

ORIGINAL RESEARCH

Workplace violence in healthcare settings: Does preventive training and education affect prevalence?

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ABSTRACT

Objective: Workplace violence is an ongoing concern in healthcare settings. Patient-initiated violence toward healthcare workers impacts employees physically and emotionally and may affect the quality of care delivered to patients. Healthcare organizations must promote safety through appropriate policies, procedures, and educational practices. The purpose of the study was to examine potential gaps in education and preparedness to manage violent patient situations and to evaluate whether workplace violence training is associated with the prevalence of patient-initiated violence.

Methods: A cross-sectional correlational design was used, including a survey with Likert-type items and open-ended questions. The survey was distributed via snowball sampling through social media and professional email listservs. Two hundred fifty-six respondents from the United States participated in the study. Quantitative data were analyzed using chi-square tests and exploratory logistic regression, and qualitative responses were analyzed to identify common themes.

Results: More than half of the respondents (66.01%) reported experiencing patient-initiated violence within the past six months. Although 82% of participants reported completing workplace violence training, no statistically significant association was observed between training and the prevalence of patient-initiated violence. Exploratory multivariate analysis adjusting for years of experience, clinical setting, and employment status yielded similar findings. Clinical setting was a significant predictor of violence exposure, indicating variability across practice environments. Qualitative responses highlighted concerns regarding training adequacy, frequency, organizational support, and emphasized the need for changes in hospital policy, procedures, and unit-level environments.

Conclusions: Patient-initiated violence toward healthcare workers remains a significant issue in healthcare. Findings from this study suggest that training alone may be insufficient to reduce violence exposure and that organizational and environmental factors play a critical role. Interventions such as enhanced scenario-based training, implementation of de-escalation teams, and stronger enforcement of policies and procedures at the organizational level may better support healthcare workers in recognizing and managing escalating situations.

Key Words: Deescalation training, Healthcare worker safety, Workplace violence

1. INTRODUCTION

Violence in the workplace is an ongoing concern in healthcare settings globally. Workplace violence has been defined as threats and direct acts of violence toward healthcare professionals to include physical violence, acts of intimidation, harassment, and/or verbal attacks directed toward patients,

visitors, or healthcare workers.^[1-3] According to OSHA, workplace violence is four times more likely to occur in healthcare settings than other work environments.^[3] National Nurses United, the largest professional organization for registered nurses in the United States, released a report from a survey deployed in 2023^[4] exploring rates of workplace vio-

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lence in the United States. Almost half (45.5%) of the nurses who responded believed that violence in the workplace had increased from the previous year and conversely; 3.8% reported a decrease in violence in the healthcare environment. In addition, 81.6% stated they had experienced some type of workplace violence within the last year, with verbal violence being the highest type of violence experienced.^[4]

Violence in the healthcare setting can result in burnout and increased stress for healthcare workers. Further, workplace violence contributes to the development of compassion fatigue, which not only negatively impacts employees' physical and psychological health, but it can also decrease productivity, affect the quality of work produced, and decrease job satisfaction. Research indicates that healthcare workers who face violence in the workplace subsequently begin to view the profession negatively which impacts their desire to care for and interact with patients.^[2,5-8] Workplace violence, which can lead to employee absenteeism, higher turnover rates of employees, and healthcare workers leaving the profession altogether, can adversely affect the current nursing shortage. The American Hospital Association estimates that employee absenteeism due to workplace violence averages 5 to 25 days of work annually per employee.^[9] Their assessment of the impact of workplace violence found that approximately 16,990 individuals missed work due to a violence related injury, and 8,740 individuals were placed on restricted duty or transferred to other units due to injuries sustained from workplace violence.^[9]

To appropriately manage workplace violence, healthcare employers must have appropriate mechanisms in place for employees to report incidents of violence as they occur. Adequate reporting allows the facility to track and trend the prevalence of violence within the organization, implement and monitor appropriate interventions, and take accountability for managing patient violence when it occurs. Several studies detail widespread issues with underreporting of episodes of workplace violence within healthcare organizations.^[1,4,9,10] One important study found approximately 45% of the participants had reported incidents of violence through informal channels; however, only 12% of all participants reported violent episodes through the appropriate reporting mechanisms.^[1] Furthermore, according to the National Nurses United survey,^[4] only 1 in 3 (31.7%) respondents felt that their organizations' workplace violence reporting process was clear. Barriers to reporting are due to multiple different factors including challenges with staff understanding how to report or inconsistencies with the reporting process, support from the organization in reporting, fear of retaliation or not being believed, and not wanting to be involved in litigation that could potentially come as a result of reporting.^[1,4,9,10]

