Violence in the Workplace: Preparedness, Prevention, Response, and Recovery Strategies for Acute and Critical Care Nurses

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Background Workplace violence has been increasing in hospitals and has been associated with employee turnover and decreased productivity and quality of care.
Objective To identify interventions acute and critical care nurses can employ to address workplace violence among patients and visitors.
Methods The methods of Whittemore, Knafl, and Torraco informed this integrative review. Ovid MEDLINE, CINAHL, Scopus, Cochrane Central Register of Controlled Trials, and Cochrane Database of Systematic Reviews were searched for publications related to hospital workplace violence.
Results Of 951 articles retrieved, 47 were included. Only 2 articles (4%) were specific to critical care, 5 (11%) were generic to hospital settings, and 40 (85%) focused on emergency departments. The highest level of evidence was in 1 randomized controlled trial; 46 articles (98%) had level 6 or 7 evidence. The evidence revealed 3 themes: preparedness/prevention, response to violence, and recovery. Preparedness/prevention was the most prevalent theme. Assessment and screening, communication, education, leadership, and infrastructure were subthemes.
Discussion Nurses can engage in efforts to promote a safe and healthy work environment. With increasing prevalence of workplace violence in health care, acute and critical care nurses must be prepared to prevent and manage violence. Focused education, including simulations and drills, are essential.
Conclusion Bedside nurses and leadership teams should collaborate to reduce workplace violence in their environments. Further research focusing on workplace violence in acute and critical care areas is needed to define the most effective interventions. (*Critical Care Nurse*. 2025;45[5]:28-45)

CE 1.0 hour, CERP C

This article has been designated for CE contact hour(s). The evaluation tests your knowledge of the following objectives:
1. Identify risk factors for violence.
2. Recognize prevention strategies to avoid escalating behaviors.
3. Articulate nursing interventions to mitigate violence.

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Workplace violence is defined as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."[1] Workplace violence has been escalating in hospitals worldwide[2] and is 4 times more likely to occur in hospitals than in any other workplace setting.[3] Four types of workplace violence related to health care settings have been identified: criminal intent, patient/client/visitor, personal, and worker-on-worker violence.[4] Patient/client/visitor violence accounts for approximately 50% of fatal workplace injuries.[5] Two hundred seven health care workers in the United States died between 2016 and 2020 due to workplace violence in the health care and social service industries.[6] Emergency departments and psychiatric units are the sites of most violent encounters.[7,8] However, no area, including acute and critical care units, is without risk of violence. Eight of 10 nurses experienced workplace violence in the last year,[8] explaining why 80% of nurses do not feel safe in their workplace.[9] Nurses often excuse workplace violence, assuming it is related to patients' medical conditions. Complex incident reporting structures have led to underreporting of workplace violence.[10] The results of ongoing workplace violence are decreased quality of care, decreased productivity, and higher employee turnover.[5,11] The purpose of this integrative review was to identify interventions that acute and critical care nurses can employ to address patient/client/visitor workplace violence.

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Methods

To assess the evidence-based recommendations in the literature, we used an integrative review.[12,13] The integrative review process allows for consideration of various primary and secondary information sources, allowing for a richer analysis. A search strategy (Table 1) was constructed and run in 5 databases (Ovid MEDLINE, CINAHL, Scopus, Cochrane Central Register of Controlled Trials, and Cochrane Database of Systematic Reviews) in March 2024. Articles were considered for inclusion if they described interventions to prevent, mitigate, or manage health care violence. Although only English-language articles were included, there were no limits on publication date or geography. Evidence syntheses were excluded.

Results were exported to a systematic review management tool (Covidence), which removed duplicates. Two team members independently reviewed each citation in both the initial review and the full-text review, with a third team member resolving conflicts. Data were extracted from full-text articles by 2 team members per article.

The results of ongoing workplace violence are decreased quality of care, decreased productivity, and higher employee turnover.

For consistency, 1 team member appraised the studies. To identify key themes, we used a grounded theory approach, allowing for inductive identification of themes during data extraction.[14] Extracted data were compiled in spreadsheet software (Google Sheets), with open coding conducted to organize and synthesize the common themes in the literature. The Melnyk and Fineout-Overholt levels of evidence tool was used to assess the levels of evidence.[15] Levels of evidence are rated from 1 to 7, with lower numbers representing higher level of evidence and higher numbers representing lower quality of evidence. The quality of articles with lower levels of evidence was appraised using the nonresearch evidence appraisal tool and the quality was rated as good or higher.[16,17]

Results

Of 951 citations retrieved and reviewed, 47 articles met the inclusion criteria (see Figure). Publication years of analyzed articles ranged from 1997 to 2024. Twenty-five of the articles (53%) were written in the United States; 9 (19%), in Australia; 6 (13%), in the United Kingdom; 3 (6%), in Iran; and 1 (2%) each, in Germany, Italy, Korea, and Taiwan. The initial search for articles focusing on

Table 1 Database search terms

Database	Search terms	Citations
Ovid MEDLINE ALL 1946 to April 12, 2024	(exp Workplace Violence/ OR (violence ADJ3 (workplace OR hospital)).ti,ab.) AND (exp Nurses/ OR (nurs*).ti,ab.) AND (exp Emergency Service, Hospital/ OR exp Intensive Care Units/ OR (emergency ADJ3 (department OR room)).ti,ab. OR (intensive care OR ICU).ti,ab.)	33
CINAHL	((MH "Workplace Violence") OR TI (violence N3 (workplace OR hospital)) OR AB (violence N3 (workplace OR hospital))) AND ((MH "Nurses+") OR TI (nurs*) OR AB (nurs*)) AND ((MH "Emergency Room Visits") OR (MH "Intensive Care Units+") OR TI ((emergency N3 (department OR room)) OR "intensive care" OR ICU) OR AB ((emergency N3 (department OR room)) OR "intensive care" OR ICU))	337
Scopus	(violence W/3 (workplace OR hospital)) AND (Nurs*) AND ((emergency W/3 (department OR room)) OR "intensive care" OR "ICU")	370
Cochrane Central Register of Controlled Trials and Cochrane Reviews	ID Search Hits #1 MeSH descriptor: [Workplace Violence] explode all trees, 20 #2 violence NEAR/3 (workplace OR hospital), 109 #3 #1 OR #2, 109 #4 MeSH descriptor: [Nurses] explode all trees, 1748 #5 nurs*, 76655 #6 #4 OR #5, 76655 #7 MeSH descriptor: [Emergency Service, Hospital] explode all trees, 3915 #8 MeSH descriptor: [Intensive Care Units] explode all trees, 6002 #9 "intensive care" OR "ICU", 50371 #10 #7 OR #8 OR #9, 54344 #11 #3 AND #6 AND #10, 10	10[a]

Abbreviations: AB, abstract; ADJ3, adjacent within 3 words; exp, expand; ICU, intensive care unit; MeSH, medical subject heading; MH, major heading; N3, adjacent within 3 words; TI, title; ti,ab, title and abstract.; W/3, adjacent within 3 words.

