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Five Topics Overlooked in Workplace Violence Discussions in Health Care Settings

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ABSTRACT

Workplace violence against health care professionals, especially nurses, is increasingly prevalent and complex. This article examines nuanced dimensions of workplace violence prevention particularly relevant to nurses practicing in nonpsychiatric settings. Although de-escalation is an essential skill, this article sought to explore additional factors that should be included in workplace violence prevention discourse, considering professional, ethical, clinical, and organizational contexts. The additional factors—derived from psychiatric nursing models, current literature, and clinical insights from trainers and nurses with workplace violence prevention expertise—include professional responsibilities, ethical tensions and competing priorities, underemphasis on engagement as a proactive practice, organizational constraints that limit effective workplace violence prevention, and unintended consequences of developing a risk-averse environment. Integrating interpersonal approaches and organizational culture change into workplace violence prevention efforts will enhance nurse and patient safety. Nurses are well positioned to lead this paradigm shift and drive systemic transformation in health care settings.

Key words: de-escalation and engagement strategies, ethical and organizational factors, intensive care unit nurses, trauma-informed care, workplace violence prevention

Workplace violence is surging across health care settings, with intensive care unit, emergency department, and medical unit staff reporting an increase in incidents.[1-3] According to Bureau of Labor Statistics data, health care workers experience nearly half of all nonfatal workplace-violence injuries.[4] Subsequently, the contemporary era of health care has shifted toward an increased focus on quantifying and measuring the violence experienced by nurses practicing in medical settings.[5] The literature on addressing and preventing staff-directed violence has also increased,[6] but there is insufficient evidence to support any single intervention.[7,8] In psychiatric settings, and to some extent emergency departments, research

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includes not just developing nurses' skills at workplace violence prevention (WVP) but also nurses' responses to patient aggression; the research also focuses on the personal and professional toll such incidents take, especially on nurses' well-being.[9,10]

Understanding these issues is critical for a number of reasons. First, nurses should feel safe at work. Achieving this requires synthesizing nurses' often diverse perceptions of safety and WVP.[11] Second, a meaningful connection exists between workplace violence, burnout, psychological distress, and workforce attrition.[12] In psychiatric settings there has been an interest in the impact of WVP on the nurse—not just restricted to the victim's response[13] but also considering the professional and ethical dilemmas that arise when dealing with aggression as part of one's clinical work.[11,14] This perspective deepens understanding of how nurses balance patient care responsibilities. Third, nurses' de-escalation efforts should be viewed within the broader context of organizational factors that may limit their effectiveness[15] and directly influence nurses' responses. Organizational policies on workflow, staffing levels, task completion, and care prioritization are a critical piece for all nurses to consider when developing effective WVP strategies.[16]

Extant research on workplace violence in nonpsychiatric settings inadequately addresses ethical and professional role dilemmas experienced by medical nurses (nurses practicing in hospital-based, nonpsychiatric settings such as medical units, surgical units, and intensive care units).[17] The discussions on WVP in nonpsychiatric units tend to focus on how well nurses develop a set of skills and the efforts to increase confidence in handling aggression,[18,19] with a preponderance of approaches involving staff training on operational techniques.[20-22] Although literature and expert opinion on best practices to prevent and address workplace violence offer important guidance,[23,24] additional elements of WVP exist beyond staff skills training. For instance, in the medical literature, there is scant attention to developing relational competence, which includes having a genuine interest in understanding and engaging the patient so that they feel acknowledged, understood, and validated.[25,26] Yet these are the very skills experienced nurses draw on to intervene in tense situations[27] and enhance de-escalation efforts.[28]

To investigate these issues, we conducted a review of the literature (2015-2025), prioritizing the impact of dealing with patient violence on nurses practicing in nonpsychiatric settings. The search strategy also focused on WVP training of medical nurses and their response to aggressions and violence as part of professional role responsibilities. Findings were informed by the authors' combined extensive experience in consulting with nurses managing difficult situations on nonpsychiatric units and training health care staff on WVP.

