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Workplace violence incidence

research brief

Heart of Safety
Coalition

Inspiring transformation for care team safety and wellbeing

An examination of reported workplace violence incidence across care settings

In 2025, the Heart of Safety Coalition published a report about the three pillars of care team safety, which include psychological and emotional safety, dignity and inclusion, and physical safety. More than 400 cross-disciplinary healthcare leaders and bedside team members provided insight on what it means to be safe at work. In the open-ended question where we asked what it means to be safe at work, workplace violence (WPV) and harassment were a concern for 43% of survey respondents. Based on these responses and the increasing incidence of workplace violence in healthcare, we took a closer look at our data to see how frequently respondents reported experiencing WPV, both verbal and physical, from patients, families and visitors (WPV type 2) as well as from colleagues and leaders (WPV type 3).

Incidences of violence by patients or visitors (WPV type 2)

Verbal violence is the most common form of type 2 WPV that healthcare professionals experience. This may come in the form of threats, yelling, identity-based epithets or other forms of abuse and harassment. More than half of respondents said they experience verbal abuse from patients or visitors at least sometimes, and 23% said it occurs often or always. Nursing professionals, hospital-based workers and those working in direct patient care (bedside team members) reported being targets of verbal abuse significantly more frequently than physicians, outpatient counterparts or leaders.

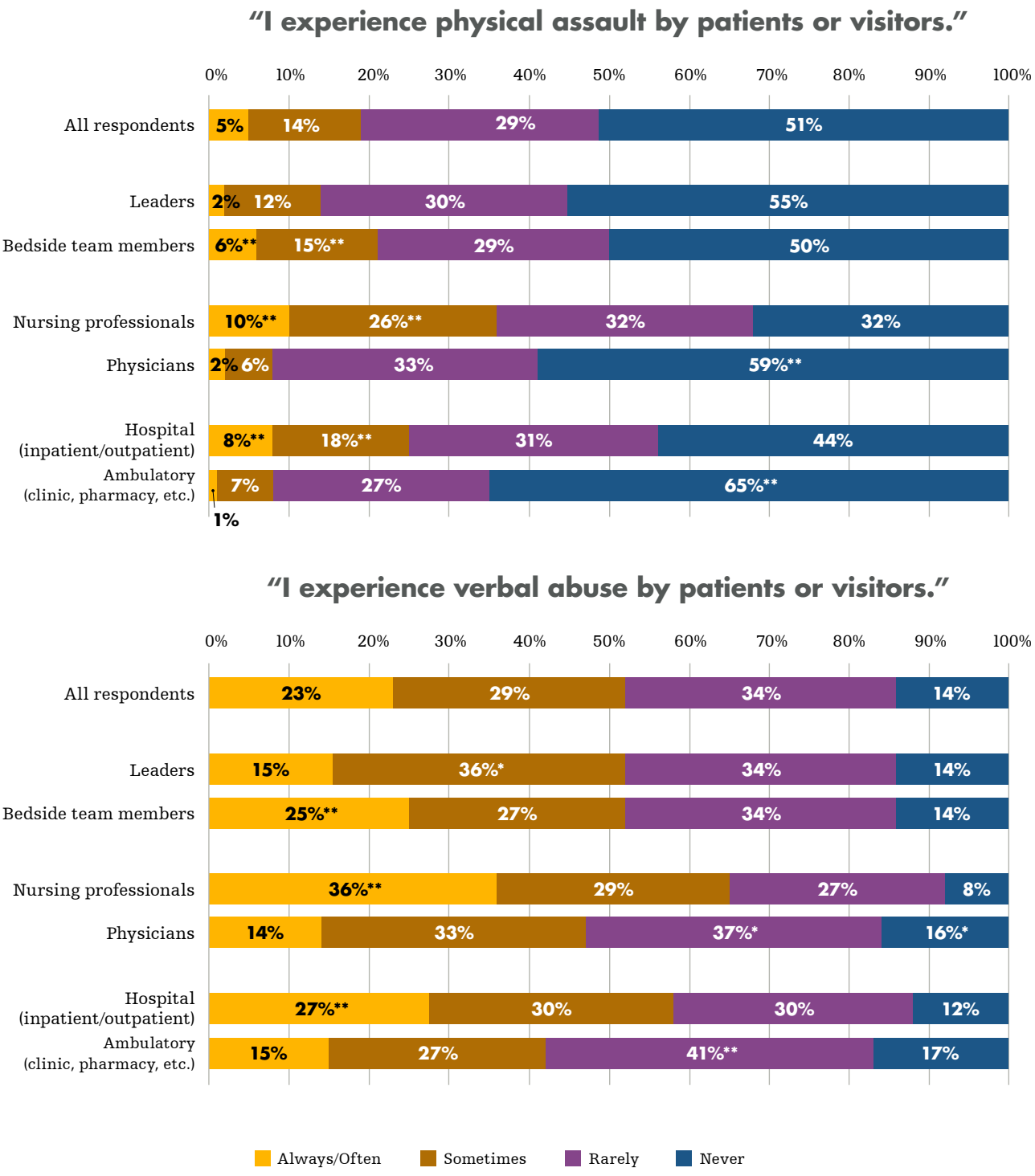
Beyond verbal abuse, almost one in five respondents said they experience physical assault at least sometimes — and one in 20 said it happens often. Healthcare professionals working in inpatient and outpatient hospital settings are three times as likely to say they experience physical violence by patients or visitors at least sometimes compared with their counterparts in outpatient clinics or pharmacies. And nursing professionals across all healthcare settings reported significantly higher likelihood of at least sometimes experiencing physical assault (36%) than physicians (8%) (see Figure 1).