Another barrier to reporting is the view of healthcare professionals that violence in healthcare is 'part of their job', which can impact the overall physical and emotional wellbeing of the employee.^[4,11]

An important component of effectively managing patient violence in healthcare settings is proper training in the management of escalating and violent situations. Although violence and escalation management training is highly recommended by many agencies including the Center for Disease Control^[2] and OSHA,^[3] the National Nurses United^[4] survey reported that only 62% of nurses surveyed had received workplace violence training at their place of employment. Training that includes relatable scenarios and role play are shown to increase participants' confidence in managing violent situations. In addition, providing practice with simulations and practice/periodic drills has been shown to be more effective than a lecture or online based education alone.^[4,5,10,11]

Decreasing workplace violence in healthcare starts with the healthcare organization completing a risk assessment where they not only look at violent events, but also look at the culture of safety within the organization, policies that surround violence such as creating a zero-tolerance culture, and what support and involvement leadership and management can give to help decrease a culture of acceptance of violence in healthcare. Organizations need to ensure employees are receiving proper training and education, that proper organizational protocols are in place to not only decrease violence but protect healthcare workers from the detrimental effects of workplace violence when it happens, and that a process for continually assessing and managing risk within the environment exists. Employees need to believe that the healthcare organization cares about keeping employees and patients safe, believes that violence in healthcare is a serious issue, will actively act on risk assessment findings, and continuously review procedures to better support their employees.^[5,12]

The prevalence of workplace violence, specifically patient-initiated violence toward healthcare workers, has been well documented in the literature; however, there remains a lack of conclusive evidence identifying effective strategies to prevent and de-escalate patient violence. Several studies focused on specialty healthcare areas, such as emergency departments and behavioral health settings, often with small sample sizes^[13-15] resulting in findings that may not be generalizable to other healthcare environments. Additionally, there is limited contemporary research examining whether workplace education and training are associated with reduced exposure to patient-initiated violence.^[5,16]

This manuscript examines the relationship between workplace violence education and healthcare workers' expe-

periences with patient-initiated violence. The primary research question was: among adult healthcare employees, is the prevalence of patient-initiated violence associated with whether employees have received workplace violence and aggression training? A secondary aim was to evaluate whether the type of training received (online only, face-to-face, or blended) is associated with the prevalence of patient-initiated violence. In addition to examining these associations, this study incorporates qualitative data to better understand healthcare workers' perspectives on workplace violence, including organizational factors, workplace culture, and perceived strategies to reduce violence in healthcare settings.

2. METHODS

The study utilized a cross-sectional correlational design to evaluate whether an association exists between workplace violence education and the prevalence of patient-initiated violence among healthcare employees. Data were collected on the prevalence and types of workplace violence experienced within the previous six months. In addition, qualitative data were collected to better understand healthcare employee perspectives on workplace violence and perceived factors contributing to a safer workplace culture. Ethics approval was obtained through the Institutional Review Board at the researcher's university in the southeastern United States.

The instrument used was the Violence in Nursing and Midwifery survey developed by Jacqui Pich, PhD.^[17] The survey was modified with permission from the original author to align with the study's research question and to ensure applicability across multiple healthcare setting and professional roles; the original instrument focused specifically on midwifery. The original instrument established face validity; however, the modified version used in this study has not undergone additional psychometric evaluation. The survey included both quantitative and qualitative items related to de-escalation and crisis prevention education for healthcare workers.

Participants were recruited using snowball sampling. Study information was distributed via social media platforms, professional email listservs, and outreach to local hospitals, university alumni, and current nursing students at the researcher's institution. Interested individuals accessed an online consent form and survey link. Inclusion criteria included: (1) age of 18 years or older, (2) currently working in a healthcare setting or having worked in a healthcare setting within the last year, and (3) able to read, write, and speak English.

Quantitative data were analyzed using descriptive statistics

and chi-square tests of independence to examine associations between workplace violence training and the prevalence of patient-initiated violence. To further explore these relationships, an exploratory binary logistic regression analysis was conducted. The dependent variable was the presence of at least one episode of patient-initiated violence in the past six months (yes/no). Independent variables included completion of workplace violence training (yes/no), years of experience, clinical setting, and employment status. Variables were selected based on theoretical relevance and prior literature. Statistical significance was set at $p < .05$. Given the cross-sectional design, all analyses were interpreted as associative rather than causal. Qualitative responses were reviewed and synthesized to identify common themes related to workplace violence experiences and perceived strategies for prevention and management.

