

Background

Workplace violence (WPV) is any act or threat of physical violence, harassment, intimidation, or other threatening behavior that occurs at work. It can include threats, verbal abuse, physical assaults, and homicide (Occupational Safety and Health Administration [OSHA], n.d.) and affects half of all healthcare professionals in emergency departments (Emergency Nurse Association [ENA], n.d.). In September 2023, the California Division of Occupational Safety and Health (Cal/OSHA) announced the implementation of the WPV prevention regulation for general industry (State of California Department of Industrial Relations, 2024). This new regulation is codified in the California Labor Code and took effect on July 1, 2024. All California healthcare facilities are strongly encouraged to provide training related to WPV and report any incidents to both the local Cal/OSHA Enforcement District Office and the appropriate local law enforcement (Cal/OSHA, 2024).

Healthcare organizations can submit WPV data to the National Database of Nursing Quality Indicators (NDNQI) to benchmark their facility- and unit-level nursing WPV data nationally. The annual and quarterly NDNQI reports include: 1) total assaults on nursing personnel, 2) injury assaults on nursing personnel, and 3) the total RN assault rate. Our organization monitors unit- and org-level data with a goal to maintain rates below the national benchmark. The Quality Council and Workplace Violence Committee monitor these data and follow up with units that underperform the national benchmark for two or more consecutive quarters to offer support strategies to address their high assault rates. Trended organization-level data over the last eight quarters for each of these measures show that both total assaults and injury assaults on nursing personnel outperformed in seven of eight quarters, while total RN assaults outperformed in four of eight quarters. While these rates are generally favorable, data have shown that nurses may underreport assaults (Spencer et al., 2023), which warrants inquiry to understand better how to support nurses to report assaults and obtain the resources needed to protect their well-being.

Our organization currently does not use a screening tool to track patients' aggressive behaviors to identify trends. Staff report WPV to nursing supervisors, who then track data for reports to the WPV Committee. Documentation of the potential for aggressive behavior versus responding to the aftermath of such incidents may support a more proactive approach to managing WPV threats. In addition, an objective record of a patient's aggressive behavior is important for understanding how the situation progressed.

