

The Effect of Workplace Violence on Work Performance and Quality of Life in the Health Sector: With the Mediating Role of Quality of Life

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Abstract: This research reveals the impact of violent incidents experienced by health workers in the workplace on their quality of life and job performance. It also aims to determine the mediating role of quality of life in the impact of workplace violence on job performance. Existing studies mostly evaluate life quality in the context of physical wellbeing. But workplace violence also causes substantial psychological consequences. Thus, evaluating life quality from a psychological perspective is believed to result a more realistic research outcome. Literature review exhibits no previous study that evaluates psychological dimension of life quality with work performance and workplace violence. In this sense this study plays a pioneering role. The research was carried out with 682 health employees. Over the past two years, more than half of the participants was subjected to any violence in the workplace and the vast majority are verbal violence. Doctors and Emergency room workers are the most exposed to violence. The vast majority of violent incidents are carried out by patients' relatives and patients. Workplace violence has negative effects on quality of life and job performance in general. The increase in life quality of the healthcare workers positively effects work performance. Also, increasing violence perception negatively effects the life quality and work performance of the healthcare employees. When quality of life is included in the impact of workplace violence on job performance, it is determined that the quality of life has a full mediating effect and mitigates the negative effects. As the perception of workplace violence increases, the quality of life and job performance of the employees are negatively affected. The increase in the quality of employees' life is positively reflected in the job performance, the occurrence and effects of workplace violence.

Keywords: Workplace Violence, Quality of Life, Job Performance, Structural Equality Model, Health Sector.

Sağlık Sektöründe İşyeri Şiddetinin İş Performansı ve Yaşam Kalitesi Üzerindeki Etkisi: Yaşam Kalitesinin Aracı Rolüyle

Özet: Bu araştırma sağlık çalışanlarının işyerinde yaşadığı şiddet olaylarının, yaşam kalitesi ve iş performansı üzerindeki etkisini ortaya koymaktadır. Ayrıca işyeri şiddetinin iş performansı üzerine etkisinde, yaşam kalitesinin aracılık rolünü tespit etmeyi amaçlamaktadır. Bugüne dek yapılan araştırmalar, yaşam kalitesini genel olarak fiziksel sağlık boyutuyla değerlendirmiştir. Ancak, yaşanan işyeri şiddeti, ağırlıklı olarak psikolojik etkilere neden olmaktadır. Bu nedenle, yaşam kalitesini psikolojik sağlık açısından değerlendirmek, daha gerçekçi araştırma sonuçlarına ulaşılmasını sağlayacaktır. Çalışanların psikolojik sağlığını içeren yaşam kalitesi boyutunu, iş performansını ve işyeri şiddetini bir arada değerlendiren, literatürde herhangi bir araştırmaya rastlanmamıştır. Bu yönüyle bu araştırma, öncü bir rol oynamaktadır. Araştırma, 682 kişi sağlık çalışanı ile gerçekleştirilmiştir. Son iki yıl içerisinde katılımcıların yarısından fazlası işyerinde herhangi bir şiddet olayına maruz kalmıştır ve büyük çoğunluğu sözel şiddettir. Doktorlar ve Acil serviste çalışanlar, şiddete en fazla maruz kalan kesimdir. Şiddet olaylarının büyük çoğunluğu, hasta yakınları ve hastalar tarafından gerçekleştirilmektedir. İşyerinde yaşanan şiddet, genel olarak yaşam kalitesi ve iş performansı üzerine olumsuz etkiler göstermektedir. Çalışanların yaşam kalitesindeki artış, iş performansına olumlu yansımakta; iş yeri şiddeti algısındaki artış ise, yaşam kalitesinde ve iş performansında düşüşe neden olmaktadır. İşyerinde şiddetin iş performansı üzerindeki etkisine yaşam kalitesi dahil edildiğinde, yaşam kalitesinin tam aracılık etki gösterdiği, olumsuz etkileri hafiflettiği belirlenmiştir. İşyerinde yaşanan şiddet algısı arttıkça, çalışanların yaşam kalitesi ve iş performansı olumsuz etkilenmektedir. Çalışanların yaşam kalitesindeki artış, iş performansına, işyeri şiddetinin yaşanmasına ve etkilerine olumlu yansımaktadır.

Anahtar Kelimeler: İşyeri Şiddeti, Yaşam Kalitesi, İş Performansı, Yapısal Eşitlik Modeli, Sağlık Sektörü.

1. INTRODUCTION

Increasing competition conditions and uncertainties in the economy make conflicts inevitable between service parties. Sometimes these conflicts reach a violent level and emerge on a different dimension every day in the environment or in the media. Insufficient deterrent sanctions or support, economic and social conditions often lead people to violence or compel them to live with violence.

According to the World Health Organization, violence is a psychological and/or physical harm, causing death or the possibility of death as a result of a deliberate threat of physical force or power against oneself, another person, group, or community. The limits of a definitive definition of violence are vague and require four basic elements as undesirable, intentional, unnecessary and harmful behavior. These elements are necessary to distinguish actions such as self-defense or accidents

from violent incident (Hamby, 2017). Violence occurs in many different ways, from a psychological or physical point of view. It comprises types such as psychological violence, verbal violence, sexual violence, threats, coercion, racial harassment and mobbing (EU-OSHA, 2010).

Workplace violence is defined as an employee's use of physical force, attempt to use, or threat that can cause physical injury in the workplace (OSHA, 2016). It is possible to classify violent behaviors as ill-treatment, employee abuse, intimidation, psycho-terror, psychological violence, inappropriate or undesirable behavior (Milczarek, Schneider and González, 2009). All violent actions negatively affect the health, work life and individuals' quality of life.