[a] Seven citations were from Cochrane Central Register of Controlled Trials and 3 were from Cochrane Reviews.

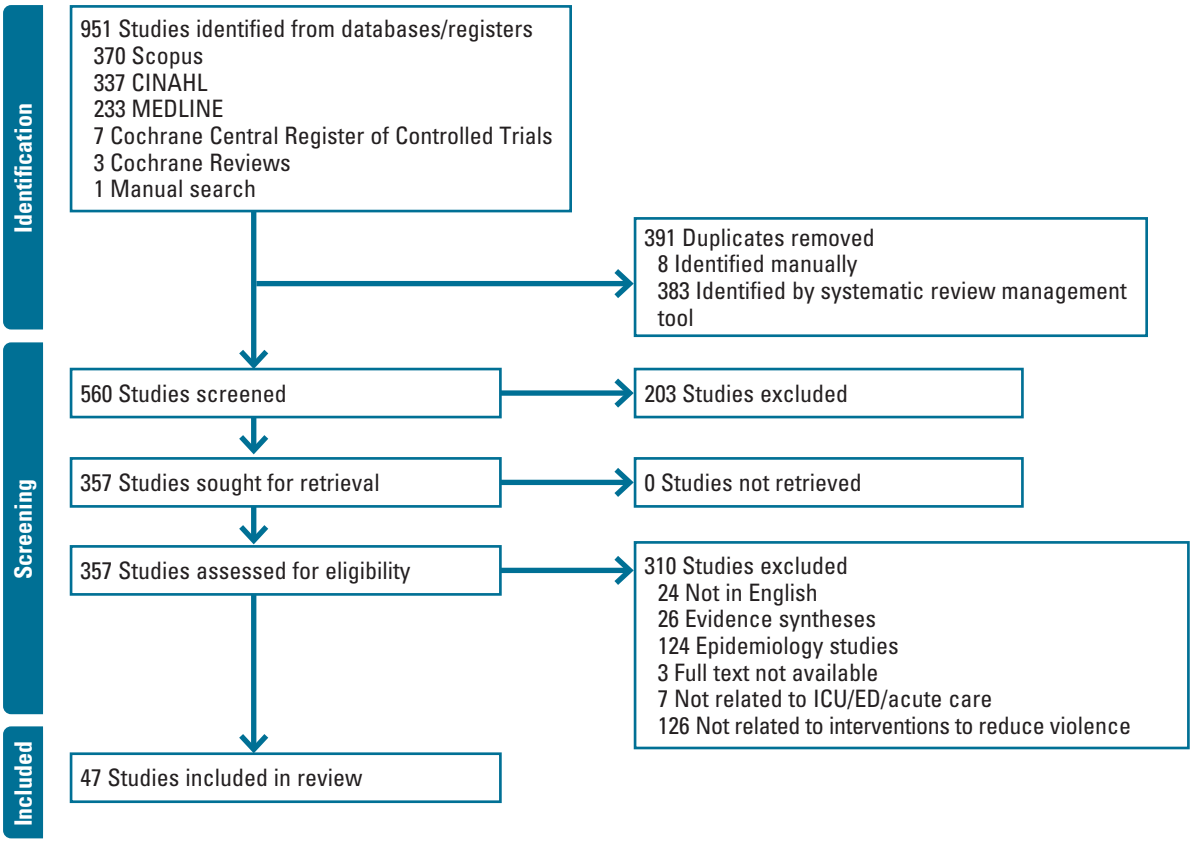

Figure PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) search strategy diagram.

Abbreviations: ED, emergency department; ICU, intensive care unit.

acute or critical care identified a paucity of studies. Therefore, we broadened the search to include emergency department studies that discussed interventions. Of the final 47 studies analyzed, only 2 articles (4%) were specific to critical care,[18,19] 5 (11%) were generic to hospital settings,[3,20-23] and 40 (85%) focused on emergency departments (Table 2). Evidence levels were as follows: 1 article with level 2 evidence (a randomized controlled trial), 27 articles with level 6 evidence (single descriptive or qualitative studies and evidence-based or quality improvement articles), and 19 articles with level 7 evidence (expert opinions, committee reports, and narrative reviews; Table 2). Three overarching themes emerged: preparedness for and prevention of violence, response to violence, and recovery. These themes follow the disaster management framework.[64,65]

Framework

The most severe forms of workplace violence, including rape and assault that leads to death or temporary or permanent harm, have been deemed sentinel events by The Joint Commission.[66] Although each organization defines unacceptable behaviors and the event severity level that should be investigated, workplace violence warrants systematic analysis because events significantly impact the hospital, units, and staff in adverse ways. The recovery of the workplace environment is essential to restoring the function of the affected staff and ensuring safe patient care. The Federal Emergency Management Agency highlights the National Disaster Recovery Framework as an effective tool to support states and local areas, providing a flexible structure, to enable effective disaster response and recovery. The Framework emphasizes restoration and revitalization to the affected community.[64] Therefore, we applied this framework to categorize the evidence. The National Disaster Recovery Framework addresses 5 mission areas: prevention, protection, mitigation, response, and recovery. The goal is to achieve a secure and resilient nation. When applying this framework to workplace violence, the goal is to secure a safe and resilient hospital staff and environment.

Three overarching themes that corresponded to the disaster management framework emerged from the literature review: preparedness for and prevention of workplace violence, response to violence, and recovery after violence.[64] Preparedness for and prevention of violence was the predominant theme; its primary subthemes were assessment and screening, communication, education, leadership, and infrastructure.

Preparedness for and Prevention of Violence

Preparedness and prevention include assessing and screening individuals for potential violence, recognizing behavioral signs of impending violence, and intervening early to prevent violence. Physical design and environmental factors can be modified to minimize escalating behaviors. Enhanced communication is a key strategy to prevent escalation. Nurse education and simulations of ways to respond can minimize the impact of a violent interaction. Leadership practices and policy strategies can also minimize the risk of violence.

Assessment and Screening.

Assessment and screening for workplace violence are important for prevention and response efforts; however, specific tools and screening frequency have not been established in the literature. We identified multiple workplace violence risk assessment tools (Table 3).[31,49,54,55] Nurses must use clinical assessments and risk stratification tools to identify high-risk patients.

