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Assessing and communicating

Type 2 workplace violence risk in healthcare

Research report

Heart of Safety
Coalition

Inspiring transformation for care team safety and wellbeing

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Executive summary

Workplace violence (WPV) continues to rise in healthcare, with both leaders and bedside nurses reporting increased incidences involving patients and visitors. Although a comprehensive WPV prevention and response program requires targeted approaches at the enterprise, facility and department levels, this report focuses on patient-level WPV risk assessment and communication. Findings from our 2026 survey of 202 healthcare leaders and 202 bedside nurses working in U.S. hospitals indicate broad agreement that protecting the safety of care team members requires stronger prevention, risk assessment and risk communication strategies.

In an effort to address and mitigate WPV incidents, many hospitals now use multiple identification and communication methods to alert staff about patients or visitors who are at risk of violent behavior — whether verbally or physically. Some of these methods include risk assessments within a patient's electronic health record (EHR), behavioral alerts distributed via team members' communication devices and visual cues. While these care team safety solutions are widely adopted, there is significant variation in how they are implemented, what information they contain about the patient and risk level, and how effectively they support bedside staff, including nurses.

Respondents to our survey generally believed risk assessments and EHR alerts improve awareness and may reduce violence, but concerns remain about alert fatigue, inconsistent use, bias and unintended impacts on quality of care. Bedside nurses were less confident than leaders in the effectiveness of existing tools implemented within their organizations and reported a need for more training and opportunities to practice WPV mitigation skills.

The findings suggest that healthcare organizations should focus on standardizing risk assessment and communication practices, providing actionable information to staff, regularly reviewing processes for bias and effectiveness, and investing in ongoing training. As WPV continues to increase, improving how organizations identify and communicate risk is an important component of creating safer environments for both healthcare workers and patients.

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Introduction

Workplace violence (WPV) in healthcare settings is a critical and persistent challenge, affecting the safety and wellbeing of healthcare workers across roles and environments.[1] The U.S. Occupational Safety and Health Administration (OSHA) defines WPV as "any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior occurring at a work site."[2] Although WPV tends to be most prevalent in emergency departments and behavioral health units, healthcare professionals in nearly all care settings — from home care to the intensive care unit (ICU) — are at disproportionate risk for verbal abuse, physical assaults and threatening behaviors compared to workers in other industries.[3] And that risk is increasing.[4] These incidents not only compromise individual safety but also disrupt care delivery, contribute to staff burnout, undermine organizational culture and constitute a significant cost.[5]

The complex nature of care environments contributes to the prevalence of WPV. Factors such as high patient acuity, long wait times, staffing shortages and heightened emotional stress among patients and families all create conditions in which violence is more likely to occur.[6] And when dysregulating factors such as mental health conditions, delirium or dementia, or substance use disorders come into play, questions of accountability, and even willingness to report, often arise.[7]

Nevertheless, all healthcare workers deserve to be safe at work. Efforts at the federal-, state- and system-level are increasingly calling for better protections for care team members and greater accountability for patients and visitors who threaten, harass or assault healthcare workers.[8,9] An increasing number of hospitals and health systems are undertaking comprehensive WPV risk assessment and mitigation strategies to try to protect their team members.[10]

While both prevention and response efforts are essential, in this research we looked specifically at strategies to assess the unique risks that may be posed by specific patients or visitors (WPV Type 2 — violence from a person having a reason to interact with a business) in the hospital setting, as well as ways to communicate a heightened risk profile to

> "For some reason in hospitals, WPV is almost accepted. In what other workplace would someone get away with hurting an employee there? Maybe the police should be called more often, and charges actually pressed and followed through on."
>
> **Program or Department Manager**
> Maine

care team members.[11] We surveyed 202 leaders who are directly involved in implementing WPV risk assessment and communication policies within U.S. hospitals, as well as 202 bedside nurses who use these tools. Our survey was fielded from February 5 to April 2, 2026, using a representative national sample from Medscape's survey database. See the About the survey section for more details.

Our goal with this research report is to help hospital and health system leaders across the country identify potential strategies for WPV risk identification and communication that can be deployed to protect care team members' safety and to better understand the level of congruence between how leaders and bedside nurses perceive these efforts.

A note on the data

We asked parallel but sometimes different questions of leader respondents and bedside nurse respondents based on their scope of responsibility. In our analysis, we used three different bases: Leaders only (teal), Nurses only (purple) or all respondents (blue). We used these colors consistently in the graphics to help with data interpretation.

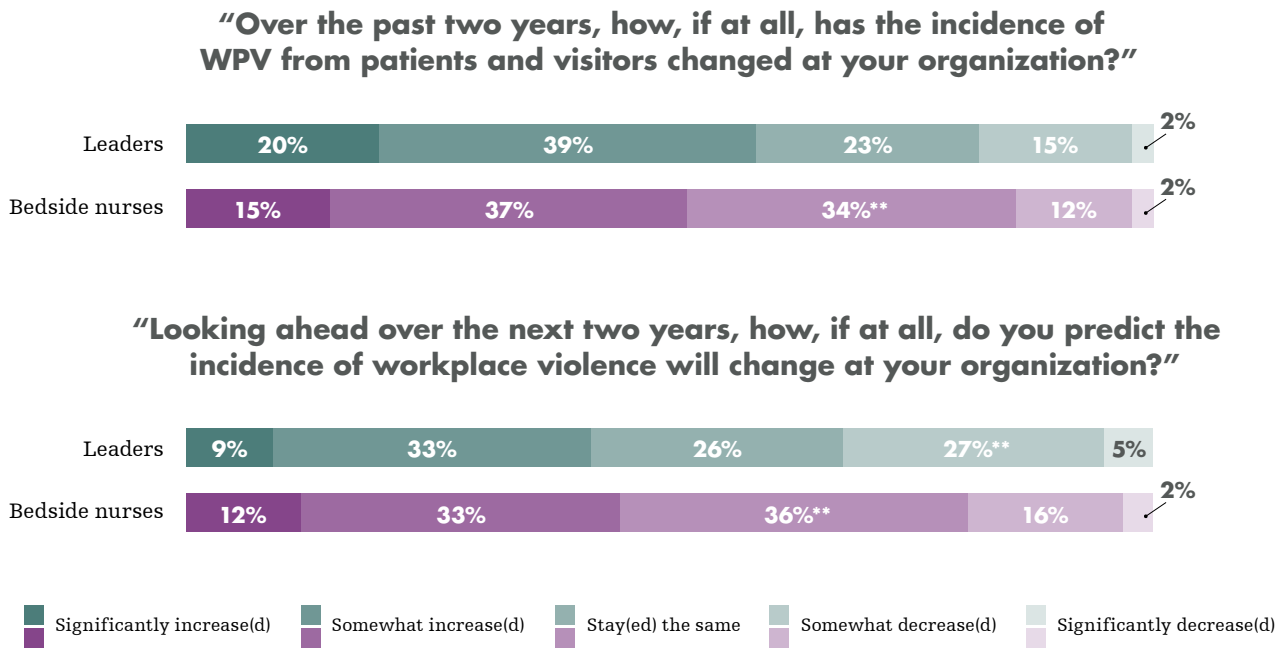
> "I think we should start focusing more on verbal abuse because that's so much more common. I work in a busy ER and the amount of abuse we take is staggering."
>
> **Bedside nurse**
> Florida

> "As a bedside nurse, I am verbally attacked, cussed at, spit at, kicked at, and bossed around daily. This is not referring to cognitively altered patients. This treatment is by alert and oriented patients that do not respect their nurses and are not held accountable by anyone for their actions."
>
> **Bedside nurse**
> Oklahoma

WPV is increasing in hospital settings, as are prevention approaches

To get a baseline of respondents' experience of WPV, we asked both leaders and bedside nurses how the incidence of WPV from patients and visitors has changed over the past two years, and how they expect it will change over the next two years. More than half of each group indicated that WPV has risen either somewhat or significantly. Only a small minority of each group think things have improved. And most don't expect things to improve in the coming years (Figure 1).