The World Health Organization defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO, 1996). The quality of life's level in a person, which is a relative concept, is mostly measured by evaluating one's own preferences and values, as well as happiness and life saturation (Watson, Pichler and Wallace, 2010). The mixture of happiness and life saturation depends mainly on the object. While tangible things such as income, education, status are compared, intangible elements such as beauty, attractiveness and honesty are evaluated by how they make feel. This dual evaluation system makes human richer than other creatures (Veenhoven, 2012).

The World Health Organization (1997) evaluates the quality of life in many dimensions such as physical health, psychological health, independence level, social relations, environment, spirituality/religion/personal beliefs. The level or adequacy of these criteria affects the quality of life, social life, work life and performance positively or negatively.

Performance, act, success, quantitative and qualitative description of what the employee can achieve for the task, all the struggles and efforts for the job can be expressed as the completion of the job as desired (Buyukozturk, 2007). An employee's performance is shaped by his/her personal characteristics. External factors such as organizational structure and technological elements are the determinants of the performance level (Dogan and Bayraktar, 2020). Lists the work and the objective features that should be in the work environment as working time, physical environment, work at the request of the employee, economic benefits, employment security, career opportunities, transportation, interpersonal

relations, coordination and decision making, product/service. An employer can achieve the desired job performance to the extent that it provides the appropriate work environment, financial and social opportunities for the organization. Job satisfaction is an important factor that affects performance. Therefore, in order to increase performance and satisfaction, the tasks and responsibilities given to employees must also be in accordance with their competencies (UNESCO, 1978).

As a result of the extensive literature review, there is a study that examines the impact of workplace violence on quality of life and job performance (Lin, Wu, Yuan, Zhang, Jing, Zhang, Luo, Lei and Wang, 2015). However, the quality of life was assessed with a scale aimed at physical health. But in this research, the quality of life was evaluated with the dimension of social and psychological health. In health establishments, the inadequacy of health professionals, working without a specific overtime concept, the people they are in contact with and the different expectations of this group can negatively affect the quality of life and job performance, up to burnout. Violent incidents experienced by employees in the workplace lead to psychological effects more than physical effects when it is wanted to be evaluated by the dimension of job performance and quality of life. Therefore, evaluating the quality of life in terms of psychological health will allow to achieve more realistic results.

2. METHODS

The convenience sampling method which is one of the sampling methods was used in this study. Time and cost make it impossible to reach the entire universe of research. It is a separate challenge to reach participants and provide participation in the high- paced health sector. The research consists of 10 District State Hospitals, Service Departments and Tekirdag Provincial Ambulance Service Chief Physician in Tekirdag. Scientific research permissions were obtained from Tekirdag Provincial Health Directorate Scientific Research Commission and Namik Kemal University Scientific Research and Publication Ethics Committee. In total, 4.500 public healthcare professionals work in these institutions. It was determined that 354 sample volume is sufficient with the formul (Yaslioglu, 2017). used to specify the sample size. The pilot study was carried out with 128 questionnaires, and the main study was carried out with 682 questionnaires.

This research (Table 1) was carried out with three scales. The quality of life scale was taken from a

study adapted to Turkish. The job performance and workplace violence scale was translated into Turkish by a C2-level English-speaking researcher and Turkish language experts. The randomly selected items from the form translated into Turkish were translated back into English and compared

with the original. It was checked by language experts. It was tested whether the scale is understandable and applicable with health management experts and health sector managers. The scale was finalized in line with expert opinions and preliminary application results.

Table 1: Data Collection Tools

Scales	Research Name	Authors
Scale of Workplace Violence in the Health Sector	From patient deference towards negotiated and precarious informality: An Eliasian analysis of English general practitioners' understandings of changing patient relations	Calnan and Gabe, 2001; Brown, Elston and Gabe, 2015
Quality of Life Scale	Validity and reliability study of the Turkish version of the quality of life scale for employees	Yesil et al., 2010; Stamm, 2007.
Job Performance Scale	Evidence that task performance should be distinguished from contextual performance	Motowidlo and Van Scotter, 1994
Demographic Characteristics Form	Age, gender, education level, marital status, working time, occupational groups, department, exposure to violence in the last two years, type and frequency of violence experienced, administrative practices after violence	

The scales were evaluated in the 5 Point Likert format which expresses an opinion as Never, Slightly, Partially, Mostly, Totally or Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree over the score of 1-5 on the total score. In scales Exploratory Factor Analysis, Confirmatory Factor Analysis, Distribution Normality Analysis of Data, Frequency Analysis, Descriptive Analysis, Chi-square Analysis and SEM (Structural Equation Model) statistical analyses methods were used. The

analyses were carried out in SPSS 24 and LISREL 8.7 package programs.

3. FINDINGS

This section contains statistical results of Exploratory Factor Analysis, Confirmatory Factor Analysis, Frequency Analysis, Chi-Square Analysis and Structural Equation Modeling.