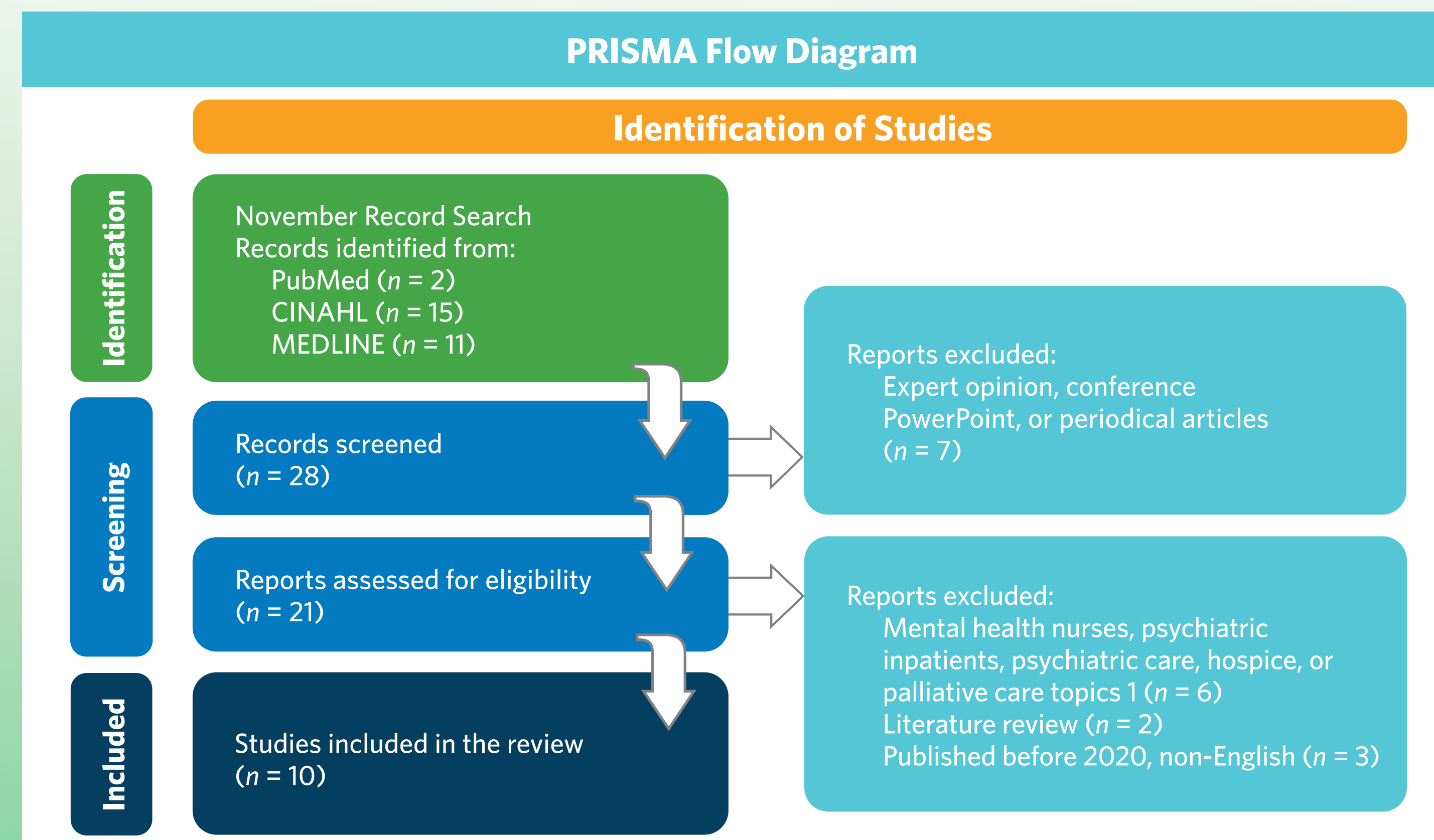
Purpose Statement

The purpose of this literature review was to explore the problem of WPV against nurses and compile recommendations to be presented to the organization's WPV Committee.

Methods

This focused literature review stemmed from the 2025 Evidence-Based Practice (EBP) Cohort. Four authors (R.M., M.B., H.D., and V.H.) searched PubMed®, CINAHL®, and MEDLINE using the keywords “workplace violence,” “workplace violence AND healthcare workers,” “Brøset Violence Checklist,” and “workplace violence AND aggression AND prevention AND health workers.” Articles were excluded if they addressed mental health nurses, psychiatric, hospice, or palliative care; were not written in English; or were published before 2019. The inclusion criteria were peer-reviewed research studies, reviews, and expert opinion articles. Settings included acute care and emergency departments. A second literature search was conducted in November 2025 by the primary author (Y.K.C.), using the keywords “workplace violence AND registered nurse AND inpatient AND Brøset Violence Checklist.” After eliminating sources that did not meet the inclusion criteria, 10 articles were included in the review (see Figure 1). The quality of the 10 articles was assessed using the Johns Hopkins Nursing Evidence-Based Practice (JHEBP) appraisal tools (Bissett et al., 2025).

Figure 1



Results

The 10 articles reviewed included two systematic reviews (Liu et al., 2019; Spencer et al., 2023), two qualitative studies (Babaei et al., 2025; Brunero et al., 2025), two pilot studies (Adams et al., 2024; Hendrickson, 2022), one cross-sectional study (Arnetz et al., 2025), one integrative review (McCamon et al., 2025), one mixed-methods study (Russell-Babin et al., 2025), and an expert opinion article (American Academy of Nursing Policy, 2024). Quality ratings for articles were classified as moderate (*n*=3) or strong (*n*=7) support for decision-making (Bissett et al., 2025). The quality ratings and findings related to the EBP questions for each of the 10 articles are summarized in the Literature Review Table.

The primary author then synthesized the articles by organizing findings into five themes: the current situation of WPV, WPV outcomes, WPV prevention strategies, WPV-related issues, and the Brøset Violence Checklist (BVC).

Current Situation of WPV. Between 1987 and 2018, studies focused on WPV from Europe, Asia, North America, and Australia raised awareness about the physical and non-physical forms of violence affecting healthcare workers (Liu et al., 2019). An analysis of 78 studies revealed that the highest prevalence of WPV occurs in prehospital settings (83.9%; 95% confidence interval [CI; 74.4%, 93.4%]), particularly among mixed-shift nurses (72.8%) compared to day shift (49.7%) and night shift (39.4%), as well as between nurses (59.2%) and physicians (56.8%), and with other healthcare workers (44.4%; *p*=0.02). Globally, emergency departments reported the highest rates of non-physical violence (62.3%; 95% CI [53.7%, 70.8%]) (Liu et al., 2019).

Three predictors of WPV were identified by Liu et al. (2019): younger healthcare workers, those working over 40 hours per week, and those who frequently change shifts. Experienced White healthcare workers in urban settings who worked longer hours reported a greater incidence of non-physical violence, whereas unmarried White males were more likely to experience physical violence (Liu et al., 2019). Although these predictors were identified across 74 studies, further research is needed regarding the association of gender with WPV incidents, as findings related to gender remained inconsistent (Liu et al., 2019).