Figure 1: Nurses and leaders report an unrelenting rise in WPV



Base: 202 leaders responsible for WPV assessment and communication strategies, and 202 bedside nurses who are familiar with WPV prevention strategies
**Indicates difference between leaders and bedside nurses at 95% confidence interval
(Numbers may not total 100 due to rounding)

> "No matter what we do, WPV seems to happen more and more because no one is held accountable."
>
> **Bedside nurse**
> Texas

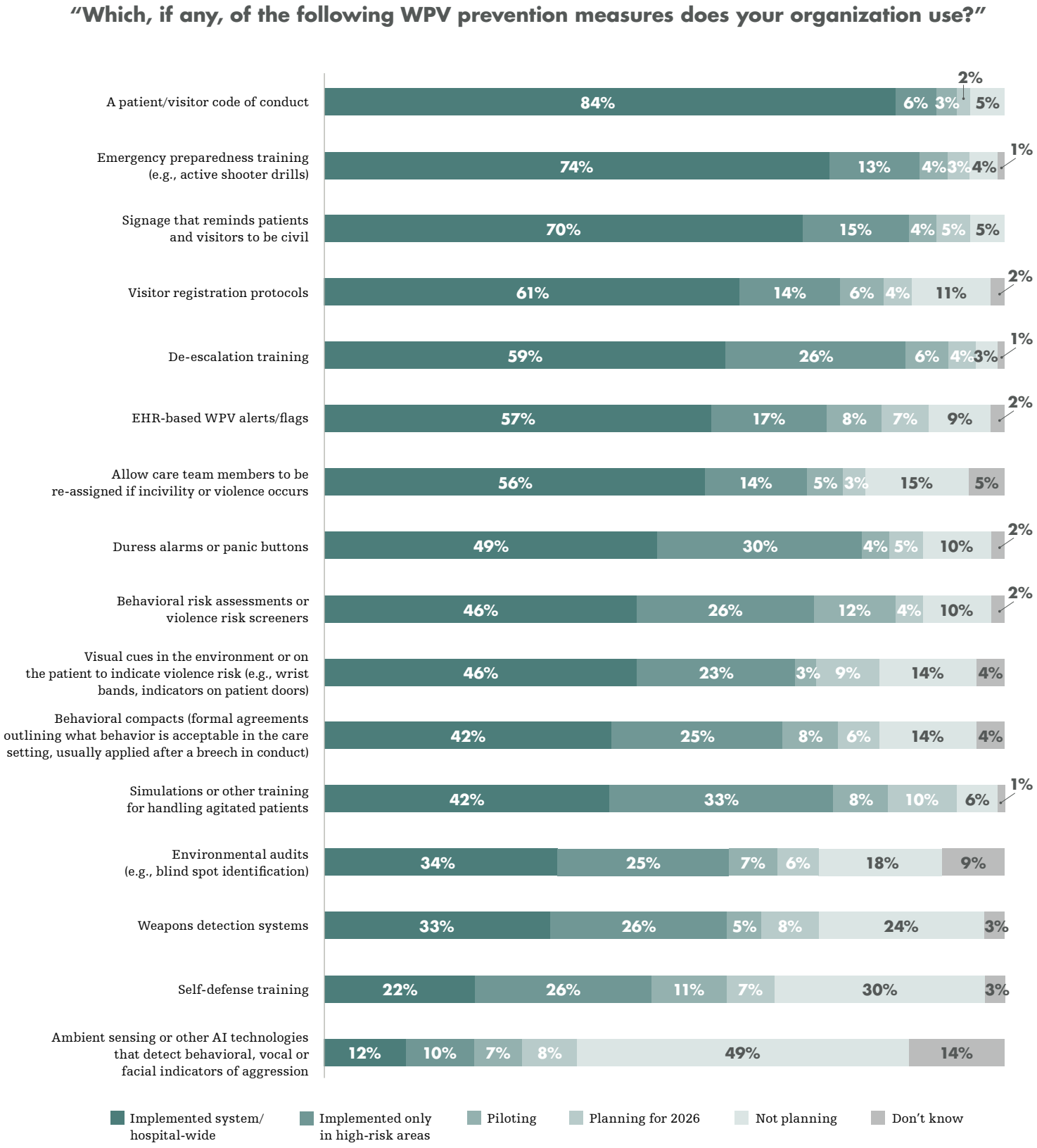
We also asked leaders about which WPV prevention measures their organization employs and how broadly each is implemented. Not surprisingly, patient and visitor codes of conduct and signage requesting civil behavior are among the most broadly implemented solutions, as these are relatively inexpensive to implement compared with broad skills trainings or infrastructure investments. Still, 74% of leaders reported having done hospital- or system-wide emergency preparedness training and 59% have done de-escalation training at the same scale. Simulation training for handling agitated patients and duress alarms are the solutions most frequently limited to only high-risk areas (see Figure 2).

We also wanted to know what respondents believe about the effectiveness of these approaches. We found that leaders were more confident about the impact of every WPV prevention option except for re-assigning care team members when incivility or violence occurs, where they are aligned with bedside nurses. Both leaders and bedside nurses rated duress alarms (wearable communication devices that allow team members to summon help at the push of a button) as the most highly effective solution, though by significantly different degrees. The next most highly rated options are emergency preparedness training, weapons detection systems, de-escalation training, and simulations for handling agitated patients. Despite their relative ubiquity, patient codes of conduct and signage reminding patients and visitors to be civil were among the least likely solutions to be rated as effective, particularly by bedside nurses (see Figure 3).

> "Overall, I think the reporting of violence at my hospital has increased as tools to mitigate have become more available. Previously it was way under reported. My institution has hands-on training, added duress alarms, BERT [behavioral emergency response team] and security response."
>
> **Bedside nurse**
> Hawaii

> "Honestly, what I would like to see is a better assessment tool, weapons screening, better alerts, self-defense training and formal de-escalation training for all bedside staff. It is frustrating to keep having this conversation after over 30 years in nursing practice."
>
> **Clinical Educator**
> Texas

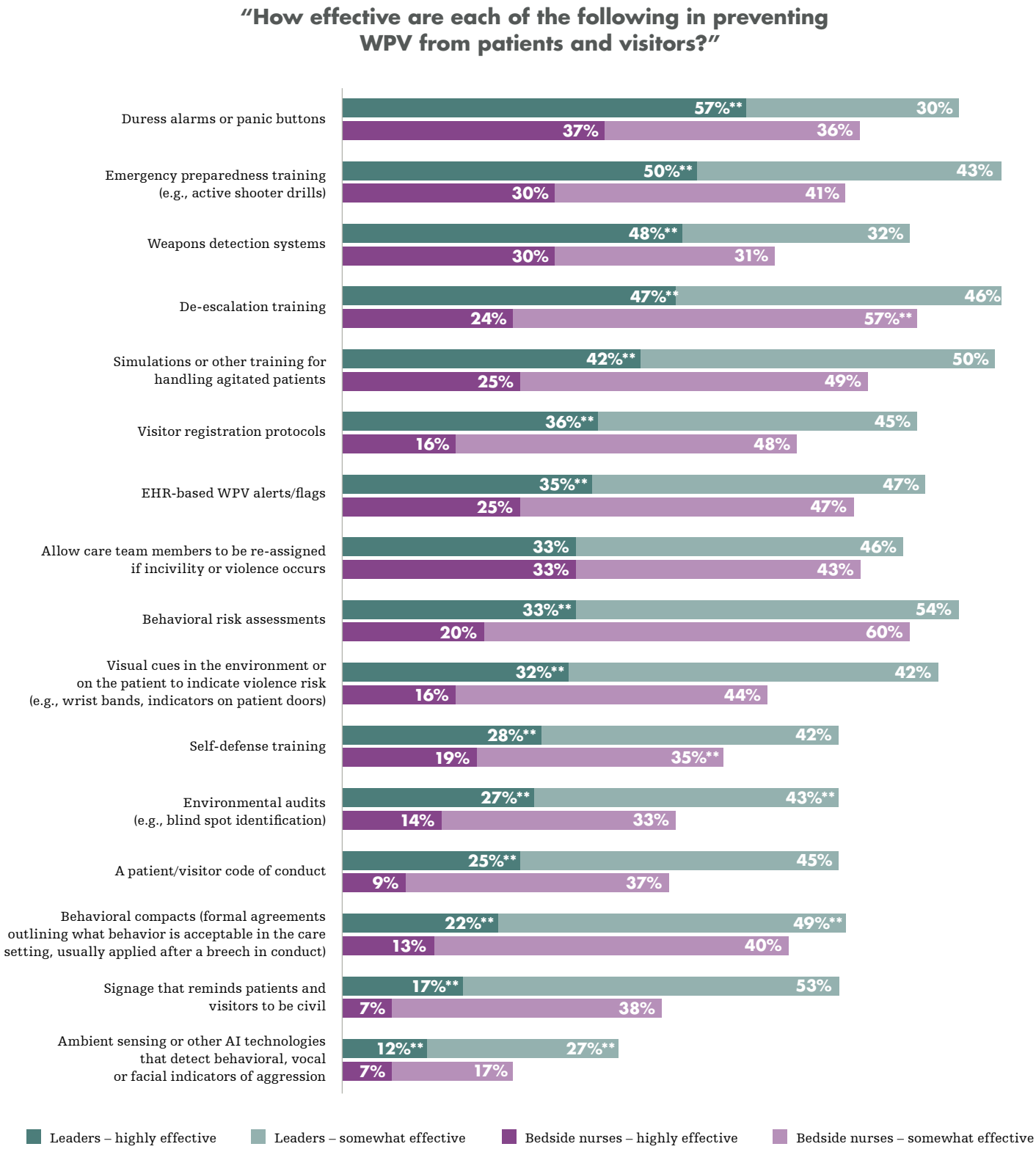
Figure 2: Leaders report using a wide variety of WPV prevention measures