> "We should not be punching bags. Changes should be made."
>
> **Nurse**
> Inpatient hospital, California

> "Need a way to protect our physical safety and ability of the provider to end a visit for any reason no matter what."
>
> **Advanced practice provider**
> Outpatient clinic, North Carolina

> "Physical threats to healthcare workers should be a chargeable offense and patients of sound mind who threaten healthcare workers should be trespassed from the hospital (unless they need emergent life/limb saving care)."
>
> **Nurse**
> Inpatient hospital, Missouri

Figure 1: More than half of respondents reported experiencing physical or verbal violence from patients or visitors at least sometimes.



Base: 407 respondents
105 US healthcare leaders, 302 US bedside team members, 173 nursing professionals, 115 physicians, 263 hospital (inpatient/outpatient), 142 ambulatory (clinic, pharmacy, etc.)
**Difference between respective pairings at 95% confidence interval
*Difference between respective pairings at 90% confidence interval
Totals may not add to 100 due to rounding.

Incidences of violence by colleagues or leaders (WPV type 3)

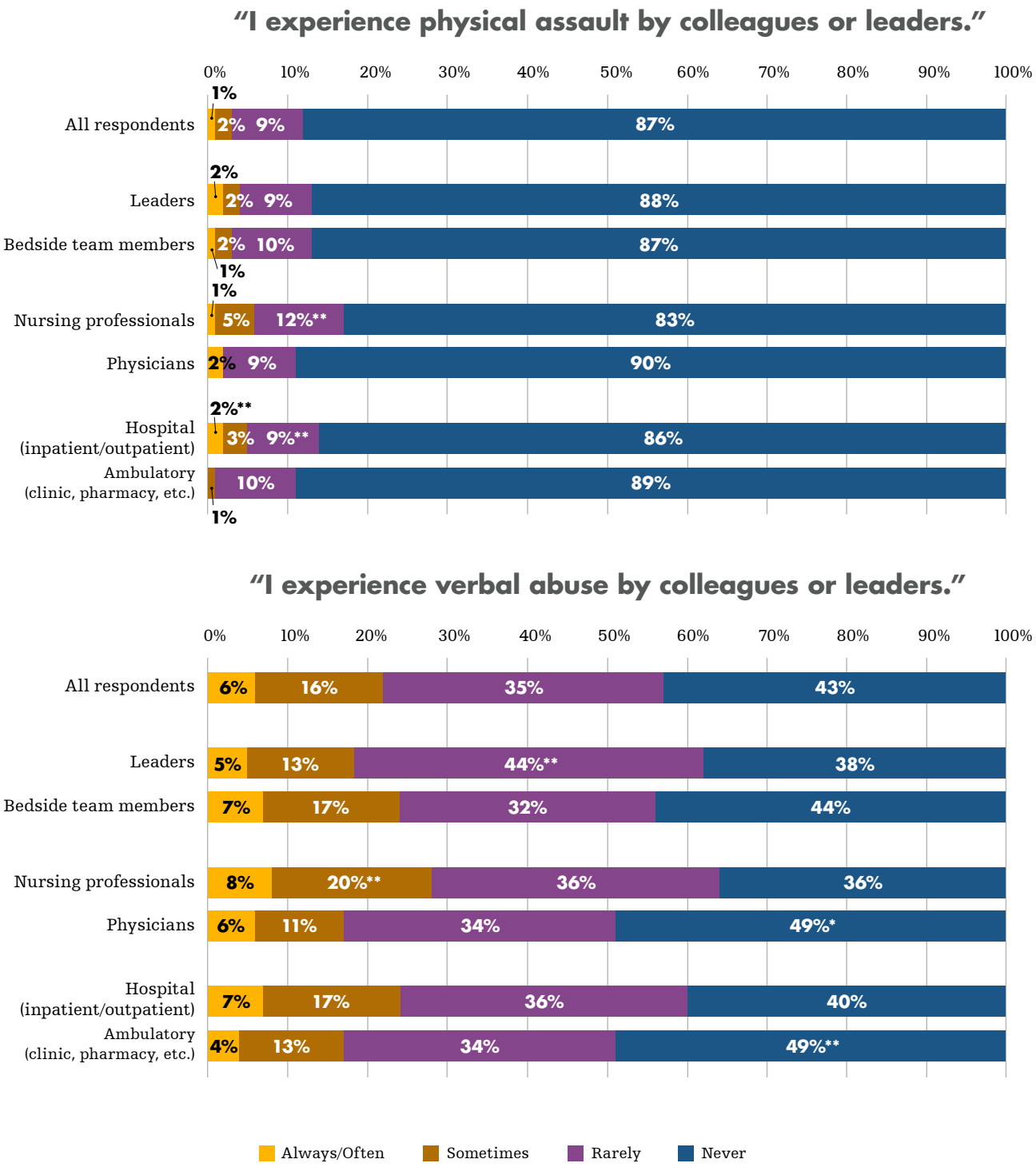
While the frequency of physical violence from colleagues and leaders is quite low, it does occur in some healthcare settings. Three percent of respondents said they experience physical violence from colleagues or leaders at least some of the time. At 7%, nursing professionals were significantly more likely than physicians (2%) to report physical assault from colleagues or leaders at least sometimes, as were those working in hospital settings versus those in outpatient clinics or pharmacies.

The picture is less favorable when we look at the incidence of verbal abuse among co-workers. Six percent of respondents reported verbal abuse from colleagues or leaders always or often, and another 16% reported that it sometimes occurs. Bedside team members, nursing professionals and those working at hospitals were more likely than their respective leadership, physician, and clinic and pharmacy counterparts to experience verbal abuse by colleagues or leaders (see Figure 2).

> "A zero-tolerance approach should be taken by management for patient and co-worker violence against nurses and other staff members. Management should encourage those harmed to press charges against the offender."
>
> **Nurse**
> Inpatient hospital, Oregon

> "Not only do we need adequate resources, but we need support from management to create clear, consistent responses to threats of violence."
>
> **Nurse leader**
> Inpatient hospital, Minnesota

Figure 2: Physical and verbal violence between colleagues or leaders is less common than from patients or families, but it's not as rare as it should be.