Certain medical conditions can predispose patients toward violence and should be screened for on admission. Central nervous system diagnoses such as delirium, dementia, head trauma, intracerebral bleeding, tumors, seizures/epilepsy, postictal states, and infections can also cause violence.[21] Genetic or psychiatric conditions such as acute psychoses, schizophrenia, mania, paranoid states, and personality disorders, as well as developmental and social factors, have precipitated violence.[47] Other less common causes include metabolic disorders, anoxia, hypoglycemia, hyperthyroidism, and Cushing syndrome.[47] The most reliable predictor of workplace violence is a history of workplace violence.[21,27,38,40,51] Frequently reported influencing factors for workplace violence are drug and alcohol intoxication (Table 4).[21,27,,37,40,47]

Impending violence is manifested by increased restlessness, pacing, excitability and raised voices, erratic movements, and tense or angry facial expressions.

Most acts of workplace violence are not random and are preceded by specific behavior patterns.[19,38] Nurses must continually assess patients for signs of escalating behaviors.[48] Impending violence is manifested by increased

Table 2 Literature review findings

Source	Objective (design)
Arnetz et al,[3] 2017	To evaluate the effects of a randomized controlled intervention on the incidence of patient-to-worker violence and related injury in hospitals
Barthel,[18] 2004	To describe a protocol for disruptive behavior at a 600-bed tertiary center
Bruccoli,[24] 2023	To design, implement, and evaluate a behavioral response team in the ED to reduce WPV and increase perception of safety
Cabilan et al,[25] 2022	To explore and collate solutions for occupational violence from ED staff
Carr and Derouin,[26] 2023	To examine the impact of a duress alarm system on WPV and user experience in an ED (QI)
Carver and Beard,[27] 2021	To describe risk factors for violence and aggression against nurses in the ED and discuss various interventions to manage violence and aggression and decrease the risk of those incidents
Chmielewski and Abbey,[28] 2012	To discuss routine nonviolent crisis intervention education and active shooter training
Cork and Ferns,[29] 2008	To review and discuss strategies nurses can use to minimize the risk of assault when caring for patients with alcohol-related aggression
Deans,[30] 2004	To investigate the effectiveness of a 1-day training program on KSA in ED nurses
Dermenchyan,[20] 2018	To answer 2 questions: (1) What can I do to meet my obligation to my patient when I feel my personal safety is at risk? (2) If I feel unsafe with a potentially violent patient, can I refuse to give care?
D'Ettorre et al,[31] 2020	To develop a methodological technique for a preliminary assessment of type II WPV risk in EDs
Gillam,[32] 2014	To evaluate nonviolent crisis intervention training impact on reducing violent events in the ED
Gillespie et al,[33] 2014	To determine level of knowledge attainment and retention of a WPV educational program
Gramling et al,[34] 2018	To determine if introduction of conducted electrical weapons carried by hospital security staff affected the rates of injury among security staff and ED nursing staff
Guliani et al,[35] 2023	To analyze the association of leadership with the prevention of violence using the concepts of health-oriented leadership and the violence prevention climate
Hemati-Esmaeili et al,[36] 2018	To plan a WPV prevention program to reduce the level of patients' and families' violence against nurses
Hodge and Marshall,[37] 2007	To examine current literature to identify the incidence of violence within the ED, precipitators of violence within the ED, and the government policy directive of "zero tolerance"
Horn and Dubin,[38] 2013	To review options to address aggressive or violent behaviors in the ED

Interventions	LOE[a]
Researchers and stakeholders met with unit leaders during a walk-through and reviewed 3 years of WPV data for their unit, including the rate, injury cost rate, type of incident, job category, and corresponding data for the hospital system. Supervisors developed an action plan to reduce WPV using a checklist list of risk factors and administrative, behavioral, and environmental strategies.	2
The protocol has 4 tiers based on the level of behavior of the family member. Each tier has an action plan. Staff were encouraged to use self-reflection regarding their actions; role playing was used to refine skills. Managers focused on creating an effective work environment.	7
BERT team (ED RNs, security, and social workers all trained in behavioral health) called overhead when a patient or family member exhibited increased agitation or anxiety.	6
Ensure adequate communication regarding care expectations and boundaries; ensure comfort such as refreshments, blankets, and pillows. Teach de-escalation techniques, self-defense, risk assessment, staff well-being, and mental health. Avoid overcrowding, have a security presence, remove clutter, control routes and ED entrance, screen for weapons, use body cameras. Use coercive measures, use of chemical restraints, and family involvement for patients. Use response team, staff escort, police involvement, and de-escalation rooms; develop department policy. Provide staff debrief and employee assistance.	6
Duress alarm badge was worn by frontline ED staff. Staff did not routinely wear alarms, and an intervention did not decrease WPV.	6
Screening: DASA tool,[b] STAMP framework[c] Risk factors: lack of progression and/or long waiting times, inhospitable environments or dehumanizing environments, unsafe environments, perceived inefficiency, inconsistent response to "undesirable" behavior Prevention: use of signs that show wait times, staff education on how to respond to patients/families who ask questions, staff education on risk factors and use of simulation Recovery: support documentation and support for nurses involved in OVA	7
Provide mock codes for nurses to respond to escalating patients and families.	7
Prevention and response: Be self-aware; maintain autonomy and dignity of patients; intervene early; approach patients with caution; do not startle patients; avoid provoking patients; be aware of facial expression and posture; use a calm, respectful language with open-ended sentences; avoid challenges and making promises; provide options and choices; remove dangerous objects from your person; be aware of exits; avoid vulnerable positions (do not turn your back on the patient); use distraction and redirection; be firm but compassionate; avoid physical confrontation. Prevention: Provide education and policy development; recognition, prevention and de-escalation of aggressive situations; environmental and clinical risk assessment and management; ongoing staff support.	7
Single 1-day training program can reduce violent events and increase staff confidence in handling violent events.	6
Use de-escalation tactics to defuse threatening situations (such as speaking directly in a reassuring tone); communicate concerns about personal safety to others; identify resources for assistance, including security, nursing leaders, clinicians, social workers, risk managers, ethics committee, legal team, psychologist or psychiatrist; set expectations of the unit; adopt a zero-tolerance policy; document concerns.	7
Use the ED WPV questionnaire to assess risk of WPV and identify actions to target specific critical issues.	6
Nonviolent crisis intervention training (skills to defuse potentially violent situations) reduced the incidence of "code purple" incidents.	6
A WPV prevention educational program (hybrid form) was used online and in a classroom setting.	6
Electrical weapons, ie, tasers, carried by hospital security staff had limited ability to decrease the overall rate of violence-related injury but may have decreased the severity of violence-related injuries.	6
Health-oriented leadership demonstrated that supervisors' self-care and employees' assessment of supervisor's staff-care positively predicted all dimensions of violence prevention climate.	6
Implementation and administration of violence prevention nurse and staff educational interventions reduced WPV.	6
Four main factors were found to influence violence: alcohol, drugs, waiting times, and organic disease conditions. Use organizational structures to manage violence and aggression, policy directives, nursing strategies to minimize violence and aggression, and de-escalation techniques. Use physical restraint, pharmacologic restraint, and seclusion as necessary.	7
To manage aggressive and violent behavior, use de-escalation techniques, nonpharmacologic interpersonal intervention strategies, pharmacologic intervention, physical restraints, and force.	7