Key Issues Identified

As noted in the introduction, most literature dealing with medical nurses' responses to WVP has focused on developing skill sets to deal with patient escalation.[22,29] However, educating nurses about WVP does not necessarily build their confidence in managing aggression.[20,30] Here we discuss 5 underrecognized yet critical domains of inquiry that form the basis for practice and cultural changes in WVP on nonpsychiatric units. Except for 1 recent publication,[31] these topics are largely scattered throughout the health care literature on training or noted as a factor in WVP interventions but rarely meaningfully explored. The 5 elements discussed here include the way nurses view WVP within the evolving scope of professional responsibilities, the ethical tensions that arise when responding to workplace violence and ordering priorities in patient care, the underemphasis on engagement as a proactive practice to mitigate perceived threats, the organizational constraints that limit effective WVP, and the unintended consequences of developing a risk-averse environment.

Evolving Scope of Professional Responsibilities

Medical nurses practice in a strenuous reality with numerous responsibilities involved in caring for patients who are acutely ill. In the current health care environment, nurses are now being asked to acquire additional WVP skills. With the increasing frequency of workplace violence in health care settings,[32] it may be helpful to explore how nurses view their clinical role with respect to WVP. If nurses consider WVP to be peripheral to their clinical responsibilities, that perception may correlate with underreporting and psychological stress.[33] Although addressing and preventing workplace violence is an accepted part of psychiatric

nurses' duty to care,[34] medical nurses may perceive such responsibilities as outside the scope of their professional role.

Nurses typically embark on their work because of an interest in helping or healing.[35] Although their specific professional interests may become more specialized or focused, a foundational belief in caring is implicit in their choice of role or job and evident in the practices of their day-to-day work.[36] As Copeland et al[31] noted, nurses reported that they go to work to care for people and to help patients and families. In fact, some nurses in this study largely believed that their intent to provide care would be recognized and, in turn, would prevent patients from exhibiting violent behavior. Yet as Copeland and colleagues point out, although nurses may expect that workplace violence happens, they do not necessarily accept that it happens.

Psychiatric mental health nurses' expectations, perceptions, and reactions to workplace violence have been studied in depth, mainly via qualitative methods.[11,13,37] These data illustrate how violence management narratives support the psychiatric mental health nurse's professional clinical role, such as interpreting agitation and anger as responses to perceived threats, consistent with trauma-informed care principles.[38] To our knowledge, these types of explorations are few among medical nurses. Greater success in WVP may be realized if there is additional study of how medical nurses view these incidents in relation to their professional identity and duty to care.

The goal of WVP is not to replace a person's purpose for what they do or why they became health care professionals but to equip them with skills and understanding that will enhance their crisis response competencies (eg, de-escalation, crisis communication) and allow them to accomplish their fundamental mission in an environment of shifting demands. The frequency and intensity of aggressive incidents have expanded beyond what was once considered typical. Thus, many health care workers are now managing risks that may feel increasingly misaligned with their intended role, accompanied by increasing emotional and practice burdens. We should focus more on reframing WVP within professional duty expectations rather than as an externally imposed and additional responsibility.[39] This reinforces the need for WVP practices to emphasize prevention strategies that address both clinical purpose and emotional tolerance.

Ethical Tensions That May Arise From Ordering Priorities

Dealing with violence and aggression may also demand that medical nurses consider how they order their priorities. Pilcher et al[40] showed that violent patient behaviors can trigger ethical tensions as nurses must weigh the duty to provide urgent care against the need to maintain workplace safety for staff and other patients. Furthermore, resolving these ethical tensions involves developing responses that prioritize adaptation of the clinical environment and a certain degree of tolerance as well as recognizing competing priorities.[40] For instance, tension may exist between using one's attention to meet the patients' physical needs while also attending to initial signs of escalation that may portend aggression.

Medical nurses are adept at detecting physiological changes—one of the cornerstones of their role. On encountering a patient, a nurse quickly integrates several physical signs and symptoms into a proposition of what is occurring with the individual. However, researchers examining nursing documentation preceding aggressive incidents concluded that based on the emphasis placed on particular patient behaviors, nurses may be less skilled at recognizing the situations that are building toward agitation and/or aggression.[41] Failure to recognize the signs of tension, frustration, or potential conflict between the nurse and patient may not be a skills issue; rather, it may stem from how medical nurses prioritize their work within a documentation system that emphasizes patients' physical deterioration. Research in psychiatric settings depicts in detail how nurses draw on situational awareness to notice subtle changes in the client and the environment that portend aggression.[42] Although de-escalation training includes the concept of situational awareness,[29] greater emphasis may be needed on recognizing situational stressors, unprovoked triggers, and early warning signs, which could support early intervention and mitigation of escalating behaviors.[41]