Base: 202 leaders responsible for WPV strategies

(Numbers may not total 100 due to rounding)

Figure 3: Leaders are more confident in the efficacy of most WPV prevention approaches



Base: 202 leaders responsible for WPV strategies; 202 bedside nurses familiar with WPV prevention strategies
** Indicates difference between leaders and bedside nurses at 95% confidence interval
(Numbers may not total 100 due to rounding)

Patient risk assessment and communication approaches vary widely

Although a comprehensive WPV prevention and response program requires targeted approaches at the enterprise, facility and department levels, this report focuses on patient-level WPV risk assessment and communication. More accurate prediction of patient violence and communicating that risk and related mitigation strategies across care teams and care settings has broad implications for care team member safety, as well as patient safety. This is because EHR-documented risks or incidents become part of the medical record that accompanies patients across their continuum of care. When done right, this enables more consistent risk mitigation for care team members and better-informed care strategies for patients.

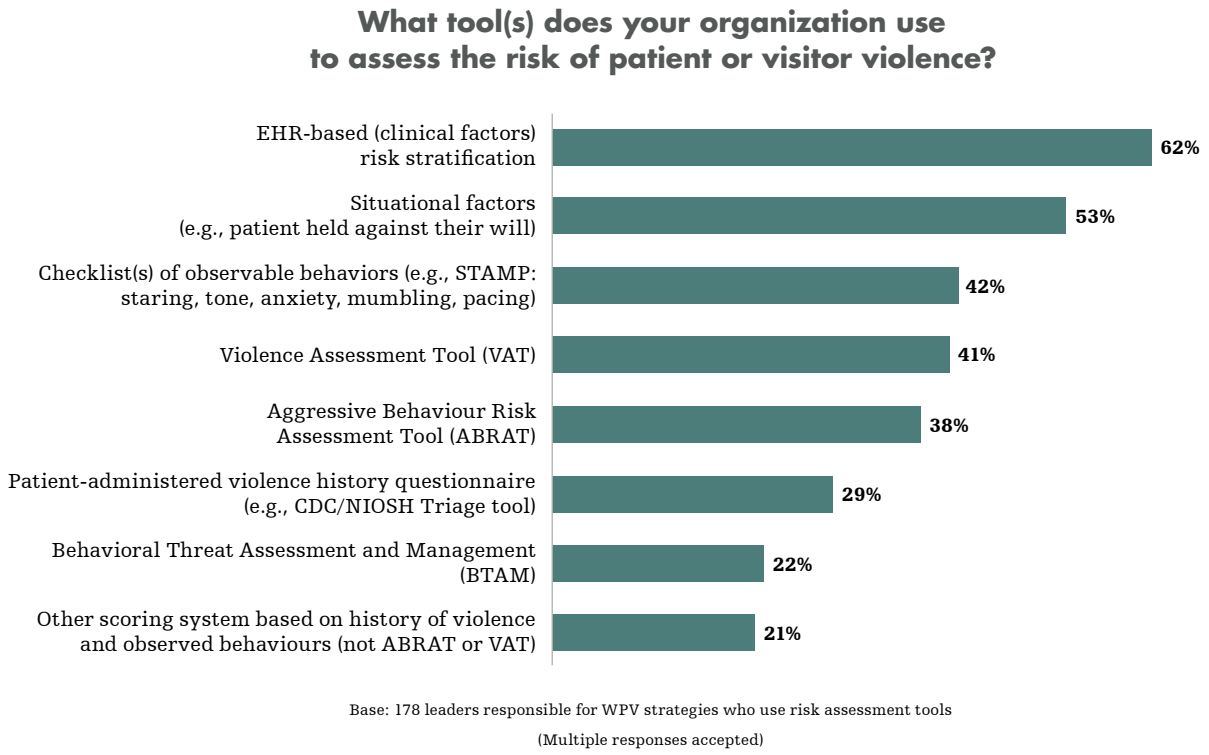
Types of WPV patient risk assessments

The first step in assessing WPV risk for early intervention is identifying the factors that could lead a person to become agitated, dysregulated or angry.[12] For leaders who indicated their organization uses risk assessment tools, we asked which tools they use. At 62%, the most commonly used were EHR-based tools that use clinical factors such as predisposing neurological conditions, history of substance use disorders or use of certain medications for risk stratification. Next were situational factors that might lead to frustration, such as patients being held against their will as a directive from law enforcement, acute intoxication or other safety-related factors. Leaders reported using an average of 3.6 different tools to assess risk of violence by patients or visitors (see Figure 4).

> "It is challenging to use a standardized tool in a hospital setting as behavior can swing from one extreme to another when patients are ill."
>
> **Manager or Director**
> Wisconsin

> "Effective risk assessment must be integrated into a multicomponent prevention strategy rather than used in isolation."
>
> **Manager or Director**
> Illinois

Figure 4: Leaders reported using an average of 3.6 different risk assessment tools



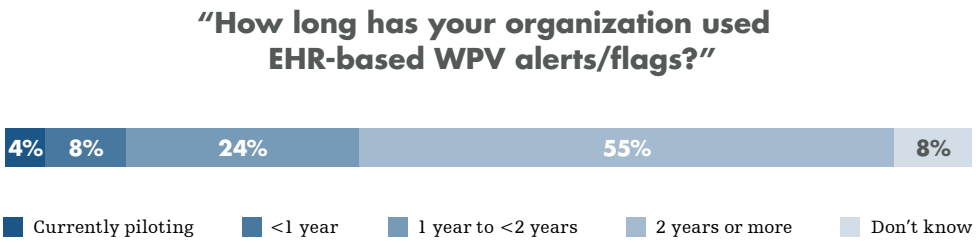
Base: 178 leaders responsible for WPV strategies who use risk assessment tools

(Multiple responses accepted)

Types of WPV communication strategies

Once risk is assessed, the next challenge is communicating heightened risk and risk mitigation approaches to care team members. Our respondents indicated that EHR-based WPV alerts or flags are the most common risk communication tactic. Among those using WPV alerts, the majority have been using them for two years or more (see Figure 5).

Figure 5: Most EHR-based WPV alerts/flags programs are well-established



Base: 180 leaders who have implemented or are piloting EHR-based WPV alerts/flags and 143 bedside nurses using EHR-based WPV alerts/flags

(Multiple responses accepted))

While the use of EHR alerts or flags is well-established, the placement and content of these communications vary. We asked both leaders and bedside nurses about how these alerts appear and got a mix of responses, including pop-ups, persistent banners, icons or symbols and structured fields in the patient's record. No single method stood out, and many respondents reported that multiple types of WPV risk alerts are in use at their hospital or health system (see Figure 6).

The reported descriptions of EHR-based WPV alert contents were also highly variable. Most alerts or flags included the type of risk, past patient behavior and level of risk, but the presence of other details such as triggers and prevention methods dropped sharply. And almost one in ten respondents reported that flags contain no information about specific risk or mitigation measures (see Figure 7).

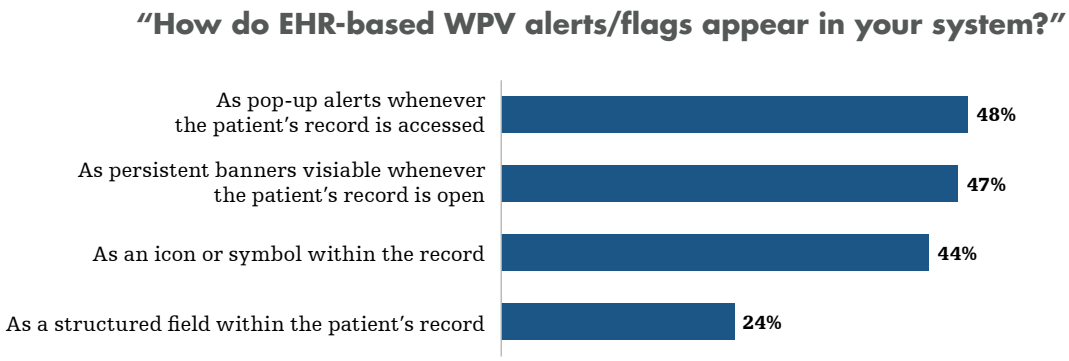
EHRs are not the only way in which hospitals and health systems can communicate a heightened risk of WPV to care team members. Visual cues in the environment or on a person can help ensure that everyone who enters a patient's room or encounters a visitor is aware of an increased need for situational awareness and de-escalation approaches. These are especially important for team members who don't access patients' medical records, including environmental services, food services or transport professionals. About two-thirds of leader respondents reported using visual cues to communicate WPV risk. Among all respondents who use them, signs or indicators outside the patient room or on the patient assignment board were the most common (see Figure 8).