Continued

Table 2 *Continued*

Source	Objective (design)
Howard and Robinson,[39] 2023	To summarize current regulations, standards, and resources available
Keely,[21] 2002	To present vital information on how to recognize and prevent violence in critical care departments and EDs
Koller,[40] 2016	To describe the necessity for ED nurses to receive violence prevention training to identify and mitigate violent events before they occur
Kotora et al,[41] 2014	To determine if health care workers could improve their performance and minimize personal risk when confronted with an active shooter inside a hospital ED through formal education and case-based scenario training
Krull et al,[42] 2019	To enhance the current violence prevention program within the facility by adding interprofessional simulation as an intervention that allows staff to practice skills (practice improvement)
Larson et al,[43] 2019	To address the risk of violent patient events (QI)
Lee et al,[7] 2023	To develop a machine learning model to predict WPV based on EHRs in the ED at a tertiary hospital.
Lenaghan et al,[44] 2018	To review best design practices to guide clinicians in meetings with hospital leaders, architects, and engineers
Mallett-Smith et al,[45] 2023	To (1) reduce patient-to-staff assaults, (2) improve compliance with use of the RVST, and (3) evaluate the accuracy of completing the RVST

Interventions	LOE[a]
Education and prevention: Nurses should take the initiative to seek education and training, improve situational awareness and de-escalation techniques, communicate with patients and families about wait times, and volunteer for committees or task forces to help identify solutions with a frontline perspective. Recovery: Provide support to coworkers who are verbally abused or physically assaulted; encourage incident reporting. Prevention: Use emergency signaling, alarms, and monitoring systems; use security devices such as metal detectors; install cameras and good lighting in hallways; provide security escorts to the parking lots at night; use waiting areas to accommodate and assist visitors and patients who may have a delay in service; design triage area and other public areas to minimize the risk of assault; enclose staff areas and nurses' stations; use deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas; arrange to minimize their use as weapons; provide secured staff-only rest areas; have evacuation exits. Leadership: Ensure commitment from management team, including the endorsement and visible involvement of top leadership; clearly defined expectations conveying a culture of respect at all levels; zero-tolerance policies (including posting prominent signs for hospital visitors addressing violence, supporting staff by removing perpetrators of unruly behavior); willingness to support legal action for violations; emergency communication systems, proper staffing, workplace analysis, and violence prevention plans; hazard identification; population risks (persons with a history of violence, abuse of drugs or alcohol, gang members, cognitive and mental health factors); weapons and active shooter policies. Response and recovery: Use event reporting systems and data analysis, analysis and improvement of operational factors that cause patient delays, prevention of unrestricted movement of the public in clinical areas, postincident debriefings, collaboration with local law enforcement, information sharing among HCOs, safety stand-downs, and drills and exercises.	7
Education can improve identification of the risks of WPV, aiding in early interventions to reduce consequences of WPV. Predictive factors for violence include age <40 years, single, urban areas, gang member, substance misusers, homeless, minimal social contact, paranoia. Patient conditions: drug intoxication or withdrawal (amphetamines, barbiturates, cocaine, alcohol, hallucinogens); child, elder, or spousal abuse; organic health disorders (eg, thyrotoxicosis, HIV-related encephalopathy, head or seizure disorders, trauma, senility); experiencing time delays; distortion of hospital events; distraught individuals who perceive staff to be rude or uncaring; grieving families (some cultures condone acts of violence); victims and perpetrators being admitted to the same vicinity; domestic violence; motor vehicle collisions; gang members in proximity with rival groups. Assess and defuse potentially violent situations, manage violent behavior, recognize security hazards. Apply restraints, use of progressive behavior control methods, use of security devices.	7
Prevention: Employ staff communication devices, alter the physical environment, check for weapons, evaluate the need for security cameras. Education: Provide ongoing violence prevention programs, practice violence prevention simulation and drills, educate nurses on signs of imminent violence. Response: Keep the patient in a calm environment, free from equipment that can be used as a weapon; allow the patient to vent frustrations; avoid being trapped inside the room; never work alone with someone who may become violent; once violent patients are identified, implement safety precautions. Recovery: Report violence and track trends for safety precautions.	7
Implement didactic and simulation training for HCPs regarding an active shooter event.	6
Team developed an interprofessional simulation regarding WPV to improve staff knowledge, skills, abilities, confidence, and preparedness in de-escalation techniques and restraint application and to promote effective communication and teamwork.	6
Team developed, tested, and refined a huddle handoff communication tool to notify receiving floor if patient was potentially aggressive. Staff reported feeling safer during the transfer process. Tool included documentation of aggressive statements, yelling, abusive language, resisting health care, verbal threats, physical aggression, suicidal and homicidal ideation, interventions that were implemented, and who attended the huddle.	6
Strongest predictor of WPV is patient dissatisfaction, long stay, volume of patients, and psychiatric disorders. WPV prediction is more accurate when both ED visit and ED stay factors were both used. Mitigating WPV can improve safety and enhance the quality of nursing care. Nurses must recognize and continuously monitor risk factors for WPV from admission to discharge.	6
Screening: Hospitals should include WPV risks as part of their hazard vulnerability analysis, including infrastructure, security response, policy response, staffing, case review, and interventions. Prevention: Areas include parking, entry zone, traffic management, care zones and room clustering, and specialized rooms.	7
Strategies added to existing approaches included weapon screening, sheriff deputy rounds on site, policy of zero tolerance for violence, behavioral response team, and mandatory nonviolent physical crisis intervention training. Assaults decreased from 2.7 to 1.3 assaults per month. The RVST violence prevention bundle, an alert system (the golden hand warning, or signage for patients exhibiting aggressive or violent behavior), and aggression reduction strategies were used.	6

Continued

Table 2 Literature review findings

Source	Objective (design)
Phillips,[22] 2007	To provide nursing staff with evidence-based knowledge and skills to manage patients and/or visitors with the potential for violence (process improvement)
Powley,[46] 2013	To analyze a violent incident involving a patient with mental health and alcohol dependence problems that occurred in an ED
Presley and Robinson,[47] 2002	To develop a model that could be used to manage violence in the ED
Quinn and Koopman,[48] 2023	To pilot use of a violence risk assessment tool, the BVC, to assess for risk of type II violence and record the interventions that nurses chose to implement to mitigate the situation (evidence-based practice)
Robinson,[49] 2024	To support triage nurses and other ED staff in United Kingdom, to assess and manage patients safely in ED waiting rooms, and to avoid confrontation
Sadat Mahalleh et al,[50] 2019	To explore the effect of a WPV management program on the incidence of WPV against nurses at hospital EDs in Iran
Sands,[51] 2007	The ABC of violence risk assessment at triage is a 3-step guide to provide a practical framework for a systematic approach to violence risk assessment
See and Catterson,[53] 2017	Not stated
Seeburger et al,[52] 2023	To understand emergency nurse perceptions of EHR behavioral flags and their potential to reduce WPV from patients to staff (qualitative study
Senz et al,[54] 2021	To evaluate the impact of the new BVC on staff knowledge, perceptions and confidence regarding OVA in the ED and the rate of security events related to OVA (pre-post study)
Sharifi et al,[55] 2020	To evaluate the effects of an education program, risk assessment checklist and preventive protocol on violence against ED nurses

