reporting forms and multi-step procedures has become a logistical barrier to speaking up [29, 58, 59]. While many healthcare systems worldwide have instituted electronic incident-reporting platforms, these platforms are often hampered by technical glitches or lack of user training [26]. The outcome is an exasperating experience, leading to low usage rates and perpetuating an assumption among nurses that "reporting is more trouble than it is worth."

The second dimension of organizational ineffectiveness, a perceived lack of managerial action or follow-through, further quells the willingness to report. Scholars have long underscored that inadequate administrative responses to WPV complaints create a cyclical dynamic: nurses see a dearth of corrective measures, so they opt not to report future incidents [103]. In our focus groups, participants recounted stories where reports seemed to vanish into a bureaucratic abyss, with minimal or no feedback returned to the complainant. Over time, this fosters an "all talk, no action" sentiment that transforms into cynicism. Existing research aligns with this observation, finding that organizational culture plays a primary role in determining the success of WPV mitigation strategies [27, 81]. Where healthcare leadership fails to demonstrate visible, timely, and supportive responses, such as investigating the incident or initiating conflict resolution, staff become resigned to violence as an inevitable facet of care delivery [75].

While our study primarily focused on nurses' perceptions of barriers rather than an objective evaluation of reporting system effectiveness, our findings revealed important insights about how current reporting mechanisms function across the three hospitals. Participants described specific procedural obstacles, including

multi-step paper-based systems requiring numerous approvals, unreliable electronic platforms, and unclear incident classification guidelines. These descriptions highlighted substantial variation in reporting processes across institutions, with nurses reporting that only an estimated 23% of documented incidents received visible follow-up action, typically in the form of staff meetings rather than systemic changes. Future research should build on these findings by incorporating institutional data and administrative perspectives to comprehensively evaluate reporting system effectiveness and implementation barriers.

The absence of accountability also resonates with Busca et al. (2021), who noted that nurses in certain Middle Eastern healthcare settings rarely see sanctions imposed on perpetrators of verbal or physical abuse [104]. Our participants' accounts mirror these findings, suggesting the normalization of wrongdoing through institutional inertia. Although sporadic staff training workshops and zero-tolerance policies have been introduced in some hospitals, their success depends heavily on consistent management oversight, interprofessional collaboration, and enforcement. Without sustained institutional commitment, such initiatives amount to mere symbolism, offering nurses little confidence in the system's capacity or willingness to protect them.

Cultural and hierarchical influences

Theme 3 (Cultural and Hierarchical Influences) provides a powerful lens into how cultural and social mores intersect with institutional structures to deter WPV reporting. Consistent with prior scholarship within Gulf Cooperation Council (GCC) countries, participants noted deep-rooted deference to authority manifested in reluctance to challenge physicians, administrators, or even senior nurses [42, 53, 55, 57, 62]. This vertical power dynamic functions as a potent subjective norm (TPB), setting the social standard that speaking out against superiors is tantamount to questioning their professional judgment or tarnishing institutional reputation. The hierarchical nature of many Saudi healthcare systems further complicates these relationships, making direct confrontation or formal reporting feel hazardous to one's career progression [46].

Normalization of workplace violence emerged as a corollary to these hierarchical underpinnings, reinforcing a collective ambivalence towards aggressions that might be deemed unacceptable in other occupational contexts. Our findings echo well-documented phenomena across high-stress specialties such as emergency and critical care, where staff experience aggression from frustrated patients or families regularly, often perceiving it as just part of the job [105, 106]. This normalization fosters an environment where those who do muster the courage to file reports can face criticism or be told they overreacted. Importantly, the cultural acceptance of certain forms of aggression, particularly verbal assaults, fuels the cycle of underreporting, validating prior quantitative analyses conducted in Saudi Arabian hospitals [107, 108].