3. RESULTS

Three hundred twelve (312) subjects consented to participate in the study, with 256 subjects completing the survey. Subjects were from multiple areas throughout the United States, primarily from the east coast. The sample consisted of predominantly female (91.37%), white (87.11%), with a bachelor's degree (72.15%), and registered nurses (79.30%). The mean years of experience on the subjects' current unit was 2.66, and the average age of the subjects was 32 years. Most subjects were employed full time (76.17%), and most were employed on a medical-surgical (18.43%) unit. Table 1 illustrates full descriptive statistics for gender, race, healthcare discipline, participant education level, work status (full-time, part-time, prn), and type of unit on which the participant is employed.

3.1 Data analysis

Based on survey data, 66.01% of the participants have experienced patient-initiated violence within the past 6 months. Figure 1 illustrates the frequency of episodes as reported by participants. Participant data indicate that 167 participants experienced either physical abuse, verbal abuse, or both; of these, the majority experienced both forms of abuse (59%), while 39% reported verbal abuse only. The breakdown of types of verbal and physical abuse is displayed in Figures 2 and 3.

Overall results showed that 73.76% of subjects were offered training on workplace violence by the facility in which they were employed. Face-to-face training was offered to 24% of respondents with 42% receiving online training only. A mix of face-to-face and online education was provided to 34% of participants. The chi-square test of independence was used to evaluate quantitative data to determine if patient violence

and de-escalation training impacted the prevalence of patient violence experienced by healthcare providers. Statistical significance was set at alpha = 0.05 and data were analyzed using Intellectus Statistics, a web-based application.

Table 1. Descriptive statistics

| Variable | n | % |
|---|-----|--------|
| Gender | | |
| Female | 233 | 91.373 |
| Male | 19 | 7.451 |
| Other | 3 | 1.176 |
| Race/Ethnicity | | |
| White | 223 | 87.109 |
| Asian | 11 | 4.297 |
| Hispanic or Latino | 10 | 3.906 |
| Other | 9 | 3.516 |
| Black or African American | 3 | 1.172 |
| Healthcare Discipline | | |
| RN | 203 | 79.297 |
| Nurse Extern | 4 | 1.562 |
| NP | 10 | 3.906 |
| Physician | 3 | 1.172 |
| RBT | 1 | 0.391 |
| PCT | 25 | 9.766 |
| CRNA | 3 | 1.172 |
| Surgical Scheduler | 1 | 0.391 |
| LPN | 2 | 0.781 |
| Student | 2 | 0.781 |
| nursing instructor | 1 | 0.391 |
| CNL | 1 | 0.391 |
| Highest Level of Education | | |
| Bachelors | 184 | 72.157 |
| Diploma | 9 | 3.529 |
| Associates | 15 | 5.882 |
| Doctorate | 14 | 5.490 |
| Masters | 32 | 12.549 |
| Post-Doctorate | 1 | 0.392 |
| Work Status | | |
| Full-time (0.75 -1.0 FTE) | 195 | 76.172 |
| Part-Time (0.PRN (0.3 FTE or less)-0.6 FTE) | 19 | 7.422 |
| PRN (0.3 FTE or less) | 42 | 16.406 |
| Practice Area | | |
| Medical-Surgical | 47 | 18.431 |
| Progressive Care/Step-Down | 24 | 9.412 |
| Long Term Care/Rehab | 6 | 2.353 |
| Family Practice/Outpatient | 11 | 4.314 |
| Other | 16 | 6.275 |
| Critical Care (ICU) | 29 | 11.373 |
| Emergency Care | 27 | 10.588 |
| Clinical Faculty for Nursing Students | 10 | 3.922 |
| Behavioral Health | 17 | 6.667 |
| Pediatrics | 11 | 4.314 |
| Surgical Services-OR, Peri-Op, PACU, Anesthesia | 20 | 7.843 |
| Telemetry | 9 | 3.529 |
| NICU | 3 | 1.176 |
| L&D/Women's Health | 12 | 4.706 |
| Transplant | 4 | 1.569 |
| Home Health/Hospice | 4 | 1.569 |
| Cardiology | 2 | 0.784 |
| Telehealth | 3 | 1.176 |

The results of the Chi-square test were not significant based on an alpha value of .05, $\chi^2(2) = 1.46$, $p = .483$, suggesting that the two variables ‘Have you been involved in one or more episodes of violence’ and ‘Have you-Choice #1-completed the training at your place of work, Choice #2-Not completed this training, Choice #3-Completed the training at your own expense outside of your place of work’ could be independent of one another.