Table 2: Distribution of Participants by Demographic Characteristics

Gender	Number	Percentage (%)
Female	418	61.3
Male	264	38.7
Total	682	100
Age	Number	Percentage (%)
20-30 years	185	27.1
31-40 years	197	28.9
41-50 years	165	24.2
51 years or over	135	19.8
Total	682	100
Marital Status	Number	Percentage (%)
Married	448	65.7
Single	203	29.8
Other	31	4.5
Total	682	100
Educational Status	Number	Percentage (%)
Secondary education	32	4.7
High school	87	12.8
College	157	23.0
Bachelor	330	48.4
Master	45	6.6
PhD	31	4.5
Total	682	100
Profession	Number	Percentage (%)

Doctor	85	12.5
Nurse	228	33.4
Midwife	35	5.1
Pharmacist	18	2.6
Other medical staff	178	26.1
Other	138	20.2
Total	682	100
Current Position at Work		
	Number	Percentage (%)
Administrator	23	3.4
Unit Chief	53	7.8
Other	606	88.9
Total	682	100
Work Unit		
	Number	Percentage (%)
Operating room	48	7
Emergency	99	14.5
Intensive Care	40	5.9
Inpatient treatment	117	17.2
Administrative	117	17.2
Other	261	38.3
Total	682	100

Over the past 2 years, 58.5 percent of participants were subjected to any type of violence. It was determined that 74.4% of the violence exposed was verbal, 9% physical, 3.8% sexual and 12.8% mobbing. It was found that 21.7% of the violent exposed were by patients, 62.7% by patient's relatives, 15.6% by personnel or management.

Frequency of participants' exposure to violence was determined as 81.6% of physical violence 1-2 times, 11.2% 3-4 times, 7.1% 5 times or more; 40.1% of verbal violence 1-2 times, 26.9% 3-4 times, 33.1% 5 times or more; 66.7% of sexual violence 1-2 times, 11.1% 3-4 times, 22.2% 5 times or more; 46.8% of mobbing 1-2 times, 28.1% 3-4 times, 25.2% 5 times or more.

The responses of the participants to the procedures carried out in the institution after the violent incident occurred in the workplace are as follows: 55.9% of responses is 'Behavior is discussed informally but not reported', 53.3% 'An official report is prepared in the workplace application case files', 39.7% 'An entry is made in the patient's chart', 80.1% 'The white code application is activated', 69.9% 'Official notification is made to the health authority'.

The result of the Chi-square analysis of the relationship between the occupational groups of healthcare professionals and their exposure to violence in the last two years is significant at 99% confidence level ($\chi^2=37.623$; $Sd=5$; $p=0.001<0.01$). It was determined that 71.8% of doctors, 64% of nurses, 68.6% of midwives, 11.1% of pharmacists, 58.4% of other medical staff and 44.9% of other personnel were subjected to violence within the last 2 years.

3.1. Exploratory Factor Analysis

Exploratory Factor Analysis was carried out with the data of a pilot study with 128 questionnaires. Items with an item-total correlation value of less than 0.25 in the Item-total Correlation Analysis were excluded due to weak item measurement power (Lorcu, F. (2015). Cronbach's Alpha analysis was used to determine the internal consistency of the scale. It was determined that the Cronbach's Alpha value of Workplace Violence scale in Health Sector is ($\alpha=0.912$), Cronbach's Alpha value of the Quality of Life scale ($\alpha=0.900$), Cronbach's Alpha value of the job performance scale ($\alpha=0.900$) and the reliability level of the scales was at a high level (Cronbach. L. (1951).

Table 3: Results of Reliability and Item-total Correlation Analysis

Scales	Item Inferences with Item Correlation Analysis	Reliability Level
Workplace Violence in the Health Sector	Three items with an item-total correlation value of less than 0.25 were removed from the 16-question scale. It is seen that the item and total scale correlation values are between 0.545-0.781 and the correlation was significant	0.912

	for each item ($p < .1$). In this context, relations at the level of $r > .30$ indicate the suitability of the data set for factor analysis.	
Quality of Life	15 items with an item-total correlation value of less than 0.25 were removed from the 30-question scale. It is seen that the item and total scale correlation values are between 434-776 and the correlation was significant for each item ($p < .01$). In this context, relations at the level of $r > .30$ indicate the suitability of the data set for factor analysis.	0.900
Job Performance	Since there was no item with an item-total correlation of less than 0.25 from the 16-question scale, no items were removed. It is seen that the item and total scale correlation values are between 520-,750 and the correlation was significant for each item ($p < .01$).	0.900

As a result of finding a certain correlation between the variables in the scales; Bartlett's Test of Sphericity, KMO value and relations between variables were taken as basis in order to decide the suitability of the data for factor analysis (Tabachnick

and Fidel, 2014). The fact that the KMO value is greater than 60 indicates that factor analysis can be performed on the data and it is obtained from a multivariate normal distribution (Buyukozturk, 2009).

Table 4: KMO and Bartlett Test Results of the Scales

	Statistics	Value	
Workplace Violence Scale in the Health Sector	Kmo Sampling Adequacy	0.879	
	Bartlett Test of Sphericity	Chi-square Value (χ^2)	1006.86
		Degrees of Freedom (df)	78
		Significance Value (p)	0
Quality of Life Scale	Kmo Sampling Adequacy	0.869	
	Bartlett Test of Sphericity	Chi-square Value (χ^2)	794.515
		Degrees of Freedom (df)	105
		Significance Value (p)	0
Job Performance Scale	Kmo Sampling Adequacy	0.866	
	Bartlett Test of Sphericity	Chi-square Value (χ^2)	1165.753
		Degrees of Freedom (df)	120
		Significance Value (p)	0

The Principal Component Analysis was used to determine the factor structure of the scales and the Varimax rotation method was preferred. The factor loading values of 45 or higher were taken as a

criterion in deciding whether the items in the scale must remain or not. In addition, the ability of items to carry a loading value under a single factor was also taken into account.