Brunero et al. (2025) conducted a qualitative analysis of 775 WPV incidents at a metropolitan hospital in Australia, revealing six key themes: escalation dynamics, warning behaviors, authoritative institutional intervention, care delivery methods, situational stressors, and unprovoked triggers. The analysis showed that 42% of incidents escalated from verbal altercations to physical violence. Warning behaviors, including verbal threats and non-verbal cues, were noted in 30.8% of cases. The involvement of security or law enforcement contributed to a 23% increase in violent incidents. Routine care activities were associated with 11.8% of events, while situational stressors like frequent transfers increased reactions by 11.2%. Sudden triggers accounted for only 4.8% of incidents. Staff ages 30-34 and 45-49 were the most frequent age groups involved in violence, linked to warning behaviors and situational stressors. Consistent with the findings of Liu et al. (2019), the emergency department was the most frequent site for WPV incidents, highlighting the need for targeted interventions in this area.

WPV Outcomes. Arnetz et al. (2025) surveyed 505 Michigan nurses to explore how WPV contributes to work-related exhaustion. Regression analysis revealed that both non-physical violence (*b* = 0.20, *p* < .001, 95% CI [0.10, 0.30]) and physical violence (*b* = 0.16, *p* = .01, 95% CI [0.06, 0.26]) were significant predictors of heightened work-related exhaustion. Work-related exhaustion was associated with significantly higher scores in the memory (*b* = 0.26, *p* < .001, 95% CI [0.15, 0.37]); attention (*b* = 0.27, *p* < .001, 95% CI [0.16, 0.38]); and action subscales (*b* = 0.23, *p* < 0.001, 95% CI [0.12, 0.34]). The indirect effects of non-physical violence were found to be significant for the workplace cognitive failure scale (WCFS) memory (indirect effect = 0.05, *p* < .01, 95% CI [0.02, 0.09]); attention (indirect effect = 0.05, *p* < .01, 95% CI [0.02, 0.09]); and action subscales (indirect effect = 0.05, *p* < .01, 95% CI [0.01, 0.08]). Similarly, the indirect effects of physical violence were significant for the WCFS memory (indirect effect = 0.04, *p* = 0.01, 95% CI [0.01, 0.07]); attention (indirect effect = 0.04, *p* < .01, 95% CI [0.01, 0.08]); and action (indirect effect = 0.04, *p* = 0.02, 95% CI [0.01, 0.07]) subscales. Arnetz et al. (2025) found that both non-physical and physical WPV significantly impact nurses' memory, attention, and action, leading to increased work-related exhaustion.

Babaei et al. (2025) explored individual nurses' strategies for managing WPV using interviews with 15 nurses from four urban hospitals in Iran. They identified the concept of “Active Endurance,” an approach used by nurses to de-escalate situations using effective communication, appropriate care, empathy, anger management, self-care, seeking support, teamwork, and a commitment to justice. This qualitative study highlights how nurses leverage their unique practices and seek resources to address WPV.

Implementation of WPV Prevention Strategies. Hendrickson's (2022) pilot study included several recommendations from the expert opinions of the American Academy of Nursing Policy (AANP, 2024) which emphasized establishing policies related to WPV, developing action protocols, implementing appropriate signage, and creating a reporting system. A steering committee focused on four key areas: policy development, staff training and resource acquisition, enhancement of unit safety, and the establishment of a Behavioral Emergency Response Team (Hendrickson, 2022). Staff were surveyed in 2018 before interventions were implemented and again in 2021. Staff reported a significant increase (46%) in their perception that violent incidents were being investigated and addressed. They also expressed greater satisfaction (63%) with how the institution managed and responded to these incidents, with an overall satisfaction rate of 87.9% in the 2021 survey (Hendrickson, 2022). Implementing WPV prevention strategies shows promise in enhancing staff satisfaction and their perception of the organization's appreciation toward the staff.

WPV-related Issues. In their integrative review, McCamon et al. (2025) examined WPV interventions from 14 articles and assessed the effectiveness of three specific interventions: behavioral intervention teams, environmental changes, and communication strategies. Among these, only communication strategies—such as de-escalation techniques and improved collaboration among healthcare staff, security, and behavioral response teams—were consistently associated with reductions in patient aggression. Findings regarding behavioral intervention teams were mixed, as studies used either single interventions or multimodal strategies. Although some studies reported increased staff perception of safety, there was not a consistent decrease in the actual incidence of violence. Similarly, enhancements to environmental safety through improved security systems presented varied challenges. The diversity in environmental support measures and inconsistencies in reporting resulted in a lack of quantified data and significant heterogeneity, making it difficult to draw conclusions about the overall effectiveness