Dealing with the challenging behaviors of people who use substances (both prescription and illicit) but are hospitalized for medical issues may create additional ethical tensions.[43,44] As Yen et al[44] point out, bias and stigma toward some patient populations may influence how the staff interpret behaviors and influence their level of beneficence, nonmaleficence, and

respect for patient autonomy. These patients may also encounter restrictive and inflexible hospital policies, such as mandatory searches of patients' belongings, which invite stigma and negative interactions with staff that might fuel additional conflict.[43,44] Although drug and alcohol overuse and misuse have been seen as increasing the risk for violence, especially in the emergency department, a recent review emphasized the need to place this risk factor within the context of environmental conditions that may intensify already tense situations.[45]

Although these ethical matters may seem a bit distant from core WVP issues, they are relevant. Nurses may experience moral distress when they face dilemmas such as the sense that they do not have the capacity or resources to meet patients' needs.[14,46] In these studies, emotional distress was particularly acute when, because of low staffing or hospital policy on defusing threats, staff chose coercive measures in response to violent behavior. Although moral distress is discussed in medical nursing, the context has usually been more on high-intensity work environments and end-of-life decisions.[47,48] However, moral distress should be recognized as a factor in the frequently reported burnout of medical nurses around managing workplace violence.[12,20]

Underemphasis on Engagement As a Proactive Practice

Educating nurses on therapeutic communication skills is effective in decreasing patient aggression and increasing staff's self-efficacy in using these skills in tense situations.[49] In psychiatry, staff engagement and therapeutic relationships are critical vehicles for supporting safety on inpatient units.[50-52] Indeed, knowing how to build trust and rapport has been identified as one of the skills seasoned nurses use in dealing with a patient who is tense and angry.[27] Thus, rather than reflexively distancing themselves from tense situations, psychiatric nurses put themselves in a position to engage before a situation escalates.

Some might assume this means actively intervening to de-escalate affect; however, the first step may actually be proactive—for example, establishing a calm and supportive presence with a patient and drawing on this presence to focus on what the patient is experiencing before taking action. Specifically, this presence has been defined as a mindful, emotionally regulated, trust-building approach that helps patients feel heard and affirms their dignity.[53] Forging engagement requires that the nurse take time to let the patient know they are there to listen. They can then move into active listening informed by knowing and respecting the timing and order of the content the individual wishes to share.[54,55] As the patient narrative unfolds, the nurse can use empathy to communicate ongoing and developing understanding of the patient's experience, bridging the emotional aspects of their experience with the thoughts and perceptions they are expressing.[56] Subsequently, that nurse's response to emotionally charged or aggressive encounters is shaped by these engagement competencies and supervision models that encourage exploration of the patient's narrative.[55]

Implicitly, it can be a challenge to communicate during a perceived escalating situation or one's own emotional distress.[57] Establishing presence also demands making engagement a priority, and yet, nurses may be so focused on their own work priorities that they fail to accommodate others' perspectives.[10] Another barrier to engagement may be the way nurses interpret angry words. A review of the literature by Curran[11] on psychiatric nurses' perceptions concluded that the way nurses make sense of highly charged situations mattered, and they were more likely to engage when they saw the patient's behavior as a reflection of their experience of threat. Copeland and Arnold[58] noted a similar balancing of intent in medical arenas where staff's reaction to strong affect may depend on if they view the patient as competent or decisional at the time of the violent event. Thus, discussions of presence should expand to include how perceptions of behavior and volition influence the nurse's response.[59] It is also important to clarify patients' expectations around how they anticipate their treatment to proceed as well as what they need to do to meaningfully participate in their care. Understanding how past trauma presents in current behavior is also critical, as is recognition that when patients are hospitalized, their sense of vulnerability, fear, stress, and lack of control impairs coping.[31] Furthermore, reframing how patient anger is recognized and responded to may dampen a tendency to take patient or family utterances personally, which can create emotional injury and may even elicit a defensive response.[31,60] Table 1 contains a detailed explanation of how unit

Table 1: Understanding Blocks to Patient Engagement

Hospitalized patients and their family are not at their optimal baseline of emotional regulation. While some can cover the degree of dysregulation better than others, nurses should expect that patients and their family members are struggling emotionally. We help them and ourselves by knowing this and letting them know that we understand that it is very difficult to be in the hospital.