Table 5: Eigenvalues of the Subdimensions of the Scales and the Variance Levels They Explained

Principal components	Initial Eigenvalues			Sums of squared loading after rotation		
	Total	Variance %	Cumulative %	Total	Variance %	Cumulative %

Workplace violence	Factor 1	6,395	49.189	49.189	3,495	26.883	26.883
	Factor 2	1,527	11.747	60.936	2,928	22.523	49.406
	Factor 3	1,291	9.928	70.863	2,789	21.457	70.863
Quality of life	Factor 1	6,343	42.284	42.284	3,041	20.276	20.276
	Factor 2	1,448	9.651	51.935	3,028	20.187	40.463
	Factor 3	1,266	8.438	60.374	2,987	19.911	60.374
Job performance	Factor 1	6,522	40.761	40.761	3,944	24.648	24.648
	Factor 2	2,302	14.389	55.15	3,369	21.054	45.702
	Factor 3	1,381	8.634	63.784	2,893	18.082	63.784

The scales exhibit a three-factor structure with an eigenvalue greater than 1.00. It is accepted that the variance explained in social sciences is between 40% and 60% (Buyukozturk, 2009). The total variance of the factors belonging to the scales after the rotation process is within these limits. It was concluded that it would be sufficient to examine the scree plot of the scale in a three-factor structure.

The factors belonging to the scales determined as a result of Exploratory Factor Analysis were named in accordance with the purpose expressed by the items belonging to the factors. In the scale of Workplace Violence in the Health Sector, items under factor 1 were called Violence and Work Life, factor 2 was called Causes of Violence, and items under factor 3 were named Aggressive

Characteristics. In the Quality of Life scale, the items under factor 1 were called Empathy Fatigue, factor 2 was called Burnout, and factor 3 was called Emotional Exhaustion. It was decided that it would be appropriate to name the items under factor 1 as Task Performance, factor 2 as Work Dedication, and factor 3 as Interpersonal Facilitation in the job performance scale.

In order to determine from which distribution the data whose factor structure is tested come from; the arithmetic mean, median, skewness and kurtosis coefficients were examined, and it was taken into account that the arithmetic mean and the median were equal or close, and the skewness and kurtosis coefficients were found within the limits of ± 2 (Tabachnick and Fidel, 2014).

Table 6: Distribution Normality Analysis of Data in Scales

Scales and Factors	Statistics	Sd	P	\bar{x}	Median	Skewness	Kurtosis
Violence and Work Life	0.078	682	0	2.91	3	-0.055	-0.853
Causes of Violence	0.091	682	0	2.38	2.25	0.37	-0.218
Assailant Features	0.116	682	0	3.11	3.25	-0.303	-0.565
Workplace Violence in the Health Sector	0.066	682	0	2.81	2.84	-0.238	0.162
Empathy Fatigue	0.14	682	0	2.15	2	0.772	-0.064
Burnout	0.088	682	0	2.34	2.28	0.633	0.318
Emotional Exhaustion	0.108	682	0	2.27	2.2	0.7	0.096
Quality of life	0.078	682	0	2.28	2.16	0.768	0.614
Task performance	0.106	682	0	4.28	4.4	-0.9	1.345
Work Dedication	0.071	682	0	3.66	3.66	-0.315	0.309
Interpersonal Facilitation	0.103	682	0	4.15	4.2	-0.742	0.691
Job Performance	0.051	682	0	4.01	4	-0.442	0.254

As a result of the distribution normality analysis of the data, it was determined that the distribution comes from normality.

3.2. Confirmatory Factor Analysis

According to the results of the Confirmatory Factor Analysis obtained with a different data after the Exploratory Factor Analysis with the pilot study; The factor loading values of the items on the Workplace

Violence scale in the Health Sector vary between 0.56 and 0.88 (Table 7). These values can be considered as an acceptable factor loading. The t values, which express the statistical significance level of the relationships between the items and the latent variables, were found to be significant at the $p < 0.01$ level and all values were seen to be greater than 2.58. If these values are above 1.96, this indicates a significance level of ,05 and above 2.58 indicates a significance level of ,01 (Field, A. (2009).

Table 7: Item Statistics on the CFA Findings of the Workplace Violence Scale in the Health Sector

Item No	Factor loading value	R ²	Error	T
1	0.80	0.64	0.36	25.54**
2	0.82	0.67	0.33	25.39**
3	0.88	0.77	0.22	28.46**
4	0.81	0.66	0.35	24.79**
5	0.63	0.40	0.61	17.56**
6	0.56	0.31	0.69	13.87**
7	0.73	0.53	0.46	20.89**
8	0.82	0.67	0.32	24.41**
9	0.74	0.55	0.45	21.35**
10	0.73	0.53	0.47	20.38**
11	0.87	0.76	0.24	25.47**
12	0.59	0.35	0.65	15.43**
13	0.71	0.50	0.49	19.70**

** $p < 0.01$

In the Path diagram, a modification was made between the items 12 and 13 to get the fit indices of the model at a better level. Fit indices as a result of the CFA (Schermelleh-Engel and Moosbrugger, 2003), it was determined that the χ^2/df value was in the acceptable fit range with 4.715, the RMSEA value was in the acceptable fit range with 0.074, and the other fit indices (CFI, GFI, AGFI, NNFI, RMR, SRMR) were within the acceptable and perfect fit

indices. These results show that the explained factor structure is confirmed.

The factor loading values of the items on the Quality of Life scale vary between 0.51 to 0.85. These values can be considered as acceptable factor loading. The t values were found to be significant at the $p < 0.01$ level and all values were seen to be greater than 2.58 (Table 8).