> "I think [a flag] can be helpful if there is specific criteria for when it is applied. It is overused in the hospital where I work so it is almost ignored because so many patients end up flagged."
>
> **Bedside nurse**
> California

> "Alert fatigue for screening and documentation may be an issue."
>
> **Manager or Director**
> Illinois

> "When they become commonplace, they are ignored, just like every BPA [best practice alert] that pops up in the EHR."
>
> **Manager or Director**
> Oregon

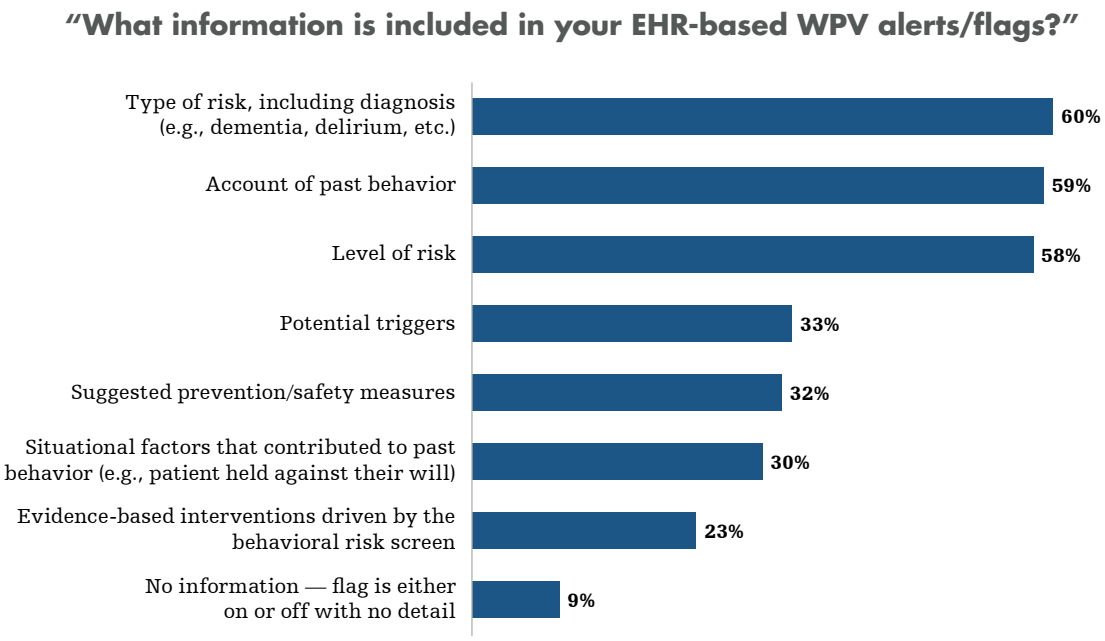
Figure 6: WPV alerts and flags in the EHR lack consistent appearance



Base: 180 leaders who have implemented or are piloting EHR-based WPV alerts/flags and 143 bedside nurses using EHR-based WPV alerts/flags

(Multiple responses accepted)

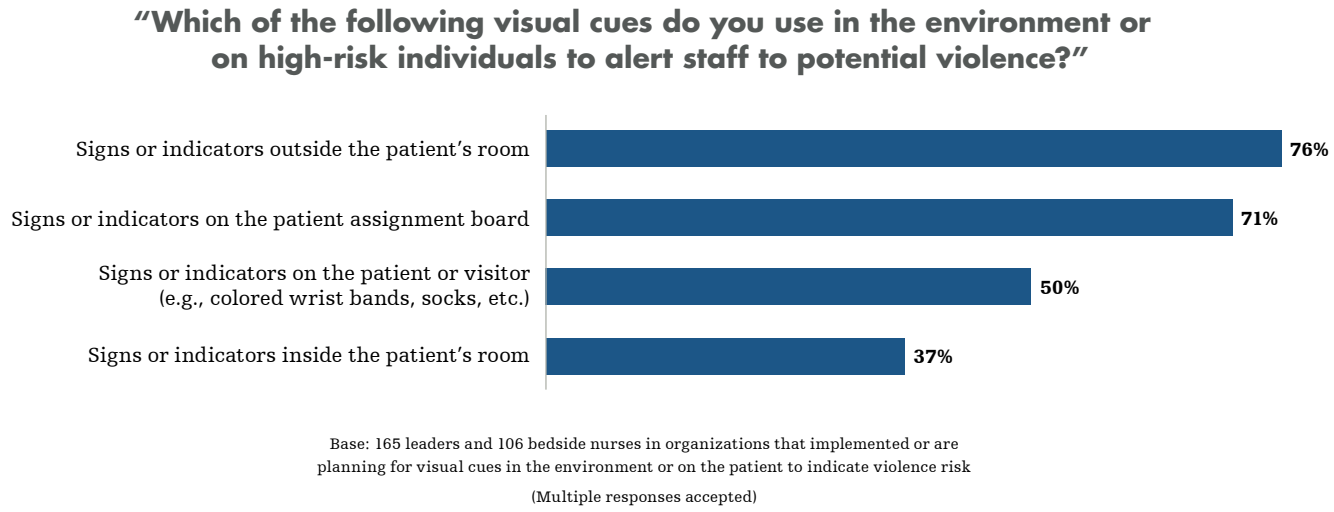
Figure 7: EHR alerts/flags often lack risk details and mitigation measures



Base: 180 leaders who have implemented or are planning to implement EHR-based WPV alerts/flags and 143 bedside nurses using EHR-based WPV alerts/flags

(Multiple responses accepted)

Figure 8: Visual cues indicating WPV risk are most often outside patient rooms or on assignment boards



Base: 165 leaders and 106 bedside nurses in organizations that implemented or are planning for visual cues in the environment or on the patient to indicate violence risk

(Multiple responses accepted)

> "We tend to chart these things after an incident occurs and not before. Bedside nurses on my unit are not always the best at documenting as a preventative measure or a way to inform the care team. Instead, we tend to start documenting behaviors after the person has already gotten out of hand and did not respond to de-escalation techniques."
>
> **Bedside nurse**
> Idaho

> "I like knowing ahead of time that there are potential issues. I am thus prepared to set boundaries, position myself in the room accordingly, etc."
>
> **Bedside nurse**
> Colorado

> "I appreciate knowing if the patient has a history of violent behavior. It allows me to be cautious while still providing care."
>
> **Bedside nurse**
> Ohio

WPV risk assessments and communication require oversight

While WPV risk assessments and EHR flags may sound simple, their value lies largely in the training, processes and controls that surround them. Improperly designed and managed approaches may lead to inappropriate flagging that could impact patient care, or to the inclusion of extraneous details that render the approach useless.