Interventions	LOE[a]
Team provided work plan overviews of the institutional and system teams on WPV; review of the employee rights and responsibilities document; introduction to clinical decision-making algorithms; preview of an 8-hour Crisis Prevention Institute class; discussion of the incident reports for tracking, trending, and QI initiatives; and presentation of the newly created storyboard on "The Violent Patient: A Nurses' Guide to Violent Patient Intervention."	6
The patient exhibited increased restlessness; body tension; pacing about and excitability; raised voice or shouting; erratic movements; and tense, angry facial expression. The patient refused to communicate, had no verbal response, and withdrew. The patient had unclear thought processes, poor concentration, violent delusions or hallucinations and made verbal threats or gestures.	7
Intoxicants: Alcohol, stimulants, recreational drugs, withdrawal states from drugs including delirium tremens. Metabolic disorders (hypoxia, anoxia, hypoglycemia, hyperthyroidism, Cushing syndrome), electrolyte imbalance, hypothermia or hyperthermia, vitamin deficiencies, dementias, seizure disorders, postictal states, temporal lobe epilepsy, central nervous system infections, brain trauma, intracerebral hemorrhage, subdural and subarachnoid hemorrhages, genetic constitutions. Psychiatric causes: acute psychoses, schizophrenia, mania, paranoid states. Personality disorders: borderline or antisocial, stress reactions; developmental and social factors. Predisposing factors to violence: long waiting times, unpleasant waiting environment, insufficient or uncomfortable seating, lack of distraction (eg, toys, television, magazines, telephones, music), lack of access to refreshments, poor patient/family-staff communication. Signs of verbal and physical escalation: posture such as sitting anxiously on the edge of bed, gripping arm rails intensely, angry or loud speech; aggressive statements, pacing.	6
Nurses completed checklists for all patients who had a score of 1 or higher, indicating at least 1 high-risk behavior, and scored hourly until the score was 0 or the patient was dispositioned. Incidents occurred most frequently between 11 AM and 3 AM, with the highest scores in the late evening and early morning hours. More incidents were captured with the BVC than with the hospital reporting system. Situations significantly associated with higher scores included providing comfort measures, addressing concerns, and applying restraints.	6
STAMP framework identifies behaviors that may indicate impending violence. Staring: prolonged glaring or an absence of eye contact. Tone and volume of voice: sarcasm and raising the voice. Anxiety: flushed appearance, rapid speech, expressions of pain, confusion. Mumbling: talking under their breath, criticizing staff, repeating requests, and slurring or incoherent speech. Pacing: walking around a confined space such as a waiting room or bed space, repeatedly returning to the nurses' area.	7
The WPV management program, an education and management program including ventilation, closed-circuit television cameras, modification of lighting, and employing a security guard for the night shift, did not reduce the frequency of violence in the ED.	6
Screening: History of aggression, male sex, youth, antisocial traits, substance misuse, intoxication, impulsivity, irritability, suspiciousness, mental illness. Education: Nurses should engage in aggression management training programs, which can provide further support and guidance for assessing and managing occupational violence.	7
Team implemented tools to improve information to patients, including improved signage about the processes a patient could expect in defined areas, a waiting room video explaining the patient journey, a patient pamphlet, a time to wait electronic information board and an appointment self-help kiosk. Intervention resulted in reduced uncooperative behavior, offensive language and swearing, aggressive tone and exposure to nonphysical aggression and increased retention.	7
Any clinician can place a behavioral flag in the EHR after an incident of verbal, physical, or sexual assault or another safety issue. Behavioral flags serve as a forewarning to approach patient interactions with caution and use safety skills. Nurses were skeptical of the ability of flags to prevent violence and noted concern for consequences of introducing bias into patient care.	6
Behaviors of concern documentation tool: 0, small risk; 1-2, moderate risk; >2, very high risk for violence. With each level, general, nursing, medical, and security interventions are noted. The intervention improved staff perception of organizational support. The intense education raised awareness of behaviors associated with violence through early detection and intervention. There was a reduction in unplanned OVA-related security responses representing a shift to proactive management of escalating behaviors.	6
Use of the BVC risk assessment checklist and preventive protocol reduced verbal abuse. Risk assessment: individuals who are confused, irritable, boisterous, physically threatening, verbally threatening, attacking objects Prevention: Respect for personal space (maintained at least 2 arms' length from the patient, be able to exit patient's room without blocking patient's way); colleagues accompany each other into the patient's room; use verbal communication such as introducing self, reviewing medical presentation and stage of treatment, speaking in short sentences and using simple terminology as agitated patients have limited ability to process information, repeating as necessary; listen to the patient's message using body language to express understanding; use empathetic statements; set limits to unacceptable behaviors early; reduce the number of visitors; allow the patient to tell their side of the story and explore alternatives to manage aggression if the patient is confused; allow the patient to remain silent; identify needs and feelings; suggest realistic alternatives; speak optimistically; create a calming environment.	6

Continued

Table 2 *Continued*

Source	Objective (design)
Spelten et al,[56] 2020	To evaluate targeted interventions to reduce violence by targeting perpetrator groups instead of giving staff more tools (focus group study)
Spencer,[57] 2024	To explore the effects of body-worn cameras in the ED
Stene et al,[58] 2015	To answer these questions: Do staff perceive violence as part of the job within the ED? Are staff aware of what acts constitute WPV?
Tadros and Kiefer,[59] 2017	To explore reasons for high rates of violence in health care, review laws regarding WPV in health care settings, and suggest steps that can be taken to manage agitated patients and mitigate violence toward HCPs
Van Godwin et al,[60] 2023	To understand how VPTs function, how they were implemented, mechanisms of impact, and wider contextual factors influencing their function
Wand and Coulson,[61] 2006	Not stated
Williams and Robertson,[19] 1997	To define WPV and discuss prevalence and first-line tools to intervene on violence and prevent escalation
Wong et al,[62] 2015	To develop an interprofessional curriculum focusing on improving teamwork and staff attitudes toward patient violence using simulation-enhanced education
Wu et al,[63] 2019	To provide a means to prevent ED violence by designing simulation training based on clinical cases of ED violence

Abbreviations: BERT, behavioral emergency response team; BVC, Brøset Violence Checklist; DASA, Dynamic Appraisal of Situational Aggression; ED, emergency department; EHR, electronic health record; ER, emergency room; HCP, health care provider; HCO, health care organization; KSA, knowledge, skills, attitude; LOE, level of evidence; OVA, occupational violence and aggression; QI, quality improvement; RN, registered nurse; RVST, Risk for Violence Screening Tool; STAMP, staring, tone, anxiety, mumbling, pacing; VPT, violence prevention team; WPV, workplace violence.