Tablo 8: Item statistics on the CFA findings of the Quality of Life scale

Item No	Factor loading value	R ²	Error	T
1	0.70	0.49	0.51	18.78**
2	0.85	0.72	0.28	25.15**
3	0.84	0.71	0.30	24.79**
4	0.51	0.26	0.74	13.46**
5	0.62	0.38	0.61	17.09**
6	0.73	0.53	0.47	20.92**
7	0.73	0.53	0.46	21.06**
8	0.65	0.42	0.58	17.90**
9	0.67	0.45	0.55	18.72**
10	0.60	0.36	0.64	16.31**
11	0.75	0.56	0.44	21.85**
12	0.83	0.69	0.32	25.20**
13	0.78	0.61	0.39	23.27**
14	0.61	0.37	0.62	16.76**

15	0.64	0.41	0.59	17.74**
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**p<0.01

In the Path diagram, modifications were made between the items 1-2, 5-6, and 14-15 to get the fit indices of the model at a better level. Fit indices as a result of the CFA, it was determined that the X2/df value was in the acceptable fit range with 3.844, the RMSEA value was in the acceptable fit range with 0.075, and the other fit indices (CFI, GFI, AGFI, NNFI, RMR, SRMR) were within the acceptable and

perfect fit indices. These results show that the explained factor structure is confirmed.

The factor loading values of the items on the job performance scale vary between 0,50-0,77 (Table 9). These values can be considered as acceptable factor loading. The t values were found to be significant at the p<0.01 level and all values were seen to be greater than 2.58.

Table 9: Item statistics on the CFA findings of the Job Performance scale

Item No	Factor loading value	R ²	Error	T
1	0.68	0.46	0.54	18.53**
2	0.73	0.53	0.47	20.29**
3	0.77	0.59	0.41	22.13**
4	0.74	0.55	0.46	20.98**
6	0.5	0.25	0.75	12.93**
5	0.59	0.35	0.66	15.62**
7	0.57	0.32	0.68	14.86**
8	0.63	0.40	0.60	17.17**
9	0.64	0.41	0.59	17.49**
10	0.63	0.40	0.60	17.01**
16	0.72	0.52	0.48	20.35**
11	0.66	0.44	0.56	18.30**
12	0.69	0.48	0.53	19.47**
13	0.77	0.59	0.41	22.70**
14	0.62	0.38	0.62	16.99**
15	0.71	0.50	0.50	20.08**

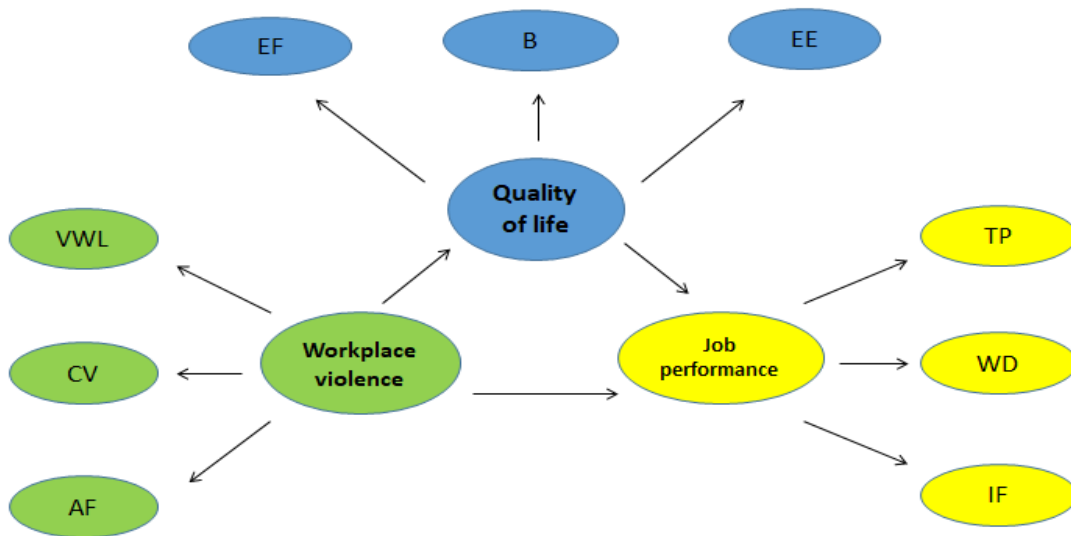
**p<0.01

In the Path diagram, modifications were made between the items 1-2, 5-7 and 7-8 to get the fit indices of the model at a better level. Fit indices as a result of the CFA, it was determined that the X2/df value was in the acceptable fit range with 3.649, the RMSEA value was in the acceptable fit range with 0.079, and the other fit indices (CFI, GFI, AGFI, NNFI, RMR, SRMR) were within the acceptable and perfect fit indices. These results show that the explained factor structure is confirmed.

3.3. Research Model and Structural Equation Model Analysis

The research model was created as a model that reveals the impact of workplace violence in the Health Sector on the job performance and quality of life. The mediating role of quality of life in the impact of workplace violence on job performance was also evaluated.