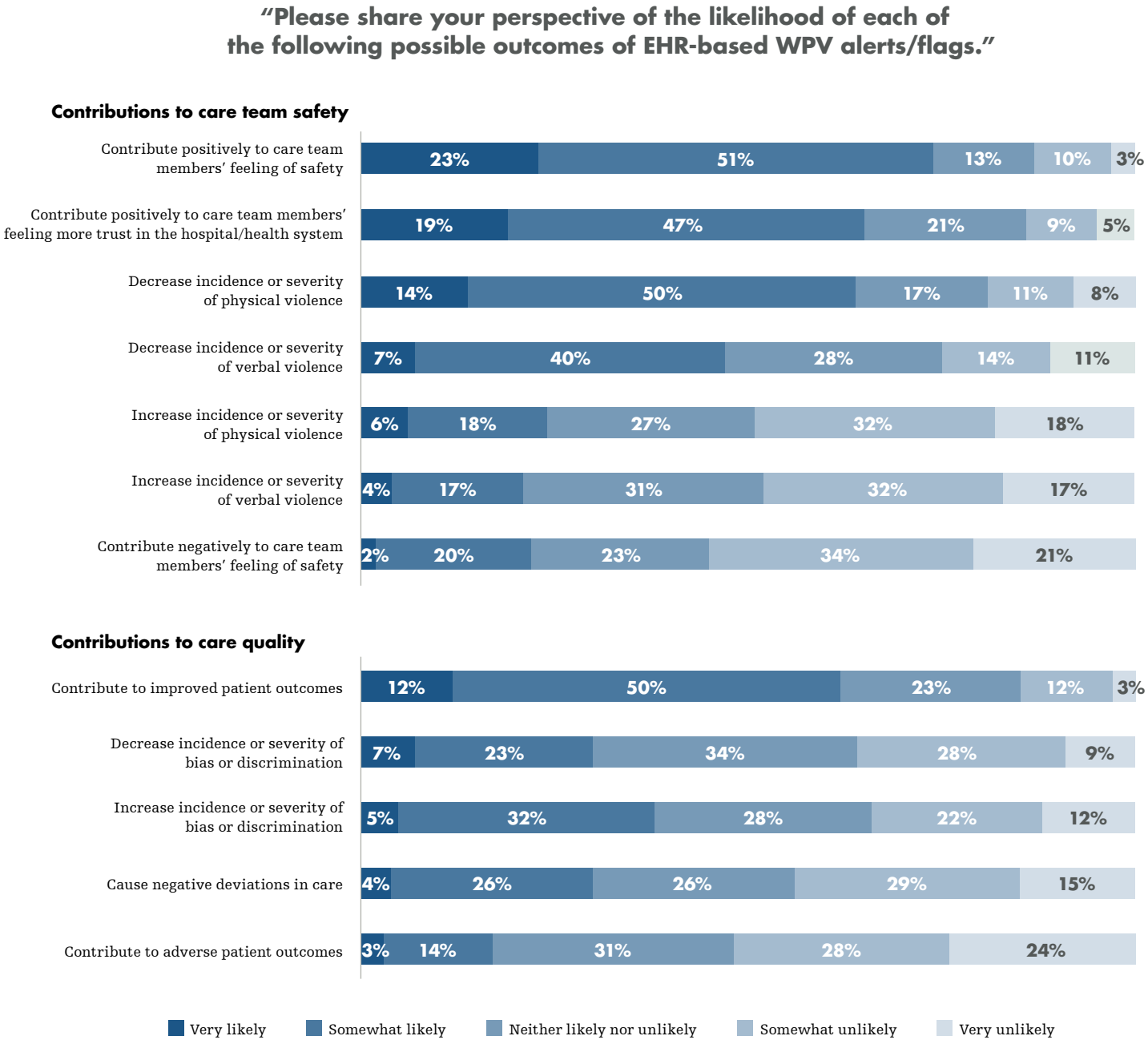
The impact of EHR-based behavioral flags

In addition to asking about the overall perceived efficacy of EHR flags in preventing WPV (see Figure 3), we wanted to understand more specific outcomes. While expectations of positive outcomes were generally higher than negative outcomes in areas of both care team safety and care quality, the results were still somewhat mixed. For example, while 64% of respondents indicated that EHR flags are at least somewhat likely to decrease the incidence or severity of physical violence, 24% said flags are likely to increase the incidence or severity of physical violence. And 47% said EHR flags are at least somewhat likely to decrease the incidence or severity of verbal violence, while 21% said flags are likely to increase the incidence or severity of this type of violence. While this may seem counter-intuitive, it is possible that the presence of a flag could cause care team members to inadvertently treat people in a way that escalates their agitation, or patients could get angry if they learn of the existence of a flag in their record (see Figure 9).

Delving in more deeply, we asked leaders if they had evidence showing how EHR-based WPV alerts or flags impacted care team safety and patient care. Slightly more than half reported having evidence for higher perceived levels of safety for care team members as a result of alerts or flags, and almost half reported having evidence that flags help reduce the incidence or severity of physical violence. But the reported evidence base dropped off quickly from there, suggesting a need to capture outcomes data more systematically (see

> “Communicating across shifts during report that a patient or family member is aggressive, abusive, manipulative, or violent has been very helpful. Sometimes we don’t go into the rooms alone in that case.”
>
> **Bedside nurse**
> California

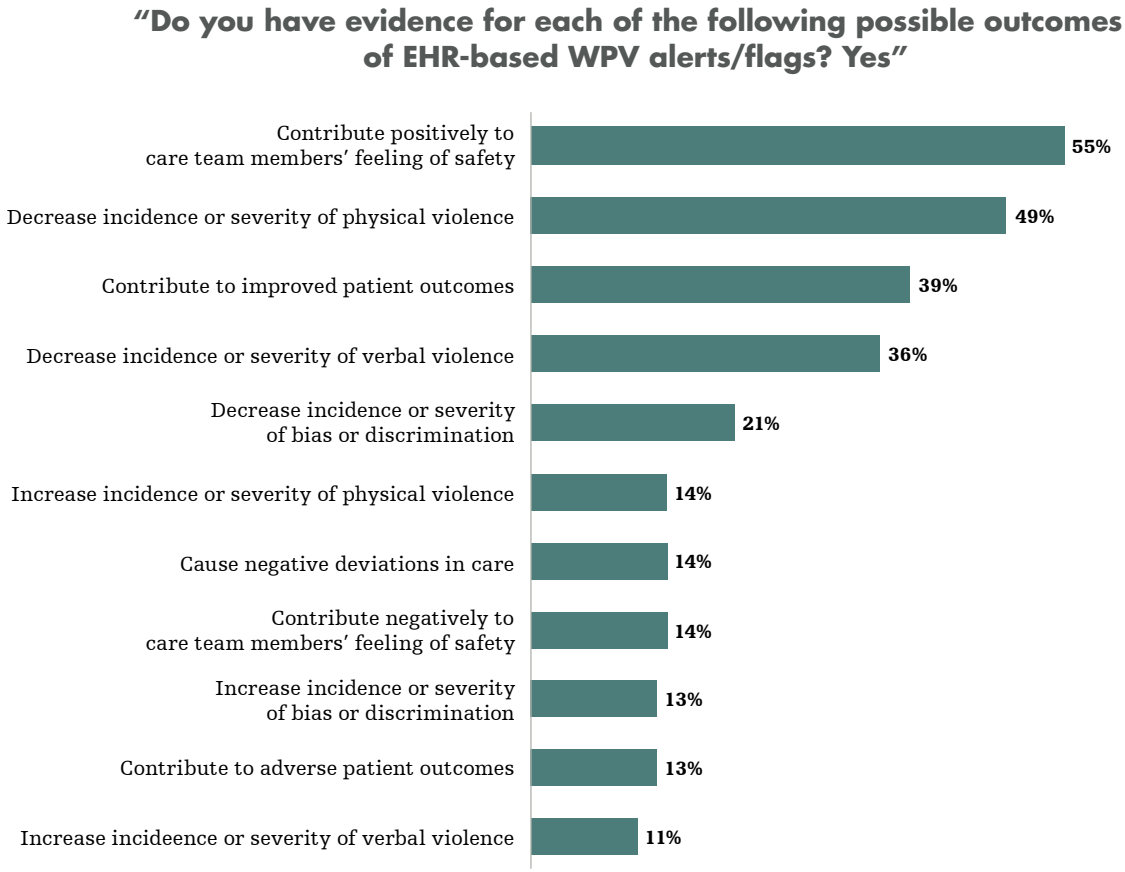
Figure 9: EHR alerts/flags can make a positive impact on care team safety and patient care



Base: 180 leaders who have implemented or are planning to implement EHR-based WPV alerts/flags and 143 bedside nurses using EHR-based WPV alerts/flags

(Numbers may not total 100 due to rounding)

Figure 10: EHR flags have positive and negative potential for WPV risk and patient care



Base: 180 leaders who have implemented or are planning to implement EHR-based WPV alerts/flags
Response options: Yes, No, Don't know. Only Yes responses reported.

> "Knowing how to prevent, identify and navigate the difficulties of workplace violence are critical skills for supervisors to create a safer work environment."
>
> **Manager or Director**
> Massachusetts

Figure 10).