Cramér’s V was used to evaluate whether the participant received any training compared to the prevalence of patient-initiated violence experienced in the last 6 months. Results showed Cramér’s V to equal 0.0824, which is not significant on a 0-1 scale. Further review of the data indicated that although most participants completed training on how to manage aggressive and violent situations, training was not significantly associated with the prevalence of patient-initiated violence. In addition, Cramér’s V was used to evaluate whether training held face-to-face, online, or a blend of both had an impact on the prevalence of patient initiated violent episodes. Cramér’s V was shown to be insignificant at 0.110 on a 0-1 scale. However, as illustrated in Table 2, there was a slight decrease in violent episodes for those who had in-person or blended training, compared to online format only. Multiple participants responded in the survey qualitative comments that their training was neither frequent enough nor adequate to know how to effectively de-escalate aggressive or violent behaviors with patients.

Table 3 illustrates the reported number of violent episodes categorized by practice area. The largest group of participants were employed on a medical-surgical unit, and 83% of those participants on medical-surgical units reported experiencing episodes of violence within the last six months. Emergency Department and Behavioral Health units had a greater frequency of episodes reported. These results support the need for education and training on patient deescalation across healthcare facility units to manage episodes of patient violence.

Data from the study showed that approximately 50% of respondents felt that upper management was approachable following a violent event, where approximately 24% felt that upper management was not approachable, and 26% felt upper management was sometimes approachable. A greater percentage of respondents (68.66%) felt that managers/team leaders were approachable after a violent event. When respondents were asked if the risk management strategies to decrease workplace violence were effective, only 20.6% stated yes, whereas 54.27% stated somewhat and 25.13% said no. When respondents were asked about effective strategies, some commented that frequent and ongoing training

was important, having a specifically trained management team to manage violence is important, and the organizations support for a safe workplace through the enforcement of a zero-tolerance culture. Other respondents stated they were

not sure of what strategies had been implemented, if any. One participant commented: “No recent changes have been implemented despite physical attacks on staff.”