[a] Level of evidence (Melnyk and Fineout-Overholt,[15] 2023)
[b] Ogloff and Daffern 2006
[c] Luck et al 2007

Table 3 Screening tools used in the articles included in literature review

Tool	Reliability	Sources using tool
Dynamic Appraisal of Situational Aggression[47]	Internal validity: 0.798 Interrater reliability: NS	Carver and Beard,[27] 2021
STAMP framework[51]	Interrater reliability: κ = 0.752 Intrarater reliability: κ= 0.635	Carver and Beard,[27] 2021 Robinson,[49] 2024
Brøset Violence Checklist risk assessment[38]	Sensitivity = 0.63 Specificity = 0.92 AUC = 0.82 (95% CI, 0.75-0.89; *P*<.001)	Quinn and Koopman,[48] 2023 Sharifi et al,[55] 2020
ABC of Violence Risk Assessment[51]	AUC = 0.77 (95% CI, 0.7-0.81; *P*<.01) Moderate risk rating had a 61% sensitivity and 91% specificity; high risk rating had 37% sensitivity and 97% specificity. Interrater reliability ranged from 0.67 to 0.75 (*P*<.01), suggesting moderate agreement.	Sands,[51] 2007
Emergency Department Workplace Violence-Questionaire[31]	Cronbach α = 0.90, indicating high internal consistency.	D'Ettorre et al,[31] 2020

Abbreviations: AUC, area under the curve; NS, not stated; STAMP, staring, tone, anxiety, mumbling, pacing.

Interventions	LOE[a]
The focus group placed perpetrators of WPV into categories of heightened risk for WPV behaviors and demographics, and each category demonstrated common themes of how the nurse could approach the perpetrator. Team provided staff education and an algorithm on types of interventions to be used with these high-risk people.	6
Nurses believed the body cameras provided support when they were confronted by abusive or aggressive patients or relatives and defused other potentially violent situations.	6
Team developed a brief, concise reporting tool and implemented an educational program to address WPV. Reporting increased and the perception that WPV was part of the job decreased. Staff realized that WPV is not acceptable and subsequently increased the feeling of a safer environment.	6
Prehospital violence spills into ED from the streets. Risk factors for violence are wait times, overcrowded waiting rooms, minimal privacy, and expectations of testing not done. Monitor for signs of impending violence, such as agitation, volume of speech, hand gestures. Use de-escalation techniques and de-escalate situations. Use comforting gestures and verbal reassurance. Use medications (benzodiazepines, typical and atypical antipsychotics) and restraints as necessary.	7
Article outlines a proposed multimethod evaluation process of the VPT protocol.	7
De-escalation education and techniques to identify high-risk patients (eg, exhibiting fear and anger, experiencing long wait times) should be employed first; the last resort should be a zero-tolerance stance.	7
Encouraged de-escalation tools, self-protection techniques, protective equipment and alarm systems, and critical incident debriefing and follow-up. Encouraged RNs to develop violence prevention skills and interpersonal communication skills to deter WPV.	7
Team developed interprofessional crisis management alert response and protocol. Education included a lecture on de-escalation techniques, restraint placement, and core tenets of interprofessional collaboration. Structured simulations were used to enhance interprofessional intervention and improved multiple facets of attitudes for behavioral emergencies.	6
Standardized patient simulation: Used standardized patients to simulate violent situations and how to de-escalate them. Course included physicians, nurses, security guards, and social workers.	6

Table 4 Risk factors for violence

Predisposing factors	Patient factors	Signs of impending violence
Patients/family members experiencing time delays	Age <40 years	Increased restlessness
Distortion of hospital events	Single	Pacing and excitability
Negative patient outcomes	From urban areas	Raised voice, shouting, erratic movements
Distraught individuals	Gang member	Sitting anxiously on the edge of the bed, gripping arm rails intensely
Grieving families	Substance use	Tense, angry facial expression
Prehospital violence	Homelessness	Refusal to communicate, no verbal response, withdrawal
Proximity of victims and perpetrators	Minimal social contact, paranoia	Unclear thought processes
Unpleasant waiting environment	Drug intoxication or withdrawal	Poor concentration
Poor communication between patients/family members and staff	Metabolic disorders	Violent delusions or hallucinations
	Hypothermia or hyperthermia	Verbal threats or gestures
	Vitamin deficiencies	Discussion of violent acts or situation
	Child, elder, or spousal abuse	
	Dementia, central nervous system infection, brain trauma, intracerebral hemorrhage, subdural and subarachnoid hemorrhage, thyrotoxicosis, seizures	
	Acute psychoses, schizophrenia, mania, paranoid states, borderline or antisocial personalities	
	Developmental factors	
	Genetic conditions	

restlessness,[37,38,47] pacing,[21,37,40,47] excitability and raised voices,[21,37,38,40,47] erratic movements, and tense or angry facial expressions.[38] Violence may be predicted by a patient withdrawing or refusing to communicate or by a patient exhibiting unclear thought processes, poor concentration, expression of violent delusions, or hallucinations.[46] Verbal threats or gestures must always be taken seriously and reported to supervisors and security personnel.[46]

Several environmental factors contribute to workplace violence and should be continually assessed.[29,49] Unpleasant waiting environments, such as uncomfortable seating and a lack of distractions such as television, magazines, and music, lead to dissatisfied patients and visitors.[47] The presence of security personnel,[20,40] providing entrance control with weapons screening, and avoiding overcrowding and clutter can help prevent violence.[25] The use of body cameras by nursing staff may also be helpful.[25,57] However, compliance with the use of cameras can be low.[26] Ensuring adequate parking, managing traffic, controlling routes and entrances, and using signs or monitors to show wait times can also be useful environmental interventions.[25,27,37,44,59]

Leadership responsibilities include adopting zero-tolerance policies and providing a physical presence, educational programming, and enhanced infrastructure.