The importance of fair and balanced risk assessment and communication

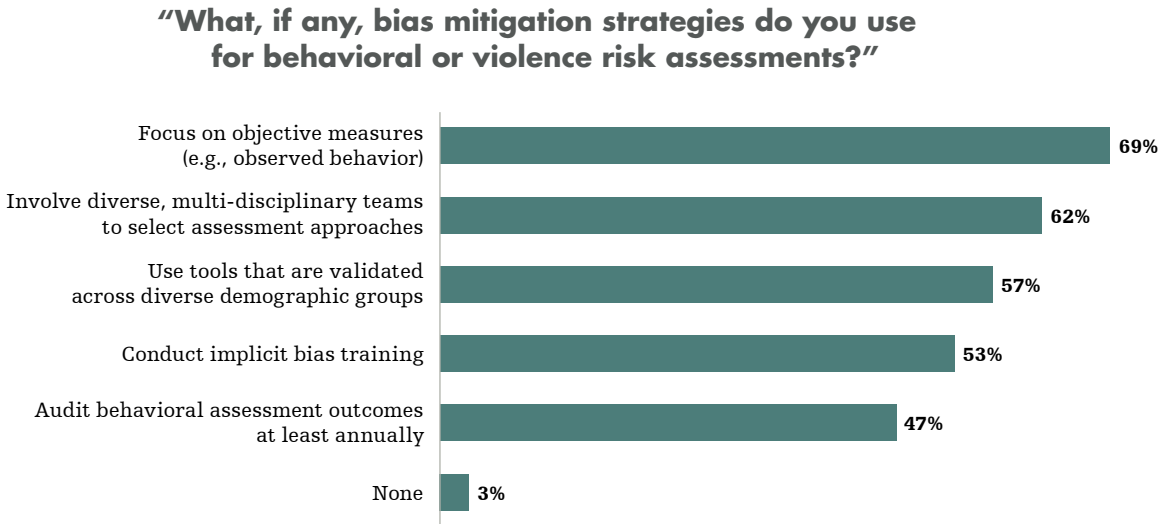
One concern with risk assessments is the potential for assessor bias to influence the results.[13] We asked leaders what, if any, bias mitigation strategies they employ for violence risk assessment. All but 3% of respondents reported using at least some kind of approach to reduce the likelihood of bias. The most common approach was focusing on objective measures such as observed behaviors (69%). Interestingly, fewer than half of respondents audit their assessment outcomes at least annually to verify whether any bias can be observed in practice (see Figure 11). This may result in a missed opportunity to reduce or eliminate systemic factors that may increase violence risk, such as availability of interpreters, the need for standing order sets for certain patient groups, or cultural sensitivity training for clinicians.

Similar to risk assessments, the most common strategy reported to reduce bias and help ensure the fairness of EHR flags is the application of standardized criteria for deciding whether to add a behavioral alert (69%). Less common approaches included implicit bias training (42%), requiring a formal incident report before a flag is applied (40%), diverse, multi-disciplinary teams reviewing flags before they are used (38%), or auditing flags

> "All patients need to be treated equally when demonstrating violence or aggression, regardless of immutable characteristics."
>
> **Program Manager or Director**
> New Hampshire

> "[EHR alerts] are a tool — not a very precise or highly effective tool. However, our priority is the safety of our team — both perceived and actual. While bias is possible and we need to mitigate that, it is a far lower priority compared to keeping our staff safe."
>
> **Senior Executive**
> Virginia

Figure 11: Leaders proactively work to limit bias in risk assessments



Base: 178 leaders responsible for WPV strategies who use or are planning to use risk assessment tools

(Multiple responses accepted)

Figure 12: Only a third of leaders report auditing alerts/flags for bias at least annually



Base: 180 leaders who have implemented or are planning to implement EHR-based WPV alerts/flags and 143 bedside nurses using EHR-based WPV alerts/flags

(Multiple responses accepted)

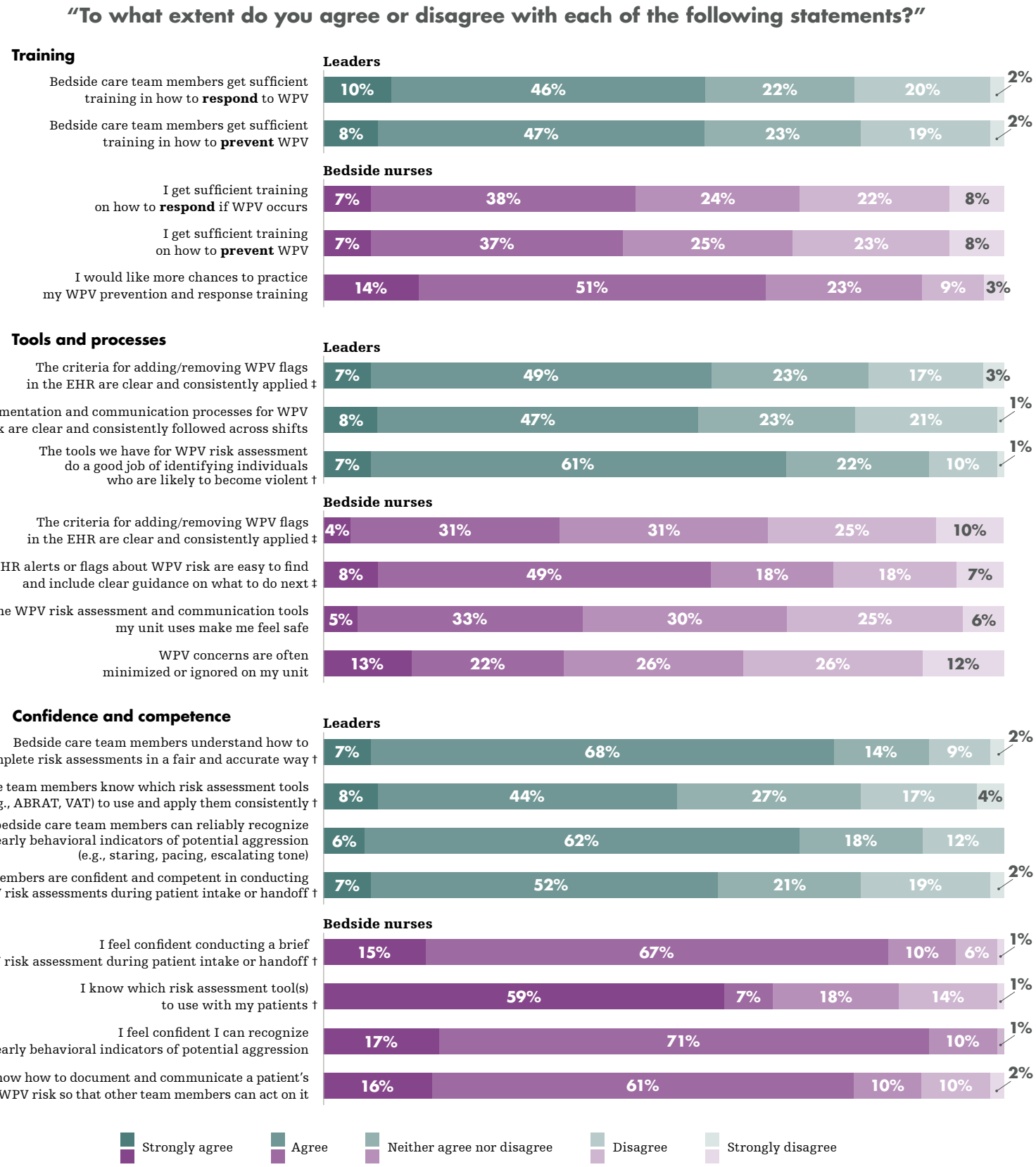
after they have been applied (23%) (see Figure 12).

Levels of training and preparation to prevent and respond to WPV

To understand how prepared leaders and bedside nurses are to respond to WPV, we asked specific questions about the need for and availability of training, tools, processes and skills related to prevent and respond to WPV. Fewer than half of leaders and ws believe that nurses and other care team members get sufficient training to prevent or respond to WPV. In addition, almost two-thirds of nurses said they would like more opportunities to practice WPV-related skills they learn. Bedside nurses were generally less positive about the tools and processes designed to identify and flag patients who are at risk of being violent, and more than a third of nurses said WPV concerns are generally ignored on their unit. The majority of both leaders and bedside nurses somewhat or strongly agreed with statements about the competence and confidence of nurses and other bedside team members in using tools for WPV risk assessment and communication and in recognizing behaviors that might lead to WPV. However, fewer than 20% of nurses and 10% of leaders said they strongly agreed with these statements (see Figure 13).