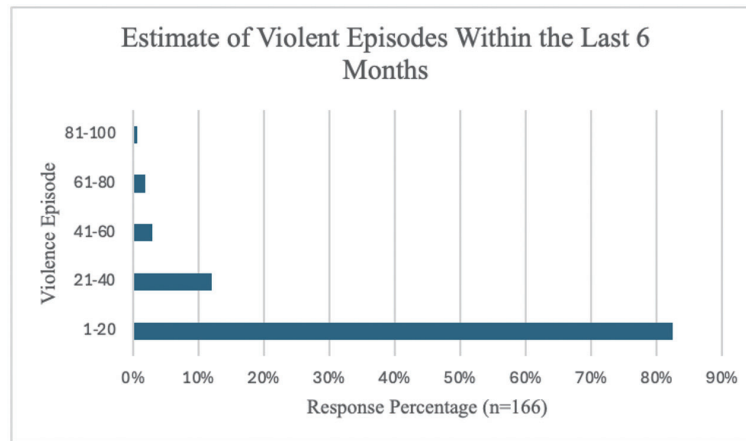


Figure 1. Prevalence of patient-initiated violence

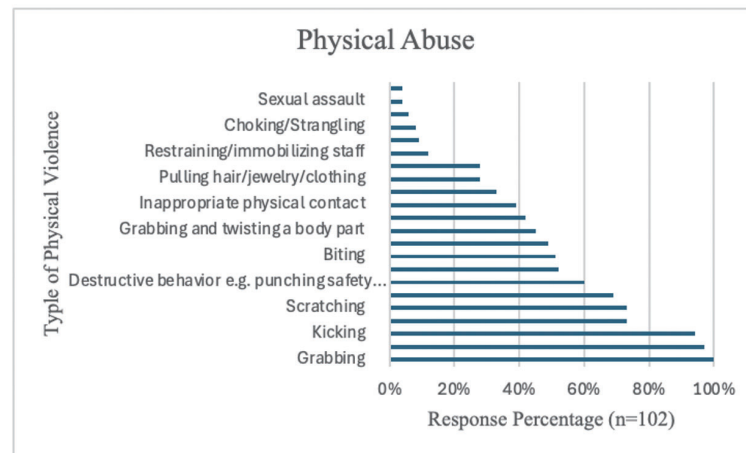


Figure 2. Categories of physical abuse

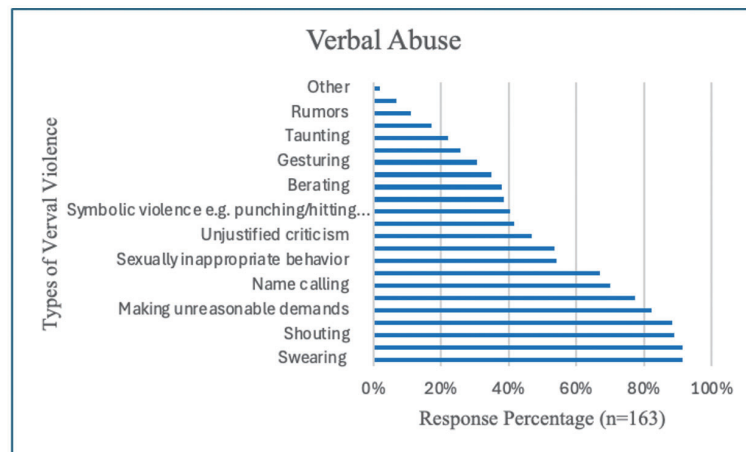


Figure 3. Categories of verbal abuse

Table 2. Training format versus episodes of violence

| Violent Episodes in the Last 6 Months | N | Training Format | | |
|---------------------------------------|----|-----------------|------------------------------------|-------------|
| | | Face-to-Face | Mixture of Face-to-Face and Online | Online Only |
| 1-20 | 84 | 25% | 37% | 38% |
| 21-40 | 14 | 36% | 21% | 43% |
| 61-80 | 3 | 33% | 33% | 33% |

Most respondents (61%) felt that violence is increasing, and 84.58% of respondents answered yes (49.75%) or somewhat (34.83%) to the question that violence was part of the job. Respondent’s comments support the belief that violence is part of the job, and there is a strong need for organizational management of violence within healthcare. To the question “Is violence an inevitable part of your job” one participant

commented: “We have created an environment where there is no consequence for when nurses and other healthcare personnel are abused making it okay and normal participant comments related to violence as part of the job, and the need for greater organizational management of violence when it happens.” Others stated: “I haven’t met a single nurse who hasn’t experienced violence.”, “Just part of the day to day in mental health care.”, “It’s just part of dealing with sick people”, “and “It’s not acceptable, but I’ve learned to expect that it will happen at least once a week.” Another participant stated “I think it is inevitable that we will encounter violent patients or patients that are unhappy with the care they receive. However, in no way do I think it is acceptable or should be tolerated” which further supports the need for ongoing organizational recognition of the problem, and support for healthcare employees.

Table 3. Episodes of violence by practice area

| Practice Area | n = 164 | 1-20 (%) | 21-40 (%) | 41-60 (%) | 61-80 (%) | 81-100 (%) |
|---|---------|----------|-----------|-----------|-----------|------------|
| Medical-Surgical | 37 | 76 | 16 | 5 | 3 | 0 |
| Critical Care (ICU) | 24 | 71 | 25 | 4 | 0 | 0 |
| Progressive Care/Step-Down | 19 | 79 | 21 | 0 | 0 | 0 |
| Emergency Care | 19 | 68 | 16 | 11 | 0 | 5 |
| Behavioral Health | 12 | 83 | 0 | 0 | 17 | 0 |
| Surgical Services-OR, Peri-Op, PACU, Anesthesia | 9 | 100 | 0 | 0 | 0 | 0 |
| Other | 7 | 100 | 0 | 0 | 0 | 0 |
| Pediatrics | 7 | 86 | 14 | 0 | 0 | 0 |
| Telemetry | 7 | 100 | 0 | 0 | 0 | 0 |
| Long Term Care/Rehab | 6 | 100 | 0 | 0 | 0 | 0 |
| Family Practice/Outpatient | 6 | 100 | 0 | 0 | 0 | 0 |
| Clinical Faculty for Nursing Students | 5 | 100 | 0 | 0 | 0 | 0 |
| L&D/Women's Health | 5 | 100 | 0 | 0 | 0 | 0 |
| Transplant | 1 | 100 | 0 | 0 | 0 | 0 |

The qualitative questions on the survey explored healthcare workers’ perceptions on how to better manage patient violence in the workplace regardless of their level of experience with deescalation training. Responses to two questions participants were asked, “What measures do you believe can be used to more effectively to manage violent patients/episodes?” and “In your opinion, what would be the most effective way to prevent/minimize the occurrence of violence in your department?” strongly indicated that healthcare workers support frequent and on-going de-escalation training education. Table 4 is a sampling of several comments by participants that support the need for enhanced, frequent training within the workplace. Other participant comments (see Table 5) support the need for zero tolerance policies, better staffing ratios, and more overall support in the

healthcare environment. More research into the most effective means of training and education for healthcare workers who experience violence in the workplace is needed.