Communication. Communication includes communication with patients and family members as well as with other nurses, hospital staff, and leaders. Several sources cited inadequate communication and wait times as predisposing factors for workplace violence (Table 5).[21,37,,47,53,59]

Clear and frequent communication with patients and families about wait times, delays, reasons for delays, and expectations about care can decrease patient frustration and aggressive behaviors.[25,47,53] Staff members should be educated on how to respond to questions, with special attention to tone and the use of empathetic statements.[21,27,38]

Nurses ought to speak honestly, precisely,[38] and directly in reassuring tones.[20,38] Setting consistent boundaries early in the stay can reinforce expectations.[25,37,59] Nurses should be attentive to basic needs and offer comforts such as refreshments appropriate to the patient's condition.[38] Nurses can delegate the provision of blankets, pillows, and a chair or recliner.[25,59] Focus on ensuring the patient and family are in a calm environment,[38,42] and allow patients to vent their frustrations.[19,40]

Nurses should communicate concerns about patient or visitor behavior and their personal safety. Identify and request appropriate resources within the institution to help manage the situation.[20,38,40] Nurses need to keep leaders and staff members apprised of escalating situations during safety huddles and handoffs between shifts. Communication tools in the electronic health record and physical signs on patients' doors can be useful, although nurses expressed concern about bias toward patients when these tools were used.[45,52] Leaders should routinely perform safety rounds to support frontline staff, enhance communication, and engage action plans.[3,18,35] Nurses must file incident reports so leadership teams can track trends in volume and details to improve institutional prevention and response strategies.[21,22,39,58,60]

Education. The mainstay of addressing workplace violence is educational programs encompassing prevention and response.[19,21,22,25,28,30,32,33,36,40-42,50,55,58,59] The Joint Commission recommends annual education related to workplace violence[66] but does not specify methods. Our findings agree with those of the Occupational Safety and Health Administration[67] that didactic education and simulation are effective methods to reduce workplace violence.[22,30,40-42,62,63] Education sessions should include a review of policies, situational awareness, patient screening, assessment for risk factors, how to communicate and interact, de-escalation techniques, restraint use, pharmacologic management, self-defense, well-being, and incident reporting.[19,21,22,25,27,29,30,32,33,36,37,39-42,50,55,58,59] All staff members should regularly complete education combined with patient risk assessment surveys.[55] Violence prevention protocols or bundles of interventions have been used to reduce violence, but specific interventions bundled together were hospital specific and varied among the articles reviewed (Table 5).[18,55,60]

Leadership. Leaders are responsible for providing a safe work environment, which begins with a hazards vulnerability assessment[45] and assessment of current policies and infrastructure.[3,22,35,39,45] Leaders can prevent and mitigate workplace violence and thereby decrease staff turnover.[28] Specific leadership activities and responsibilities include reviewing, assessing, and enforcing policies,[28,37,44] adopting zero-tolerance policies,[20,37,39,45,61] providing a physical presence,[3,22,24,26,35,39,45] facilitating quality improvement projects,[3,20,22,32,37,39,42-45,47] providing educational

Table 5 Synthesis of evidence by theme

Preparedness for and prevention of violence

Communication	Nursing education	Environment	Leadership
Signs indicating the processes a patient can expect Video for waiting room explaining the patient journey Patient education pamphlets Electronic information boards **Verbal communication** Review medical status and treatments. Speak in short sentences and use simple terminology. Repeat information as necessary. Listen to the patient's message. Use body language to express understanding. Allow the patient to remain silent. Suggest realistic alternatives. Create a calming environment. Allow patients to vent their frustrations. Respect personal space. Ensure adequate communication regarding care expectations. Set boundaries. Ensure comfort. Communicate wait times, delays in care. Be aware of facial expression and posture. Use calm, respectful language. Speak directly in a reassuring tone. **Team communication** Use huddles to notify receiving floor of patient behaviors. Use behavioral flags in the EHR. Communicate concerns about personal safety to peers and leaders. Identify resources for assistance (eg, security personnel; leaders; clinicians; social workers; and risk management, legal, and psychiatry personnel) Document concerns.	Policies Risk factors Signs of imminent violence Screening tools Situational awareness How to respond to patients/families Nonviolent crisis intervention training De-escalation techniques How to assess and defuse potentially violent situations How to manage violent behaviors Recognition of security hazards Self-defense Simulations on how to manage escalating behaviors Interprofessional simulations to promote teamwork Promotion of staff well-being and mental health	Avoid overcrowding. Install cameras in hallways. Implement badge access. Have a security presence. Control entrance. Use panic alarms. Use metal detectors for weapons screening. Use body cameras. Provide security escorts to the parking lots at night. Enclosed staff areas and nurses' stations. Provide deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas. Arrange environment to minimize use as weapons. Provide secure staff-only rest areas. Designate evacuation exits. Avoid being trapped inside the room. Never work alone with someone who may become violent.	Ensure proper staffing. Engage in hazard identification. Engage staff on committees/task forces to implement solutions. Maintain a physical presence. Ensure visible involvement of top leaders. Conduct environmental assessment. Develop departmental policies. Adopt a zero-tolerance policy. Conduct data analysis on WPV. Develop an action plan to reduce WPV. Improve documentation requirements/processes. Streamline event reporting systems and data analysis. Survey staff about safety. Survey to assess risk of WPV and identify actions to target critical issues. Analyze and improve operational factors that cause patient delays. Prevent unrestricted movement of the public in clinical areas. Facilitate drills and exercises. Encourage use of emergency communication systems. Clearly define expectations, conveying a culture of respect at all levels. Develop zero-tolerance policies (including prominent signs addressing violence for hospital visitors). Support staff by removing perpetrators of unruly behavior. Support legal action for violations. Health-oriented leadership demonstrated that supervisors' self-care and employees' assessment of supervisors' staff care positively predicted all dimensions of a violence prevention climate.

Response to violence[a]

Patient escalation

Continue communication skills. Intervene early. Use de-escalation strategies. Use clinical decision-making algorithms. Approach patients with caution. Do not startle patients. Avoid provoking patients. Avoid challenges and making promises. Provide options and choices. Use distraction and redirection. Engage family members.	Remove dangerous objects from your person. Avoid vulnerable positions (do not turn your back on the patient). Be aware of exits. Be firm but compassionate. Avoid physical confrontation. Use progressive behavior control methods. Activate staff-worn body cameras. Use de-escalation rooms.	Apply restraints. Activate staff duress alarm badges. Activate behavioral response teams. Engage interprofessional crisis management alert response team and protocols. Use pharmacologic interventions (benzodiazepines, typical and atypical antipsychotics). Use chemical restraints. Use coercive measures. Involve police.

Recovery after violence[b]

Provide immediate medical assistance to injured staff members (including those working in EHS and the ED).
Provide emotional support to coworkers who are verbally abused and/or physically assaulted.
Document incident in the patient's medical record.
Report incident.
Debrief staff members (emotions, processes).
Refer staff members to employee assistance program or counseling as needed.

Abbreviations: ED, emergency department; EHR, electronic health record; EHS, employee health services.