Base: 407 respondents
105 US healthcare leaders, 302 US bedside team members, 173 nursing professionals, 115 physicians, 263 hospital (inpatient/outpatient), 142 ambulatory (clinic, pharmacy, etc.)
**Difference between respective pairings at 95% confidence interval
*Difference between respective pairings at 90% confidence interval
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Correlations between type 2 and type 3 WPV incidences

As we evaluated the data, we wanted to know whether respondents' reported incidences of WPV by patients or visitors (type 2) correlated with responses calling out incidences of violence by colleagues or leaders (type 3). To determine if such a correlation existed, we combined the responses to "I experience physical assault" and "I experience verbal abuse" into a single WPV variable for type 2 violence and one for type 3 violence. We then assigned the value as "high" if the response to either question was "always" or "often" and as "low" otherwise (see Figure 3).

> "Physical harm from patients has gone up considerably since Covid."
>
> **Nurse**
> Inpatient hospital, California

Analysis of the resulting two-by-two matrix comparing type 2 and type 3 WPV shows a moderate positive association between the two (Pearson r = 0.21). Specifically, respondents who reported high type 2 WPV were more than four times as likely to also report high type 3 WPV than those reporting low type 2 WPV (relative risk ratio RR = 4.2). Similarly, those who reported high type 3 WPV were about two and a half times as likely to also report high type 2 WPV (RR = 2.7). While the correlation is clear, further research is needed to explore any causal relationships and specific drivers.

Figure 3: Incidence of type 2 and type 3 WPV are positively correlated.

	Type 2 WPV: high	Type 2 WPV: low
Type 3 WPV: high	4%	20%
Type 3 WPV: low	3%	73%

The probability of reporting **high type 3 WPV:**

For those reporting **type 2 WPV:**		
High	17%	RR = 4.2
Low	4%	

The probability of reporting **high type 2 WPV:**

For those reporting **type 3 WPV:**		
High	58%	RR = 2.7
Low	21%	

Pearson r = 0,21 (moderate positive correlation)

Base: 407 respondents
Analysis of responses to questions about frequency of experience of WPV
High = response of often or always to either physical or verbal violence, Low = response of sometimes, rarely or never to either physical or verbal violence
RR = relative risk ratio
Type 2 WPV = verbal or physical violence from patients or visitors, Type 3 WPV = verbal or physical violence from colleagues or leaders

Discussion

Our data findings confirm that bedside team members experience higher rates of violence than leaders, that violence occurs at higher rates in hospital settings where acuity levels are typically more severe than in ambulatory settings, and that nursing professionals, who typically spend more time with patients and visitors, experience higher levels of WPV than physicians and other care team members. More research is needed to understand the many factors associated with the higher levels of WPV and the correlations between incidences of type 2 and type 3 WPV.

Potential interventions for healthcare leaders in both inpatient and outpatient settings to explore include:

- **Publish and enforce system-wide codes of conduct.** One foundation of reducing WPV is setting and communicating clear expectations for patients, visitors and employees about appropriate and acceptable behavior. This strategy includes outlining fair consequences for behavioral violations and acting consistently to enforce standards. As WPV escalates, and as organizations' definitions expand to include incidents of verbal assault and other violent conduct, clear codes of conduct are a critical part of setting shared expectations, communicating consequences and enforcing policies.[1] In our research, team members from all care settings cited patient codes of conduct as essential to safety.[2]

- **Create a culture of respect and dignity.** Trauma-informed and human-centered leadership practices can help prevent WPV by supporting trauma-informed care practices, and by building environments in which team members feel safe to speak up and seek support when WPV incidents occur. This can help victims of violence process the trauma more effectively and build cultures of respect and dignity.[3] And it may also impact retention. Research shows that when organizations have policies and processes in place to help ensure care team members are treated with dignity and respect, physicians' intention to leave following experiences of mistreatment are reduced.[4]

> "Policies against WPV must be enforced each and every time."
>
> **Nursing leader**
> Outpatient hospital, North Dakota