Divergent evidence does, however, come from some Western contexts where progressive institutions have robust, well-publicized anti-violence policies that actively dismantle hierarchical intimidation [91]. In those settings, staff have begun to challenge the notion that violence is inevitable, supported by managerial frameworks that swiftly address reported incidents. Our study highlights that while attempts to adopt similar frameworks exist in Saudi Arabia, the successful implementation faces additional cultural headwinds, including strong paternalistic norms and a deeply ingrained fear of damaging workplace relationships [29, 47]. This suggests that straightforward policy transplantation, lifting a zero-tolerance policy from a Western model and imposing it on a Saudi context may be insufficient. Instead, interventions must consider the nuance of local cultural contexts if they are to facilitate genuine shifts in reporting norms.

Implications for research and practice

Context-specific interventions are needed to address the hierarchical and cultural complexities in Saudi tertiary care. Future studies could explore how leadership coaching, culturally grounded conflict-resolution frameworks, and structured debriefing sessions reshape nurses' norms and attitudes about reporting workplace violence (WPV). Cross-sectional designs, like this study, offer limited temporal context; thus, longitudinal methodologies that track nurses' WPV experiences over various career stages would illuminate the resilience factors or pivotal turning points influencing reporting behaviors. Investigations focusing on middle-management training could clarify how leadership accountability mechanisms reinforce or undermine organizational policy implementation around WPV. Comparative research spanning diverse regions of Saudi Arabia or other GCC countries may further reveal how healthcare governance and cultural variations affect WPV reporting, informing best practices that could be adapted across the Middle East.

From a practical standpoint, policy revision and simplification are paramount. Implementing user-friendly, technologically supported reporting processes paired with training and real-time IT assistance could reduce administrative burdens and enhance reporting feasibility. Organizational leadership should respond proactively to violence complaints through transparent communication, swift investigations, and meaningful accountability measures, all of which may restore trust in the reporting system. Psychosocial support programs, including counseling and stress management, could mitigate the

emotional toll on nurses who experience WPV. Training that addresses hierarchical power dynamics and cultural reverence for authority, particularly through structured workshops on conflict resolution, empathy, and professional communication, can gradually shift organizational culture away from punitive tendencies and toward a more respectful, supportive environment.

Healthcare institutions must also implement comprehensive awareness campaigns that foster a zero-tolerance culture toward workplace violence. These should include visible signage at hospital entry points and unit doors explicitly stating that violence against healthcare workers will not be tolerated and will result in disciplinary or legal action. Educational materials targeting patients, families, and visitors should clearly outline expected behaviors and potential consequences of aggressive actions. Regular awareness sessions for staff, patients, and visitors would reinforce institutional commitment to violence prevention and promote a culture of mutual respect. These visible manifestations of zero-tolerance policies would complement the reporting mechanisms and accountability measures, creating a comprehensive approach to workplace violence prevention.

Policy integration and enforcement

Our findings highlight the urgent need for stronger integration between national violence prevention policies and hospital-level implementation. Healthcare institutions should develop clear mechanisms for disseminating information about existing legal protections, reporting requirements, and potential consequences for perpetrators of workplace violence. This includes regular staff education about Saudi Arabia's healthcare worker protection laws and visible documentation of how these policies are enforced within the specific institutional context. To effectively operationalize these policies, hospitals should establish standardized reporting protocols with multiple access points, including anonymous options. Reporting forms should be simplified and available in both paper and electronic formats, with completion time limited to 10–15 minutes. Each unit should designate a reporting champion responsible for assisting staff with documentation and ensuring follow-through. Specialized training on reporting procedures should be incorporated into orientation and annual competencies.