[a] Interventions listed in order of appropriateness as violence by patients/visitors escalate.
[b] Measures listed in order of importance.

programming,[22,30,40-42,62,63] and providing enhanced infrastructure.[3,20,21,24,25,34,39,40,44,50-52,54,57] Specifically, facilitation of both didactic and simulation educational offerings improved staff members' perception of leadership support (Table 5).[22,30,40-42,62,63]

High levels of leader presence support the team in preventing, mitigating, and managing workplace violence, resulting in staff members feeling supported.[3,22,35,39,45] Leaders who are present during team huddles and make rounds through patient care areas can immediately respond to staff concerns. Leaders collaborate with law enforcement personnel.[39,60] The physical presence of leaders, hospital security personnel, or public safety officials improved staff members' feelings of security, respect, and confidence.[3,43]

Leaders who supported quality improvement projects and education related to workplace violence gained greater respect from their teams.[3,20,37,39,43,45,53] Leaders need to encourage workplace violence incident reporting[39,44] and data analysis to identify local problems.[3,39,60] Leaders should encourage staff engagement in implementing improvement ideas and evaluating outcomes. Examples of quality improvement projects include implementing staff surveys about workplace violence; implementing patient screening tools; teaching de-escalation techniques, self-defense, and risk assessment; and ensuring staff members' well-being and mental health.[22,24,26,32,42,43,45,47]

Education—didactic lessons and simulations—improves nurses' identification of and response to patients showing escalation and results in decreased violence.

Infrastructure. Leaders can influence hospital and unit environmental and facility design to mitigate workplace violence.[44] Infrastructure upgrades can include adequate lighting,[39] entrance control, weapon screeners,[25,40,45] security video cameras,[3,39,40,50,57] unit-based panic buttons,[3] avoidance of overcrowding, visitor traffic control, and removal of clutter.[25] Nonfacility infrastructure improvements that improved staff members' sense of safety included body-worn cameras[25,57] and visible security staff presence.[20,21,24,25,39,44,50,51,54] One quality improvement project, equipping hospital security personnel with conducted electrical weapons, did not reduce the frequency of workplace violence events but may have decreased the severity of injuries.[34]

Response to Violence

Nurses must continue to implement de-escalation techniques as escalating behaviors are observed.[19,37,38,46,59] Once patients or visitors become violent, nurses must shift the focus to protecting themselves. Protecting oneself can take multiple forms. Suggestions include the following: do not work alone with someone who may become violent; do not turn your back on a patient; do not allow a patient to come between you and the exit; run, hide, and fight if there is an active shooter; remain calm and self-controlled; use nonthreatening nonverbal communication; move to a safe space or move the patient to a safe room; and call for help early.[19,40,41,46,68,]

Several interventions can be useful to treat a violent patient. The use of an assessment tool combined with an action plan, algorithm, or bundle of actions can guide nurse interventions.[18,56] Potential elements of the action plan include de-escalation techniques, activation of an interprofessional violence response team,[24,25,45,62] and engaging security personnel or local police.[24,25] At times, security and law enforcement may be needed to subdue a violent patient or visitor. Leaders collaborate with law enforcement personnel during and after these events.[39,60]

Physical restraints may be required. Nurses must adhere to institutional policies to ensure the safety of patients and staff members.[19,46,59] Chemical restraints, such as benzodiazepines or atypical antipsychotics, are commonly prescribed to prevent escalation or treat violent patients. Nurses must monitor and assess patients for respiratory depression and prolongation of QT intervals once these agents have been administered (Table 5).[59]

Recovery After Violence

Exposure to violence can be highly traumatic and may negatively impact nurses' confidence, clinical performance, emotional health, and overall well-being. Immediately provide clinical care to injured nurses to address their physical injuries. Emotional support should also be provided. It is essential for nurses who have experienced workplace violence and others who have witnessed violence to have the opportunity to reflect on their response[18] and debrief both the team's response during the event and the emotional response to the violence. Leaders should offer ongoing support to the staff and, if needed, encourage nurses to seek counseling or employee assistance; leaders may need to facilitate this handoff.[19,25,27,39,51] Leaders

should encourage nurses to pursue legal action against assailants (Table 5).[39]

Discussion

Most articles had a low level of evidence, and only 2 were directly applicable to the critical care setting. Most articles focused specifically on the emergency department; however, the content and interventions were directly applicable to acute and critical care nurses' practice. Many articles focused on prevention of workplace violence. Although a few articles discussed the response and recovery phases, future research could add to the body of literature on response and recovery. These findings were consistent with those of other literature syntheses,[69,70] national recommendations,[66] and a position statement[70] and healthy work environment standards[71] published by the American Association of Critical-Care Nurses.

Education as a form of prevention was a major theme. Education including both didactic lessons and simulations improves nurses' identification of and response to patients showing escalation and results in decreased violence. This education enhances nurses' perspectives of organizational support. Hospitals could consider implementing a violence assessment tool and adding associated interventions or bundles of interventions to reduce violence.[67]

The findings support augmenting required annual education to incorporate simulation, including training for the most severe form of violence: shootings in health care settings.[41,68] All patients could be assessed for the potential for violence, and these risks must be communicated to other staff members and leaders. Nurses could engage in quality improvement projects to pilot test safety ideas. Additionally, education on violence prevention and de-escalation skills could be integrated into nursing school curricula.

Strengths and Limitations

The 47 articles in this integrative review evaluated interventions to prevent and manage workplace violence. Most articles had a low level of evidence. Synthesis of the literature identified practical ways for bedside nurses to prevent and respond to violence from patients and visitors and revealed areas for further research. This integrative review had limitations similar to those of other evidence syntheses, including a low level of evidence with few randomized controlled trials and the inclusion only of articles written in English.[72-74] Because of the nature of workplace violence, randomized controlled trials are not feasible. Due to a paucity of studies that focused specifically on acute and critical care nurses, we broadened our search to include studies conducted in emergency departments. We acknowledge that some of the articles were older than 10 years at the time of retrieval, but reviewers agreed the articles contained contemporary information relevant to the topic.

Implications for Further Research

Few articles about violence specific to acute and critical care nurses exist. Validated tools for use in acute and critical care areas are lacking. Research is needed to identify effective interventions specific to acute and critical care nurses.[73,74] Further research is needed to identify which of the identified interventions are most effective.[74] Additional research is needed to identify best practices in the recovery phase of disaster management. Other gaps in the literature include policy analyses of the effectiveness of laws supporting prosecution of violent offenders toward health care personnel and the effectiveness of zero-tolerance policies.

Conclusions

With the aging population and increased workforce demands, the health system cannot afford to lose a single nurse due to violence in the workplace. Nurses are empowered to address workplace violence and should be actively engaged in education, simulation, and quality improvement projects to reduce workplace violence and advance toward a healthy work environment.[71] CCN

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See also

To learn more about healthy work environments, read "A Hospital's Roadmap for Improving Nursing Excellence Using AACN's Healthy Work Environment Standards" by Blake et al in *AACN Advanced Critical Care,* 2022;33(2):208-211. https://doi.org/10.4037/aacnacc2022632. Available at **www.aacnacconline.org.**

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