Figure 1: Research Model

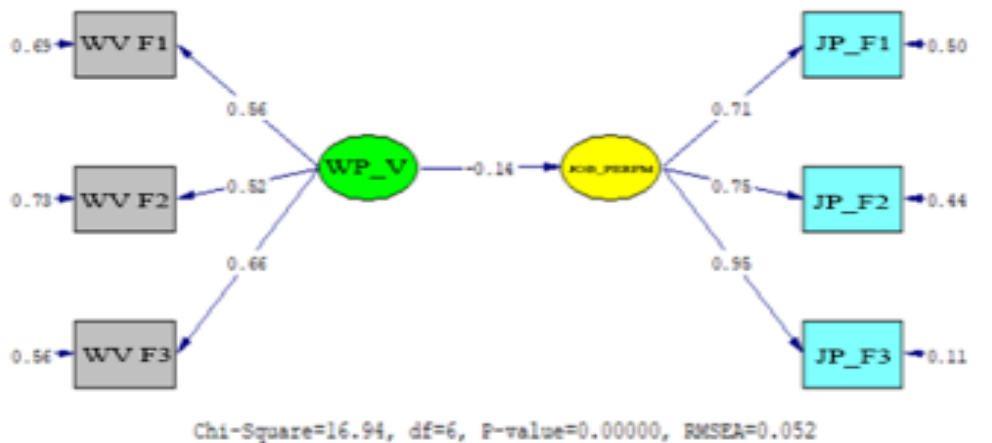


Workplace violence scale in the health sector: Violence and work life, Causes of violence and Assailant features
Job performance scale; Task performance, Work dedication, and Interpersonal facilitation
Quality of life scale; Empathy fatigue, Burnout, Emotional exhaustion

The model consists of the Workplace Violence in the Health Sector, Job Performance and Quality of Life variables. The Workplace Violence in the Health Sector scale consists of 3 factors: Violence and Work Life, Causes of Violence and Assailant features; Job Performance scale consists of 3 factors: Task

Performance, Work Dedication and Interpersonal Facilitation; The Quality of Life scale consists of 3 factors: Empathy Fatigue, Burnout, and Emotional Exhaustion. The findings of the model established for the research are given below.

Figure 2: Path Diagram of the impact of the Workplace Violence on Job Performance

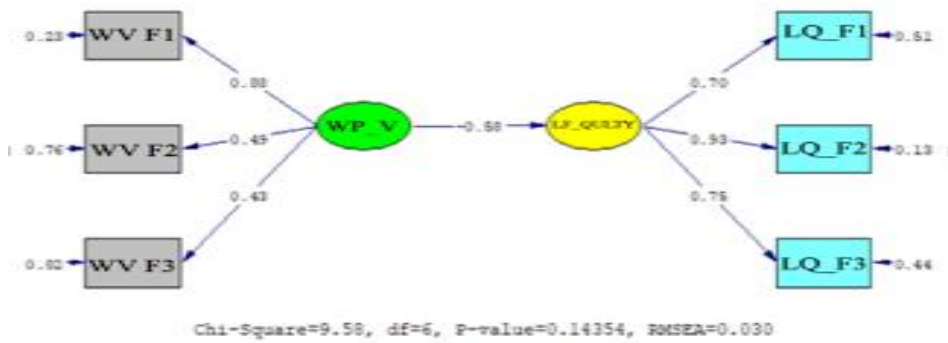


WP_V= Workplace Violence, JOB_PERFM= Job Performance

The impact of workplace violence on the job performance was found to be statistically significant. This indicates that a one-unit increase in participants' workplace violence will cause a 0.14-unit decrease in job performance. It was determined that the most important fit indices

value, χ^2/df , was in the perfect fit range with 2.823, the RMSEA value was in the acceptable fit range with 0.52 and the other fit indices values were within the perfect fit criteria. Therefore, it was considered as a valid model.

Figure 3: Path Diagram of the impact of the Workplace Violence on the Quality of Life

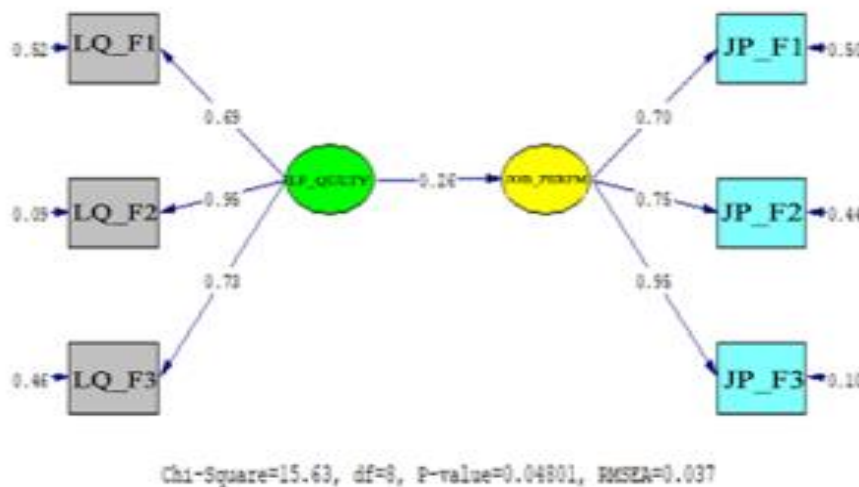


WP_V= Workplace Violence, LF_QULTY= Life Quality

The impact of workplace violence on the quality of life was found to be statistically significant. This indicates that a one-unit increase in participants' workplace violence will cause a 0.58-unit decrease in quality of life.

As a result of the established model, it was determined that the most important fit indices value, X^2/df , was in the perfect fit range with 1.596, the RMSEA value was in the perfect fit range with 0.030 and the others fit indices values (CFI, GFI, AGFI, NNFI, RMR, SRMR) were within the perfect fit criteria.