Healthcare facilities must establish explicit non-retaliation policies that guarantee confidentiality and protect nurses who report violence from negative performance evaluations or career consequences. Post-incident support protocols should include mandatory debriefing sessions, immediate access to counseling services, and temporary reassignment options if psychological recovery requires it. Administrative leadership should establish transparent accountability systems that track both the reporting of incidents and the subsequent application of appropriate measures as stipulated in national frameworks. This includes quarterly reporting of workplace violence statistics to hospital boards with mandatory action plans for addressing trends. Annual policy compliance audits should evaluate the percentage of reported incidents that receive documented follow-up and the timeliness of responses. Future research should further examine the specific barriers to policy implementation, including resource constraints, competing priorities, and cultural factors that may impede the consistent enforcement of punitive measures against perpetrators of workplace violence in Saudi healthcare settings.

Drawing from global best practices, healthcare institutions should implement enforcement strategies that have proven effective in countries like Canada, the United States, and European Union nations. These include (1) consistent application of legal penalties for perpetrators as outlined in Saudi national frameworks; (2) dedicated protection programs with visible security personnel, emergency response teams, and silent alarm systems in high-risk areas; and (3) mandatory reporting requirements that remove individual discretion from the decision to report serious incidents. While Saudi Arabia has established legal foundations through Directive 39281 and Royal Decree No. M/46, our findings indicate these mechanisms often remain unimplemented at the institutional level. Adapting these international enforcement strategies to Saudi cultural contexts could bridge the identified policy-practice gap and demonstrate institutional commitment to staff safety.

Internationally recognized best practices in reporting systems include robust whistleblower protection laws and real-time digital reporting platforms that have significantly improved reporting rates. Saudi healthcare institutions should implement EHR-integrated reporting tools that automatically capture incident details while maintaining reporter confidentiality. Such digital transformation would address the technological inefficiencies identified in our study, particularly in Hospital B, where electronic systems were frequently offline. Additionally, institutions should establish formal whistleblower protection protocols that explicitly prohibit any form of retaliation against those who report incidents. These protections should be codified in institutional bylaws, communicated during staff orientation, and visibly posted throughout facilities. Implementing these accountability mechanisms would signal a meaningful shift in safety culture and align Saudi healthcare facilities with global standards for workplace violence prevention

To address the urgent nature of workplace violence incidents, healthcare facilities must implement immediate response mechanisms that facilitate real-time reporting and intervention. This should include: (1) a dedicated

24/7 violence reporting hotline staffed by trained personnel who can document incidents and activate response protocols; (2) mobile-based reporting applications allowing nurses to document incidents in real-time with minimal workflow disruption; (3) designated "safety officers" on each unit with direct communication channels to hospital leadership and security; (4) simplified "urgent report" forms requiring minimal information (under 2 minutes to complete) with provisions for expanded documentation later; and (5) a "no wrong door" policy ensuring that reports initiated through any available channel receive consistent handling and follow-up. These urgent reporting mechanisms directly address the frustrations expressed by our participants regarding administrative burdens during crisis situations and delays in organizational response.

Strengths and limitations

A key strength of this study lies in its comprehensive qualitative perspective. Focus groups allowed for a deep exploration of context-specific barriers to WPV reporting, capturing nuances that might be overlooked in quantitative approaches. The dual-theoretical framework of Ajzen's Theory of Planned Behavior (TPB) and the Social Ecological Model (SEM) provided a robust lens to examine how multi-layered factors influence reporting behaviors, facilitating targeted interventions. Including nurses from multiple departments (emergency, ICU, medical-surgical, and obstetrics) and diverse shifts strengthened the study's transferability by encompassing a wide range of clinical perspectives.

While our qualitative approach provided rich insights into barriers to reporting workplace violence, we acknowledge that supplementing these findings with quantitative data (such as hospital incident reports or prevalence surveys) could have strengthened our conclusions. Future research employing mixed-methods designs would offer a more comprehensive understanding of underreporting patterns, quantifying the scope of the problem while maintaining the contextual depth achieved through qualitative inquiry. Additionally, our study captured perceptions at a single point in time, limiting our ability to assess changes in attitudes or evaluate the effectiveness of interventions over time. A follow-up longitudinal study with the same participant cohort would provide valuable insights into the evolution of reporting behaviors following policy modifications or educational interventions.