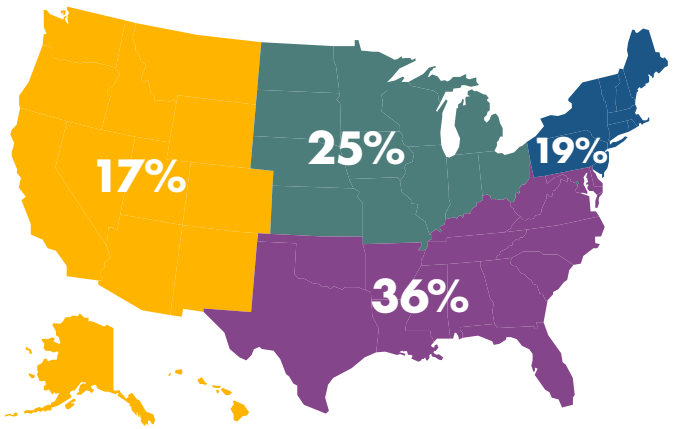
- **Examine proactive prevention and response measures.** The ability to manage tense or potentially volatile situations before they escalate is crucial to protecting both care team and patient safety in every healthcare setting. In the context of a human-centered care culture, de-escalation techniques can help prevent emotional distress and physical confrontations from patients, visitors and colleagues. Leaders should look at expanding de-escalation to all care settings, even outpatient care settings where violence is less prevalent.

About the survey

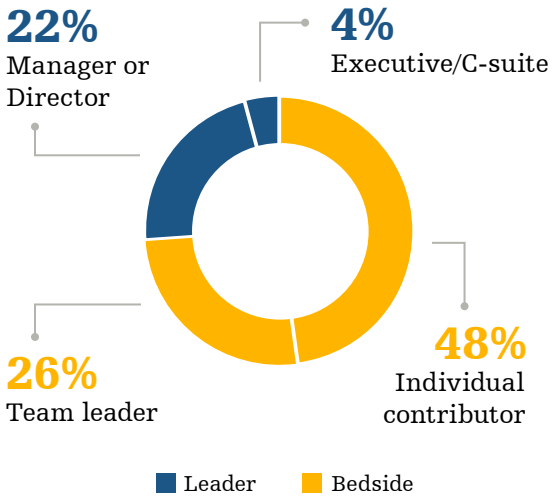
We are grateful to all the healthcare professionals who gave their time to share their perspectives and insights. The survey was fielded in July, August, November and December 2024. The following characteristics are represented in the data set:

407 healthcare respondents

Region



Organizational level



Clinical background

- **45%** **Nursing professional** (RN, LPN, PCT, CNA, etc.)
- **30%** **Physician** (MD, DO, etc.)
- **10%** **Advanced practice provider** (NP, PA, etc.)
- **9%** **Behavioral health** (MD, PsyD, PhD, MSW, etc.)
- **4%** **Pharmacy** (PharmD, BCOP, BCACP, etc.)
- **2%** **Therapist** (PT, OT, RT, etc.)

Demographics

Female	**53%**	Hispanic	**6%**
Male	**44%**	Black, Indigenous or person of color (non-Caucasian)	**10%**
Non-binary/gender not reported	**3%**	Born outside the U.S.	**14%**
LGBTQIA+	**7%**	Identifying as a person with a physical, neurological or psychological disability	**6%**
40+ years of age	**38%**		
Caregiver for an aging parent or loved one	**12%**		

Care settings

- **47%** Inpatient hospital
- **17%** Outpatient hospital
- **35%** Outpatient clinic, pharmacy, etc.

References

1. Heart of Safety Coalition report, Patient codes of conduct
2. Heart of Safety Coalition report, Three pillars of care team safety
3. Blair EW, Allen DE, Delaney KR, et al. Pitfalls and Platforms in Workplace Violence Prevention. *Journal of the American Psychiatric Nurses Association.* 2025;31(5):519-525. doi:10.1177/10783903251320377
4. Rowe SG, Stewart MT, Van Horne S, et al. Mistreatment Experiences, Protective Workplace Systems, and Occupational Distress in Physicians. *JAMA Netw Open.* 2022;5(5):e2210768. doi:10.1001/jamanetworkopen.2022.10768

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About the Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety at the heart of healthcare. This national community of industry leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systemic, team and individual change that improves working and healing environments. The Coalition's three pillars of care team safety advance the Heart of Safety Declaration, which intersects the essential wellbeing principles of dignity and inclusion, physical safety, and psychological and emotional safety. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www.HeartofSafetyCoalition.com.

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