of environmental interventions (McCamon et al., 2025). A systematic review of 19 articles from throughout the world explored nurses' reluctance to report WPV incidents (Spencer et al., 2023). The findings were categorized into three main areas: nursing, management, and organizational factors. Nursing factors included personal characteristics such as being female, younger, inexperienced, or working in a specialty care area; desensitization to violent patients; personal biases against reporting; fear of repercussions; lack of knowledge regarding reporting procedures; time constraints; and perceptions that violence is unavoidable. Other negative perceptions, such as feelings of guilt or shame, peer pressure to remain silent, viewing incidents as preventable, and previous negative experiences with reporting also contributed to underreporting. Management-related factors encompassed dissatisfaction with reporting outcomes, insufficient support for reporting incidents, and an inadequate culture of safety. Organizational factors included the absence of clear policies and procedures, ineffective reporting systems, and a lack of comprehensive training programs (Spencer et al., 2023).

The Brøset Violence Checklist. Effectively quantifying WPV remains a challenge and has hindered efforts to address WPV (Spencer et al., 2023) and intervention outcomes in a quantifiable manner (McCamon et al., 2025). The BVC is a six-question risk assessment tool designed to predict the likelihood of aggression over 24 hours (Frenzs, n.d.). Scores range from 0 to 6, with 0 indicating no risk of violence, 1 to 2 suggesting a moderate risk warranting preventive measures, and scores from 3 to 6 indicating a high risk for violence, necessitating both preventive strategies and a comprehensive plan to manage potential aggressive behavior.

A pilot study implemented the BVC with a multidisciplinary team to develop a screening tool and escalation process. The goal was to enhance nurses' safety, reduce staff assaults, minimize public safety interventions, and increase psychiatric involvement (Adams et al., 2024). Outcome measures included BVC completions, psychiatry consults, nursing restraint use, staff assaults, and calls to public safety. A rounding and post-implementation nursing survey was used to evaluate the program. The mean weekly usage of BVC increased significantly from 72 (*SD* 13.1) to 179 screenings (*SD* 54.7). BVC scores of 3 or greater also increased, from an average of 1.2 (*SD* 1.1) to 4.3 per week (*SD* 2.7). Additionally, there was a 17.6% reduction in restraint use and decrease in calls to public safety (average of 5.4 to 1.6 calls per week). Among the 19 nurses who completed the post-implementation survey, 89.5% reported feeling confident in completing the BVC, and 78.9% agreed that the BVC effectively identifies patients displaying aggressive or violent behavior (Adams et al., 2024).

Russell-Babin et al. (2025) conducted a mixed-methods study using the BVC in adult inpatient care settings, including five ANCC Magnet®-designated hospitals in Northern Virginia. A retrospective record review from March to October 2023 was used to evaluate BVC sensitivity and specificity, demonstrating a sensitivity of 0.85 and a specificity of 0.83 for predicting any violent behavior within 12 hours, and a sensitivity of 0.91 and a specificity of 0.83 for predicting physical violence (Russell-Babin et al., 2025). Focus group interviews with 28 nurses indicated that the BVC was simple and quick to use, enhanced communication about potentially violent behaviors, and increased awareness during handoffs and unit huddles. It allowed for a proactive approach that incorporated BVC data into practice, ultimately fostering collaboration and coordination with other teams (Russell-Babin et al., 2025).

Conclusions

This literature review on WPV highlighted the high prevalence of WPV, particularly in emergency departments and among specific demographics, such as younger workers and those with irregular work hours (Liu et al., 2019). The qualitative insights underscore the complex dynamics (Brunero et al., 2025) that lead to violence in healthcare environments, emphasizing the need for proactive identification of escalation signs and situational stressors. The detrimental effects of WPV on nurses (Arnetz et al., 2025), including increased work-related exhaustion and cognitive failures, call for intervention strategies to mitigate these incidents. Addressing WPV requires a multifaceted approach, including improved training, support systems, and institutional policies aimed at fostering a safer working environment for healthcare professionals (AANP, 2024; Hendrickson, 2022). Further research is needed to refine prevention strategies and enhance understanding of WPV dynamics across different healthcare contexts (McCamon et al., 2025).

Based on the findings of this literature review, we made the following recommendations to our organization's WPV Committee:

- Integrate the BVC into *Epic* in the acute care and emergency department settings
- Engage super users from the affected units to support the enculturation of the tool
- Use BVC data to accurately capture WPV incidents
- Comparison of total WPV incidents (number of Code Grey activation and restraints usage) to those formally reported by staff to evaluate degree of underreporting and potential underestimation of prevalence

References

References and the Literature Review Table are available upon request from the lead author, Youn Kyeong Cummings, ycumings2@SalinasValleyHealth.com.