Despite these merits, the research was confined to three tertiary hospitals in the Aljouf region, which may limit broader generalizability. Self-selection bias could also be present, as participants with strong views on WPV might have been more inclined to join the focus groups, while others chose not to share potentially sensitive experiences. The cross-sectional design captures reporting behaviors at one point in time, rendering it difficult to measure changes that emerge with evolving organizational policies or cultural shifts. Additionally, focus groups might have constrained open dialogue due to hierarchical concerns, even though precautions were taken to encourage candor and maintain confidentiality. Overall, the dual-theoretical framework and methodologically rigorous design still provide valuable insights, reinforcing calls for more context-sensitive, multi-faceted investigations into WPV and its underreporting [109].

Conclusion

Workplace violence remains a distressing constant in tertiary healthcare settings, as confirmed by the emotional, organizational, and cultural barriers highlighted in this study. By marrying Ajzen's Theory of Planned Behavior with the Social Ecological Model, we reveal that underreporting stems not only from fear, trauma, and perceived futility but also from the deeply rooted cultural hierarchies in Saudi healthcare contexts. Nurses across different shifts and units carry emotional scars, dread management backlash, and question the utility of arcane reporting mechanisms. These results signal an urgent mandate for healthcare institutions to implement far-reaching reforms that go beyond drafting generic 'zero-tolerance' policies. Central to these reforms is a transformation of institutional culture in which nurses are empowered to break their silence without the looming threat of blame or professional stigma. Achieving this requires dismantling hierarchical structures that shield perpetrators and discourage open communication, bolstering accountability, and equipping nurse managers and senior leaders to respond swiftly and decisively to reports. Simplified and transparent reporting pathways, psychosocial support, and management oversight could help nurses regain trust in institutional processes. Ultimately, the study adds to a growing consensus that WPV prevention and reporting strategies must accommodate local cultural nuances, organizational complexities, and the nurses' own emotional realities. We hope to eradicate WPV's harmful legacy from the healthcare domain and promote a safer, more supportive environment for front-line nursing staff only through a multipronged, culturally attuned, and systematically enforced framework.

While this study focused on Saudi Arabian tertiary care settings, our findings have broader applicability to healthcare systems in other Gulf Cooperation Council (GCC) countries, the wider Middle East, and regions with similar cultural and hierarchical structures such as parts of Asia and Africa. The interplay between cultural deference to authority, organizational ineffectiveness, and emotional barriers likely transcends national boundaries in regions with comparable healthcare governance

structures and cultural values. Healthcare institutions throughout these regions may benefit from our findings when developing culturally attuned reporting mechanisms and violence prevention strategies. This wider regional relevance positions our research as a case study with implications extending beyond Saudi Arabia to inform workplace violence interventions in culturally similar healthcare contexts.

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Author contributions
N.B.E. and A.N.A. contributed equally to this work as co-first authors. They conceptualized the study, developed the methodology, conducted the literature search, and drafted the initial manuscript. M.M.A. assisted with data extraction, performed the quality assessment of the included studies, and provided critical reviews of the manuscript. A.A. contributed to data analysis and interpretation of the results, offering valuable insights for the discussion section. E.M.A. and O.M.E.R. supervised the project, contributed to the study design, and reviewed and edited the final manuscript. All authors have read and approved the final version of the manuscript for publication.

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Data availability
The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request, subject to institutional data-sharing policies and ethical considerations regarding participant confidentiality.

Declarations

Ethics approval and consent to participate
This study received ethical approval from the Bioethics Institutional Review Board at Jouf University (Approval No. 6852-2024), adhering to the Declaration of Helsinki's principles. Written informed consent was obtained from all participants following a comprehensive explanation of the study protocol, with assurances of confidentiality and the right to withdraw.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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