Figure 4: Path Diagram of the impact of the Quality of Life on the Job Performance

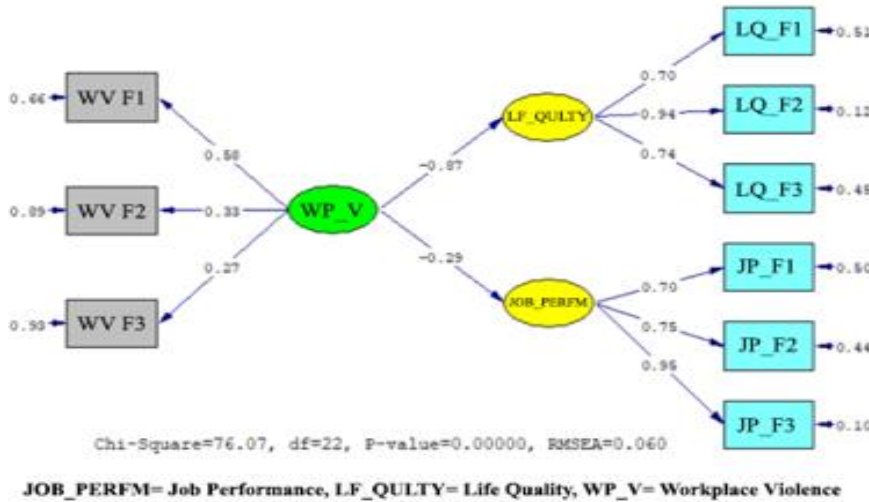


JOB_PERFM= Job Performance, LF_QULTY= Life Quality

The impact of the quality of life on the job performance was found to be statistically significant. This indicates that a one-unit increase in participants' quality of life will cause a 0.58-unit decrease in job performance.

As a result of the established model, it was determined that the most fit indices value, X^2/df , was in the perfect fit range with 1.953, the RMSEA value was in the perfect fit range with 0.037 and the others fit indices values (CFI, GFI, AGFI, NNFI, RMR, SRMR) were within the perfect fit criteria.

Figure 5: Path Diagram of the impact of the Workplace Violence on the Quality of Life and the Job Performance



The effect of the workplace violence on the job performance and quality of life were found to be statistically significant. These results mean that when participants' perceptions of workplace violence increase, it will cause a decrease in their quality of life and job performance. This indicates that a one-unit increase in participants' quality of life will cause a 0.58-unit decrease in job performance. In this model, in which workplace violence was considered as an independent variable, it was determined that its effect on quality of life was -0.87, and on job performance was -0.29, and these two ways were statistically significant ($t > 2.58$).

As a result of the established model, it was determined that the most important fit indices value, χ^2/df , was in the acceptable fit range with 3.457, the RMSEA value was in the acceptable fit range with 0.060 and the others fit indices values were (CFI, GFI, AGFI, NNFI, RMR, SRMR) within the perfect fit criteria.

3.3.1. Findings of the Mediating Effect of the Quality of Life in the Impact of Workplace Violence in the Health Sector on the Job Performance

The mediating role of quality of life was tested in three steps. In the first step, the a and b regression coefficients shown in the second model must be significant. In the second step, it is examined whether the b regression coefficient in the third model is significant. In the third model, the direct relationship of the independent variable in the model with the outcome variable should be less important than the relationship determined in the first model (Baron and Kenny, 1986).

3.3.2. Testing the Model for the Relationship Between Workplace Violence in the Health Sector and Job Performance

When the first model formed by the workplace violence and the job performance variables was tested, it was seen that the relationships established between workplace violence and job performance ($t = -2.75$, $p < 0.01$) were statistically significant. Chi-square at the level of $\chi^2 = 16.94$; $sd = 6$; $p = 0.0000 < 0.01$ were found to be significant in relation to the model. When the ratio of the chi-square value to the degrees of freedom is examined ($\chi^2/sd = 2.823$), a value below 3 indicates a perfect fit. It is seen that the goodness of fit indices of the structural model are RMSEA = .052, RMR = .014, SRMR = .023, GFI = .98, AGFI = .97, CFI = .99, NNFI = .99 and NNFI = .99. It shows that the constructed structural model has acceptable fit.

3.3.3. Testing The Model Created By the Workplace Violence In The Health Sector, Job Performance and Quality of Life

When the second model, formed by the workplace violence, quality of life and job performance variables, was tested; it was seen that the relationships established between workplace violence and quality of life ($t = -9.66$, $p < 0.01$) and quality of life and job performance ($t = 5.92$, $p < 0.05$) were statistically significant. Chi-square at the level of $\chi^2 = 77.24$; $sd = 23$; $p = .000$ were found to be significant in relation to the model. When the ratio of the chi-square value to the degrees of freedom is examined ($\chi^2/sd = 3.358$), a value below 5 indicates a perfect fit. It is seen that the goodness of fit indices of the structural model are RMSEA = .059, RMR = .023, SRMR = .036, GFI = .98, AGFI = .95 CFI

= .98 NFI= .96 and NNFI= .97. It shows that the constructed structural model has a perfect fit.