> “There is inconsistent use of the EHR flags — some nursing leaders have verbally suggested they are in support, but at the same time have discouraged bedside nurses from escalating to a formal request because in my system the flag remains in the patient chart indefinitely, as far as we have been told. They appear to not want to create a situation where a flag was created “on their watch,” so to speak, that may be noted by a patient or that cannot ever be modified or removed in the future. The policies and procedures around these flags are poorly understood, and we do not receive formal training, as bedside nurses, for how they are implemented and how to determine what information is included in the notes.”
>
> **Bedside nurse**
> California

Figure 13: Leaders are more confident in the efficacy of most WPV prevention approaches



Base: 202 leaders responsible for WPV strategies or 202 bedside nurses familiar with WPV prevention strategies
† 178 leaders or 162 bedside nurses in organizations using behavioral risk assessments or violence risk screeners
‡ 180 leaders or 143 bedside nurses in organizations using EHR-based WPV alerts/flags

(Numbers may not total 100 due to rounding)

Discussion

In our 2025 research on The three pillars of care team safety (psychological/emotional safety, dignity and inclusion, and physical safety), 43% of unaided responses by 407 healthcare leaders and bedside team members included references to WPV when asked "In your opinion, what does it mean for healthcare team members to be safe at work?" Additionally, more than half of respondents cited "flags in the EHR to signal a patient's propensity for violence" as an essential aspect of team members' physical safety from WPV.

Behavioral risk assessments, EHR flags and other WPV risk communication approaches are part of a broader WPV prevention and response strategy.[14] While by themselves these tactics do not prevent WPV, they can help improve care team members' awareness of potential risks and empower them to be ready to take action if an incident occurs. Like previous studies, our research confirms that there is a high degree of variability in how assessments and EHR-based WPV risk alerts are applied in different care settings.[15,16]

While implementing WPV risk assessment and communication tools may seem relatively straightforward, they require a thoughtful approach.

Risk assessment

It is beyond the scope of this research to evaluate the different tools available for WPV risk assessment. However, it is worth noting that the Aggressive Behavior Risk Assessment Tool (ABRAT) was originally validated for acceptable inter-rater reliability, sensitivity and specificity in med-surg settings in 2012 and has since been validated in electronic format for additional non-psychiatric in-patient care settings,[17] emergency departments,[18] emergency medical services[19] and long-term care environments.[20]

In addition to patient-specific risk assessment, there is increasing evidence that factors such as length of stay, whether a patient is held against their will and other environmental concerns contribute to WPV.[21,22] Some of these data can be factored into risk assessments and should be collected systematically to assess a heightened environmental risk that may amplify individual risk factors.

> "The visitors are the issue most often not the patients, which makes some of the tools worthless because they are patient based."
>
> **Bedside nurse**
> Ohio

It is also worth noting that formal risk assessments are typically administered on patients, and not on visitors. In our literature review we found very few references to documenting family or visitor risk factors, apart from some references to behavioral compacts. Some risk awareness approaches, such as STAMP (staring, tone, anxiety, mumbling, pacing) apply equally to anyone in the environment, so it may be worth including both formal risk assessment and more general behavior awareness approaches in training programs, as well as aligning work pertaining to behavioral compacts with EHR-based risk documentation strategies.

Risk communication

While there is no national standard for what goes into EHR-based WPV behavioral flags, there are some emerging best practices. In our research, almost one in 10 respondents reported that flags contain no information beyond the heightened risk of WPV. EHR flags should include a concise summary of the safety concern (threat of what, towards whom, in what conditions) and specific mitigation steps, not just vague indicators such as "violent", "aggressive" or "behavioral problem".[23] The focus of flag contents should be the essential information that care team members need to know at the very start of an encounter to enhance safety.

Also, if WPV flags are applied too broadly, they risk contributing to alert fatigue, which may cause them — or other clinical risk flags — to be ignored.[24] This underscores the need to have a thoughtful process to review EHR-based alerts and flags, as well as a process to remove them if a WPV risk is determined to have been sufficiently reduced or eliminated. Regardless of the behind-the-scenes flag review process, the initial process should be as simple as possible for bedside nurses to avoid contributing to burnout.[25]

> "[EHR flags] are helpful in alerting staff and providing interventions that can mitigate WPV, but I feel they need to be more standardized, so they always include pertinent information, not just some information without interventions."
>
> **Bedside nurse**
> Illinois

Finally, early evidence suggests that persistent visual cues in the environment, such as signage, can remind clinical and non-clinical team members to pay extra attention to personal safety measures.[26]

Training and policy

More than 30% of bedside nurses in our respondent group strongly disagreed or somewhat disagreed that they get sufficient training in how to prevent or respond to WPV, and almost two-thirds strongly agreed or somewhat agreed that they would like more chances to practice the skills they do learn. Creating and implementing an approach to WPV risk communication

that ensures care team members are adequately protected, patients and visitors are held appropriately accountable, and care is not compromised requires extensive training of both leaders and bedside care team members.[27]

Evidence suggests, and our survey confirms, that creating appropriate training and policies around risk assessment and communication is essential to protect patient dignity and maintain care quality. Subjective assessments and unbalanced communication may exacerbate disparities for vulnerable patient groups unless training and policies account for unconscious bias and other perceptual inaccuracies.[28]

Positioning risk assessment and communication within a broader behavioral threat and management (BTAM) program can ensure appropriate ethics and governance for alerts. Creating or engaging a WPV prevention and response committee to select tools, define processes, educate staff and audit the intended and unintended consequences of using risk assessments and EHR-based alerts is likely necessary to make programs effective.

> "I think that flags get put into patient charts without the ability to remove them, causing staff to fear patients and not provide them with the care they need and deserve. Patients may act out during illness with delirium, and this is a sentence that never gets removed from the documentation."
>
> **Nurse Manager or Director**
> Wisconsin

> "The population we serve at my institution are at high risk for WPV behaviors. It is essential to include trauma informed care when caring for these patients."
>
> **Bedside nurse**
> Oregon

> "I think increasing staff numbers, so we can take more time listening and involving patients and family members will go a long way in mitigating the helpless anger we are seeing."
>
> **Bedside nurse**
> Washington

In conclusion

WPV in hospitals and other healthcare settings is not part of the job. The risks that arise from verbal and physical violence, aggression and threatening behavior by patients and visitors deserve the same level of attention and rigor as any other safety hazard. Every care team member has the right to work in an environment where their emotional, psychological and physical safety are protected, where their dignity is respected, and their concerns are taken seriously. Ideally, they work in an environment where preventable WPV risks are identified and mitigated before they occur.

Every act of violence that is prevented represents more than a safety success. It protects a healthcare worker's dignity and wellbeing, preserves human connections and relationships, and supports the delivery of compassionate care. As healthcare organizations continue to confront the growing challenge of WPV, investing in stronger risk assessment and communication processes is not simply an operational improvement, it is a commitment to improving the safety and wellbeing of every care team member.

> "We need to do better. The violence is awful."
>
> **Bedside nurse**
> California

> "Everyone, no matter how entitled or angry they may be, has to be made aware that they cannot act in any way other than respectfully."
>
> **Bedside nurse**
> Massachusetts

Resources

There are publicly available resources related to WPV risk assessment and communication, as well as overall WPV prevention. While the Heart of Safety Coalition does not endorse or contribute to these resources, they may prove useful to leaders creating policies related to WPV prevention.

Resource	Content overview
U.S. Veterans Administration VHA Directive 1166	• Criteria for behavioral patient record flags (BPRFs) • Requirements for entering a BPRF • Process for reviewing BPRFs • Ownership and transfer of BPRFs • Inactivation of BPRFs • Patients requesting amendments to BPRFs
Public Services Health Administration Canada Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventative Care	• Flagging overview • Balancing worker safety with patient privacy • Steps for developing a flagging program • Sample flagging policies • Symbols and signage
American Nurse Journal Flagged and at risk	• Algorithm to remove inappropriate behavioral flags
American Hospital Association Implementing Behavioral Threat Assessment and Management (BTAM)	• Defining targeted violence in healthcare settings • What is BTAM? • Establishing BTAM teams and partners • Training and educating the workforce about BTAM • Case studies
U.S. Centers for Disease Control and Prevention | National Institute for Occupational Safety and Health Online Workplace Violence Prevention Course for Nurses Note: not specific to patient-specific risk identification or communication	• WPV definition, types, and prevalence • WPV consequences • Risk factors for WPV • Prevention strategies for organizations • Prevention strategies for nurses • Includes links to triage tools, STAMP explanation and danger assessment tool • Post event response
U.S. Occupational Health and Safety Administration Guidelines for Preventing Workplace Violence for Health Care and Social Services Workers Note: not specific to patient-specific risk identification or communication	• Overview and guidelines • Impact of WPV • Violence prevention programs • WPV prevention checklists

About the survey

We are grateful to all the healthcare professionals who shared their perspectives and insights. Special thanks to Jennifer Peltzer-Jones, PsyD, for her contributions to the creation of this survey.

The survey was fielded using Medscape's survey panel in from February 5 to April 2, 2026. Respondents were screened for their experience assessing patient-specific WPV risk, communicating that risk to care team members or setting policy with regard to risk assessment and communication. Overall incidence was 45%. Response rate was 11%.