Responses to the question, “Please add any additional comments below” provided a wealth of suggestions and recommendations for healthcare facilities in preparing workers to manage episodes of patient to healthcare worker violence. In addition, responses to this question support the need for more attention to patient violence in healthcare. One participant indicated: “It’s hard to say what would help. There seems like there will always be violence towards healthcare workers, especially verbal. Even though my department has lots of measures in place to help there doesn’t seem to be a method to truly stop it.” Another participant stated, “It is sometimes expected that our patients are not feeling their best and ag-

gressive behavior is possible.” Further comments support the need for more attention to violence in the healthcare setting. “I love that you all are doing this project. Workplace violence against nurses is SO prevalent and should absolutely be taken more seriously.” “Thank you! Taking this survey has let me get things I have wanted to say for years off my

chest.” “Please share your findings with as many people as possible. We get told we are complaining, and it’s what we signed up for if we say how we feel. The world needs to have a wakeup call to how we are treated and they won’t have any nurses left if the conditions continue.”

Table 4. Participant comments associated with De-Escalation education

| |
|---|
| Question: What measures do you believe can be used to more effectively manage violent patients/episodes? |
| “Training-offsite in a simulation lab, not on a computer” |
| “Increased knowledge of options on the unit that are not just restraints” |
| “Patient consequences enforced. Police on site, defense training and deescalation training” |
| “Education available to units, not just high risk (ed, behavioral health)” |
| “De = escalation techniques, sensitivity and awareness training, and collaboration with local law enforcement” |
| “Continued education to decompress situations calmly” |
| “Frequent rounding, increased staffing, more frequent training” |
| “More training/refresher training on violence/agitation management in patients. More staff. Continued use of Behavioral Response Teams (psych RN, various providers, police presence)” |
| “Encouraging non-violent, non-hands-on early intervention skills” |
| “Clear guidelines for staff, no tolerance policies, better conflict resolution classes” |
| Question: In your opinion, what would be the most effective way to prevent/minimize the occurrence of violence in your department? |
| “Smaller ratios, preventative classes” |
| “De-escalation training quarterly for all employees” |
| “Prevention and recognizing signs” |
| “Staff training face-to-face and practice with restraints and calling security codes- less frequency means people are less prepared” |
| “Training of all employees along with resources to help manage these situation” |
| “Organized prevention plan with training for all staff and providers” |
| “I also work in a residential treatment program and feel that our training is lacking on de-escalation, and we do not hold drills on procedures for violent situations; my responses here are largely based on that work environment” |

To further examine these relationships while accounting for potential confounding variables, an exploratory binary logistic regression was conducted to examine whether the availability of workplace violence training was associated with experiencing patient-initiated violence within the previous six months, while adjusting for years of experience, clinical setting, and employment status. The overall model was statistically significant, $\chi^2(5) = 29.96, p < .001$, indicating that the predictors, as a set, reliably distinguished between participants who reported experiencing violence and those who did not. The model demonstrated acceptable fit (Hosmer–Lemeshow test, $p = .372$) and explained approximately 17.3% of the variance in violence exposure (Nagelkerke $R^2 = .173$).

Availability of workplace violence training was not a statistically significant predictor of violence exposure ($p = .912$).

Years of experience approached but did not reach statistical significance ($p = .097$). Clinical setting was a significant predictor (OR = 0.45, 95% CI [0.32, 0.64], $p < .001$), indicating that the likelihood of experiencing patient-initiated violence varied across practice environments. Employment status was not significantly associated with violence exposure ($p = .383$). These findings suggest that, after adjusting for key covariates, workplace violence training was not associated with reduced reports of patient-initiated violence within this sample.

3.2 Limitations

This study has several important limitations. First, a notable dropout rate was observed in survey completion, which may have impacted the representativeness of the final sample. While the survey captured a wide range of data related to workplace violence, education, and participant perspectives,

it did not include detailed measures assessing the effectiveness of specific training components (e.g., role-playing, simulation, or scenario-based learning), limiting the ability to evaluate which elements of training may be most beneficial.