3.3.4. Examining the Mediating Role of Quality of Life in the Impact of Workplace Violence in the Health Sector on the Job Performance

In the third model, when the mediating role of quality of life on the workplace violence in the health sector and job performance is tested; it was seen that although the relationship between workplace violence and quality of life ($t = -9.50$, $p < .01$), and quality of life and job performance ($t = 4.02$, $p < .01$) was found to be significant, the relationships between workplace violence and job performance ($t = -1.23$, $p > 0.05$) were not found to be statistically significant. Chi-square at the level of $X^2 = 76.07$, $sd = 22$, $p = .000$ were found to be significant in relation to the model. When the ratio of the chi-square value to the degrees of freedom is examined ($\chi^2/sd = 3.457$), a value below 5 indicates an acceptable fit. It is seen that the goodness of fit indices of the structural model are RMSEA = .060, RMR = .023, SRMR = .036, GFI = .98, AGFI = .95 CFI = .98 NFI= .97 and NNFI= .97. It shows that the constructed structural model has acceptable fit.

It is seen that the coefficients calculated between workplace violence and quality of life ($\beta = -0.58$) and quality of life and job performance ($\beta = 0.26$) for Model II are significant in determining whether the quality of life variable is a mediating variable. When the coefficients for the Model III are examined, it is seen that quality of life and job performance ($\beta = 0.22$) are still significant. In the third step, when the changing amount of the relationship between the determined independent variable and the outcome variable of Model I is examined, while the observed coefficient of the impact of workplace violence on job performance was $\beta = 0.14$ in Model I, the same coefficient decreased to 0.07 in Model III and lost its significant effect. Normally, the impact of the workplace violence on the job performance was -0.14, but when the quality of life is included in the model, it was determined that the impact of the workplace violence on the job performance disappeared. In other words, the quality of life is a great power since the job performance is not affected by violence experienced.

4. RESULTS

According to this research, which aims to determine the impact of the workplace violence on the job performance and quality of life, and the mediating role of the quality of life in the impact of the workplace violence on the job performance; More

than half of the health workers participating in the study were exposed to a violent incident in the last two years. Studies support that healthcare professionals are more exposed to violence (Mantzouranis, Fafliora, Bampalis and Christopoulou, 2015; Elston and Gabe, 2015; Lin and etc, 2015; Cheung, Lee, and Yip, 2017; Hamzaoglu and Turk, 2019; Tabachnick and Fidel, 2014). Doctors are the most exposed to violence (Mantzouranis, etc, 2015). Those who take an active role in the diagnosis and treatment process are more exposed to violence in general. The vast majority of violent incidents are verbal violence (Devebakan, 2018; Liu and etc, 2018; Lin and etc, 2015; Tabachnick and Fidel, 2014). The vast majority of violent incidents are carried out by patient's relatives and patients (Elston and Gabe, 2015; Cheung, Lee and Yip, 2017). These results show that the patient/patient's relatives cannot manage this disease process well that they accompany or experience. One-to-one communication with patients and their relatives, or increased hospital services without walls, makes healthcare professionals more vulnerable than employees in many sectors.

The participants stated that the application made after the violent incidents is activated as a maximum of White code application and official notification is given to the Health authority. A substantial part of the participants reported that the behavior was discussed informally, but not reported. Administrative attitude and support towards violent incidents affect the employees' reporting of violent incidents. Therefore, the supportive role of corporate policies against undesirable behavior and violence is very important and must encourage reporting of violence.

Among the causes of violence respectively; long waiting times for treatment, disappointment with the service received, and failure to inform the patient. Studies support that violent incidents occur for similar or identical reasons (Devebakan, 2018; Cai, Tang, Deng, Lv, Xu, Sylvia and Pan, 2019). The long waiting times and the lack of information in the feelings of uncertainty are the most important factors that force the patience of the patients and their relatives. Especially the services provided with insufficient doctors and medical staff negatively affect both the quality of work and waiting times. The inability to devote enough time to patients leads to a lack of information. Health is the most important thing. Therefore, the reactions to the negative attitudes experienced are much more severe.

The healthcare professionals' quality of life is generally below average. The increase in the workplace violence among healthcare professionals causes a significant decrease in the staff's quality of life and the increase in the quality of life leads to an increase in the job performance. In other words, when the quality of life increases, the job performance of employees also increases. When the employees' perception of workplace violence increases; It causes a much more serious decrease in the quality of life and a lesser decrease in job performance compared to the quality of life. As a result, workplace violent incidents negatively affect both the quality of life and job performance of employees.

The healthcare professionals' high quality of life, that is, the mediating role of quality of life, reduces the negative impact of the workplace violence on the job performance. The employees' quality of life is a great power in terms of the fact that violent incidents do not affect job performance and it seriously mitigates effects of violence. The mediating role of quality of life in the impact of workplace violence on the job performance is the full mediation effect.

In research in China (Lin and etc, 2015) when quality of life was included in the impact of the workplace violence on the job performance, quality of life showed a semi-mediating effect. In this research, it is determined that the healthcare professionals' high quality of life has a significant effect on the negative impacts of the workplace violence on the job performance and mitigated the negative effects of the workplace violence on the job performance.

As a result, workplace violence has a significant impact on the quality of life, job performance and productivity of employees. Working conditions and employees' quality of life can increase the possibility of workplace violence. There is no single solution for these problems. Identifying the diversity of factors that contributing to workplace violence is a key importance to the design of effective anti-violence control programs. Implementation of the improvements that need to be made at the macro level to increase the quality of life and welfare of employees is necessary in order to increase performance, alleviate the effects of violence or prevent undesirable behaviors. In particular, the excessive workload of healthcare professionals negatively affects every aspect of life. The importance of human resources planning is revealed here. Excessive demands cause psychological problems that lead to burnout in employees after a while. A healthy and productive workforce is a key element in this service sector,

which is open to important and irreparable mistakes such as human health. In order to achieve corporate goals, managers should create a working environment in good and safe conditions within the organization.

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