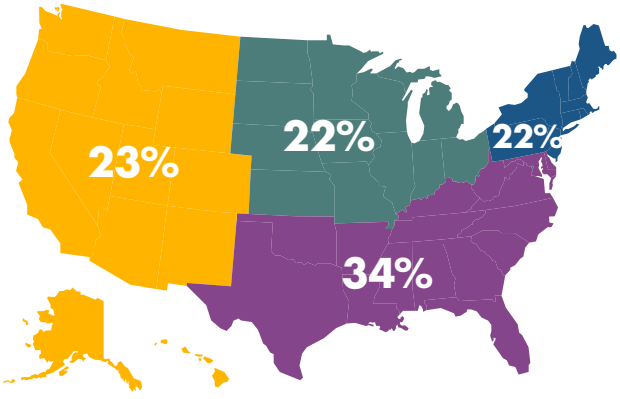
We used three different bases for the analysis:

- For questions unique to the experience of bedside nurses, we narrowed to only respondents who identified as bedside nurses who interact with WPV tools, policies or processes.
- For questions unique to the experience of leaders, and for questions for which leaders would have the broadest purview, we used respondents who identified as leaders responsible for WPV tools, policies or processes.
- For questions where the combined perspectives of leaders and bedside nurses is relevant, we used the whole data set.

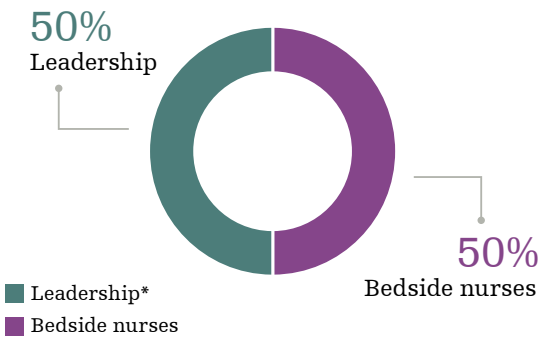
The following characteristics are represented in the data set:

404 healthcare respondents

Region



Organizational level



* Includes Executives, Program Directors or Managers and Managers or Supervisors of bedside staff

All respondents work primarily in hospital-based settings

Hospital/system size



57% >350 beds



33% 100 to 350 beds



10% <100 beds

References

1. U.S. Bureau of Labor Statistics. Workplace violence in healthcare, 2018. Updated April 2020. Accessed September 14, 2026. https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm
2. U.S. Department of Labor, Occupational Safety and Health Administration. Workplace violence. Accessed September 14, 2026. https://www.osha.gov/healthcare/workplace-violence
3. U.S. Bureau of Labor Statistics. Annualized incidence rate of DART cases per 10,000 full-time workers due to intentional injury by other person, by selected industry sectors, private industry, All U.S., 2021-2022. Published October 7, 2024. Accessed September 14, 2026. https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022-chart1-data.htm
4. Lombardi B, Jensen T, Galloway E, Fraher E. Trends in workplace violence for health care occupations and facilities over the last 10 years. *Health Aff Sch.* 2024;2(12):qxae134. doi.org
5. American Hospital Association. A comprehensive assessment of financial costs and other impacts of workplace and community violence. Published June 2, 2025. Accessed September 14, 2026. https://www.aha.org/costsofviolence
6. Lim MC, Jeffree MS, Saupin SS, Giloi N, Lukman KA. Workplace violence in healthcare settings: the risk factors, implications and collaborative preventive measures. *Ann Med Surg (Lond).* 2022;78:103727. doi.org
7. Abreu AR, Gonçalves F, Oliveira S, Ribeiro I. Workplace violence against healthcare workers: a scoping review of reporting practices, barriers to reporting and institutional responses (2020–2025). *BMC Health Serv Res.* 2026;26:419. https://doi.org/10.1186/s12913-026-14244-4
8. Lombardi B, Tapen C, Fraher E. State laws that address workplace violence in health care settings. *Health Aff Sch.* 2026;4(2):qxag022. doi.org
9. Arnetz JE. The Joint Commission's new and revised workplace violence prevention standards for hospitals: a major step forward toward improved quality and safety. *Jt Comm J Qual Patient Saf.* 2022;48(4):241-245. doi.org
10. U.S. Department of Labor, Occupational Safety and Health Administration. Workplace violence. Accessed September 14, 2026. https://www.osha.gov/healthcare/workplace-violence
11. Boehm, L. An examination of reported workplace violence incidence across care settings. Heart of Safety Coalition. 2026.
12. O'Brien CJ, van Zundert AAJ, Barach PR. The growing burden of workplace violence against healthcare workers: trends in prevalence, risk factors, consequences, and prevention - a narrative review. *EClinicalMedicine.* 2024;72:102641. doi.org
13. Dharma C, Bondy SJ, Sikstrom L, Muirhead PS, Zaheer J, Maslej MM. Examining systemic and interpersonal bias in violence risk assessments of patients in acute psychiatric care. *Psychiatr Serv.* 2025;76(4):326-335. https://doi.org/10.1176/appi.ps.20240108
14. ECRI. Preventing violence in healthcare settings. Published January 2026. Accessed September 14, 2026. https://members.ecri.org/guidance/preventing-violence-in-healthcare-settings
15. Weerahandi H, Burden M, Kopp Z, et al. Clinician perspectives on electronic health record behavioral alerts and hospital workplace violence prevention: a mixed methods study at 20 organizations. *J Hosp Med.* 2025;20(12):837-846. doi.org
16. Seeburger EF, Gonzales R, South EC, Friedman AB, Agarwal AK. Qualitative perspectives of emergency nurses on electronic health record behavioral flags to promote workplace safety. *JAMA Netw Open.* 2023;6(4):e239057. doi.org
17. Kim SC, Vejnovich C, Hall L, Rawlings M, Thompson K. Aggressive behaviour risk assessment tool for hospitalised patients in non-psychiatric inpatient units. *J Adv Nurs.* 2025;81(5):2393-2401. doi.org
18. Kim SC, Kaiser J, Bulson J, Hosford T, Nurski A, Sadat C, Kalinowski N. Multisite study of Aggressive Behavior Risk Assessment Tool in emergency departments. *J Am Coll Emerg Physicians Open.* 2022;3(2):e12693. https://doi.org/10.1002/emp2.12693
19. Kim SC, Dunn K, Youells C, et al. Aggressive behavior risk assessment tool for emergency medical services. *JACEP Open.* 2025;6(3):100095. https://doi.org/10.1016/j.acepjo.2025.100095
20. Kim SC, Berry B, Young L. Aggressive behavior risk assessment tool for long-term care (ABRAT-L): validation study. *Geriatr Nurs.* 2019;40(3):284-289. https://doi.org/10.1016/j.gerinurse.2018.11.006
21. Heart of Safety Coalition webinar. Workplace violence: Risks, reporting and the importance of understanding both. June 2026. https://www.stryker.com/content/m/hsc/en/index/resources/workplace-violence--risks--reporting-and-understanding-both.html
22. Lee H, Yun H, Choi M, Kim H. Predicting workplace violence in the emergency department based on electronic health record data. *J Emerg Nurs.* 2023;49(3):415-424. doi.org
23. Seeburger EF, Gonzales R, South EC, Friedman AB, Agarwal AK. Qualitative perspectives of emergency nurses on electronic health record behavioral flags to promote workplace safety. *JAMA Netw Open.* 2023;6(4):e239057. doi.org
24. McGreevey JD 3rd, Mallozzi CP, Perkins RM, Shelov E, Schreiber R. Reducing alert burden in electronic health records: state of the art recommendations from four health systems. *Appl Clin Inform.* 2020;11(1):1-12. doi.org
25. Kim S, Lynn MR, Baernholdt M, Kitzmiller R, Jones CB. How does workplace violence–reporting culture affect workplace violence, nurse burnout, and patient safety? *J Nurs Care Qual.* 2023;38(1):11-18. https://doi.org/10.1097/NCQ.0000000000000641
26. Kim SC, Kaiser J, Hosford T, et al. A workplace violence prevention program targeting high-risk patients in emergency departments. *J Am Coll Emerg Physicians Open.* 2024;5(4):e13206. doi.org
27. Li C, Bentley S, Gulati MS, Snedeker K, Marks MR. Staff safety alert banner program against workplace violence at an urban American hospital. *Workplace Health Saf.* 2025;73(1):38-46. doi.org
28. Haimovich AD, Taylor RA, Chang-Sing E, et al. Disparities associated with electronic behavioral alerts for safety and violence concerns in the emergency department. *Ann Emerg Med.* 2024;83(2):100-107. https://doi.org/10.1016/j.annemergmed.2023.04.004

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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