Table 5. Patient comments associated with zero-tolerance policies, staffing, overall support

| |
|---|
| Question: What measures do you believe can be used to more effectively manage violent patients/episodes? |
| “Public awareness of the situations that occur in the hospital/bedside setting because most of the public see hospitals as a safe/nonviolent area. Also teaching nurses, especially new nurses, not to tolerate any kind of mistreatment whether it is physical or verbal” |
| “Stricter hospital policies. Less Nurse patient ratio for known violent patient” |
| “More nursing staff” |
| “Zero tolerance and actual support from management.” |
| “Zero tolerance policy. Medications when appropriate” |
| “I believe for oriented patients there should be a zero-tolerance rule in hospitals. There’s no excuse for full grown oriented adults to be sexually inappropriate towards nurses, putting their hands on nurses in any way, etc. I believe that if that occurs the patient is forfeiting their right to care at that facility. It may seem extreme but at the end of the day offices and other places of work don’t tolerate that behavior so why should nurses have to endure it without the patient facing repercussions?” |
| “Clear policies on what will and won’t be tolerated, including what actions will be taken (i.e. immediate removal of violent partner/visitor vs a two-strike policy) if policies are not followed” |
| “More staffing, one-to-one sitters which are not present at my organization, and more awareness by management” |
| “Strict policies to dismiss violent patients and make patients aware of no tolerance policies” |
| “Zero tolerance for violence. Not just pretending with signs. Increased staffing. Patients having access to their team without waiting, because the team is stretched thin and burnt out, would decrease some of the agitation that leads to aggression” |
| Question: In your opinion, what would be the most effective way to prevent/minimize the occurrence of violence in your department? |
| “Adequate staffing and better patient ratios” |
| “Less nurse-to-patient ratio when you have violent patient. Policies in handling violent patients” |
| “Clear policies and enforcement” |
| “Policies that are enforced” |
| “Zero tolerance! If patient/family is cognitively aware of their actions, they should be dismissed unless it is an emergent situation” |
| “Expectation management, zero tolerance policies” |
| “More staff advocacy, better staffing overall” |

The use of snowball sampling introduces potential selection bias and limits generalizability, as participants may share similar characteristics or professional networks. Additionally, data were self-reported and are subject to recall bias, as well as potential normalization of workplace violence experiences, which may have further influenced how participants interpreted and reported events.

The cross-sectional design precludes temporal sequencing and limits causal inference; therefore, findings should be interpreted as associative rather than causal. This is particularly important when considering the lack of a statistically significant association between workplace violence training and violence exposure, as unmeasured factors may contribute to this relationship. For example, clinical setting was found to be a significant predictor of violence exposure, suggesting that environmental and organizational factors may confound

the relationship between training and outcomes.

Additionally, the modified survey instrument has not undergone formal psychometric evaluation beyond face validity, which may impact measurement reliability and construct validity. Finally, unmeasured confounding variables, such as workload intensity, staffing levels, and prior exposure to violence, may have influenced findings. Future research should consider longitudinal or pre-post designs that better assess the impact of workplace violence training over time, as well as more detailed measurement of training content and delivery methods to identify the most effective approaches.

4. DISCUSSION

4.1 Education

Decreasing workplace violence involves a culture of change within healthcare organizations. One factor that is part of

that change is the need for proper education for employees. Survey results indicated that a high percentage of respondents received either online, in-person, or blended education on workplace violence, with the majority completing online-based training. Results also indicated that patient violence was slightly higher for individuals who completed online training only. However, in the present study, no statistically significant association was observed between workplace violence training and prevalence of patient-initiated violence, even after adjusting for years of experience, clinical setting, and employment status. This finding suggests that training alone may not be sufficient to reduce the likelihood of experiencing workplace violence and highlights the need to consider additional contributing factors.

Previous research supports the need for education that involves role play and relatable scenarios. Providing in-person training allows time for hands-on practice and real-time feedback from educators. This is further supported by participant data from this research. A part of decreasing workplace violence is having education that is useful to the learner and applicable to their specific setting. Creating training that is setting-specific would allow the learner to practice in real-life scenarios that they may encounter, versus scenarios that allow them to engage in practice but are not applicable to their work environment.

Importantly, clinical setting emerged as a significant predictor of workplace violence exposure in this study, suggesting that environmental and organizational factors may play a more substantial role in violence risk than individual-level training alone. As noted in the research, many different units, both inpatient and outpatient, experience patient violence; however, the frequency and nature of that violence may vary considerably by practice environment. This reinforces the need for education that is not only broadly implemented but also tailored to the specific risks associated with different clinical settings.

In-person, scenario-based training should be required for all staff and all units, not just units that have a larger population of violence. This will allow staff to be proactive and prepared to manage violent situations when they occur. Consideration should also be given to the frequency of education. Qualitative data from this study supports the need for more frequent training within the hospital. Employees could complete a full training annually, followed by more frequent refresher sessions to maintain skill proficiency and confidence in managing escalating situations. In addition, healthcare organizations could conduct patient escalation drills, like fire drills, that are unannounced and allow the staff to practice skills in real time within their own units.

Each drill should include structured debriefing to reinforce learning and identify areas for improvement.^[18]

The American Nurses Association^[19] discusses the need for early education of nurses, recommending de-escalation and crisis management training for nursing students prior to entering practice. This would allow nurses to enter practice prepared to manage patient violence and escalating situations. In addition, this would allow nursing students who are caring for patients in hospitals to manage potentially violent or escalating situations that arise during clinical rotations. Students could learn how to manage patients on a day-to-day basis by developing non-escalation skills, which focus on preventing escalation through therapeutic communication, appropriate behavioral responses, and awareness of environmental triggers.

Teaching only how to respond when escalation occurs represents a reactive approach, whereas teaching non-escalation techniques promotes prevention by emphasizing respectful, patient-centered interactions. Students should also learn how to respond when escalation occurs, including the use of verbal, non-verbal, and physical strategies to safely manage crisis situations.^[20] Providing this education would promote safety for both students and patients and support the delivery of safe, high-quality care.^[21]

A recommendation from study participants was the formation of Behavioral Emergency Response Teams (BERT), along with specific training for team members. In addition to security personnel, BERTs could include a multidisciplinary group of healthcare professionals such as physicians, nurses, and social workers who are trained to respond to escalating situations. The intent of the BERT team would not be to manage all patient escalation events, but rather to intervene early when staff recognize warning signs of escalation, potentially preventing progression to violence.^[19,22] These individuals could receive advanced training and serve as a resource to frontline staff, helping to promote both patient and staff safety. BERT teams could also lead unit-based de-escalation drills, further reinforcing preparedness across the organization.

4.2 Organizational culture change

Participant comments suggested the implementation and use of zero-tolerance policies in healthcare workplaces. A fully publicized and enforced zero-tolerance policy would ensure that patients are aware they will be held accountable for their actions toward healthcare workers.^[19,23] In addition, legislation in support of these policies, including laws that enforce consequences for individuals who harm healthcare workers, is essential. Healthcare facilities implementing clear

policies, combined with supportive legislation, can create a unified approach to addressing workplace violence. Workplace violence can be understood within broader frameworks of organizational climate and psychological safety, which emphasize the role of leadership, culture, and systems-level factors in shaping employee experiences.^[24,25]

Importantly, the findings of this study suggest that organizational factors, including workplace culture, leadership responsiveness, and environmental context, may be critical determinants of workplace violence, particularly given that training alone was not associated with reduced violence exposure. Qualitative responses from participants further emphasized the need for stronger leadership engagement, consistent policy enforcement, and improved staffing patterns to effectively address workplace violence. Together, these findings reinforce that meaningful reductions in workplace violence will likely require multifaceted system-level interventions rather than reliance on education alone.

5. CONCLUSIONS

Although no statistically significant association was identified between workplace violence training and the prevalence of patient-initiated violence in this study, qualitative findings suggest that the format and delivery of education may influence healthcare worker preparedness for managing escalating situations. Findings from this study suggest that training alone may be insufficient, and that system-level and environmental factors play a critical role in shaping workplace violence risk. In addition, results indicate that workplace violence exposure may be influenced by factors beyond individual training, including differences across clinical settings and organizational environments.

Healthcare employees require appropriate structure, resources, and support to maintain both personal and patient safety. Early intervention is essential, including the integration of de-escalation and crisis management training into nursing education programs to better prepare students for clinical practice and promote safe patient care. Participants also emphasized the need for specialized Behavioral Emergency Response Teams (BERT), as well as comprehensive training for all healthcare employees.

Efforts to address workplace violence should extend beyond education alone and include collaboration with healthcare leaders, policymakers, and professional organizations to develop and enforce policies that support safe work environments. In the context of ongoing healthcare workforce challenges, it is critical that both current employees and new graduates feel supported and protected in their practice settings.

Continued research, education, and policy development is needed to advance a culture of safety and effectively address workplace violence in healthcare.

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AUTHORS CONTRIBUTIONS

Dr. Sutherland was responsible for creating the study design, initial manuscript draft, data collection, and data evaluation. Dr. Herron was responsible for idea generation and qualitative research evaluation. Dr. Buchanan was responsible for quantitative data analysis. All three authors were responsible for drafting, revising, and editing the manuscript.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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DATA SHARING STATEMENT

No additional data are available.

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