All behavior has meaning. When patients and families are fearful, anxious, or confused, their behaviors often express that verbally in ways we find off-putting or worse. This is in addition to physical and physiologic events impacting the body and mind that brought the patient to the hospital. Understanding this does not mean condoning unkindness, harsh language, or workplace violence. But understanding can open the door to interactions that can ameliorate these kinds of angry responses.

Patients' anger is not about you personally. A patient speaking in angry, frustrated, or insulting ways is typically a sign that something is not working. That does not mean you are not performing your role well or are inadequate or wrong. It does mean you will likely need to pause, breathe, and take a step back. This might look like letting them know you hear them and are going to get some assistance to move forward together. Experiencing someone's anger and then managing yourself when feeling fearful, anxious, or confused requires practice.

Preceptorship in the work environment that models an attitude of "I don't know, let's figure it out together" promotes shared understanding and confidence. When tensions are high, considering what is happening and taking an interest in the patient's background story and personhood can be difficult. Curiosity about why a person might act this way alongside an understanding that all behavior has meaning within some context places nurses in an excellent position to learn about the situation at hand. Shadowing an experienced nurse who is managing a challenging encounter followed by debriefing would be of considerable benefit.

leadership might enlist a precepting model to explore assumptions and broaden how nurses perceive and come to understand the patient experience.

Organizational Constraints and Proactive Responses to Distress

Nurses responding to anger and strong emotions with presence demands more than the development of engagement skills; it requires an environment and organization that support such proactive responses.[61,62] In psychiatric nursing, it is well established that an organizational culture that prioritizes task completion is a barrier to nurses establishing presence and engagement.[63-65] This same external and internal need or drive for speed in task completion is also present in medical nursing and is reflected in the belief that one must finish the shift and get everything done. This belief is often examined in the context of unfinished nursing care.[66] These drivers become barriers to the overarching role of the nurse, which ideally includes having an understanding of the patient experience. Although the issue of missed nursing care is beyond the scope of this discussion, there is increased awareness of organizational factors that contribute to this drive for task completion, including unit features such as inadequate continuity of care, staffing issues, and level of teamwork; as a result, patients can experience this task urgency as depersonalized fast-moving parts and may direct a reaction in the form of angry behavior to the nurse at the bedside.[67,68]

As nurses deal with escalation and incivility in the health care setting, their need for organizational support is increasingly evident.[13] How the need to support employees is influenced by organizational policies can be subtle yet overarching as it relates to the delivery of care.[69] Medical unit operations often situate nurses within unit-based silos. Specifically, they have assigned patients, and quite naturally task completion is the focus. However, those practices interfere with nurses' ability to collaborate as a team to respond to more complex patient situations and provide additional support as needed. In psychiatric settings, the team works together to support each other, interpret patient behavior, and develop intervention strategies.[70,71] On medical units, without a team culture for responding to escalating situations, individual nurses may not be comfortable with acknowledging their own vulnerability in a given situation and asking early for help.[15,72]

An organizational culture also prioritizes nursing tasks, and these may not include allowing nurses time for engagement at the bedside. Establishing a supportive presence with patients takes time, and that may be

limited in a hospital that relies on a lean staffing model. A popular idea in WVP is the development of a safety culture—that is, the collection of group and individual values, attitudes, and practices that guide safety behavior. Within this idea is the way the culture shapes how staff adapt their understanding of the way things are done on their unit.[73,74] One study of multiple hospitals showed that safety cultures and norms were related to incident reporting, teamwork, and a work environment supportive of staff needs.[75] Workplace violence prevention is most effective when it is part of a culture, and although cultures lead to actions, they begin with something more—that is, shared values and beliefs as well as common practices and fundamentals of language.[76] Professional or workplace cultures are often guided by a common mission of the organization paired with individual values that, once combined, create a collective understanding.[77] Thus, an organizational culture can support nurses' WPV efforts or, via implicit messages on how care is prioritized and staffing models are implemented, inhibit nurses' meaningful interactions with patients around their illness and hospitalization experience.

Development of a Risk-Averse Environment

In their review of de-escalation, Price et al[15] list barriers to successful staff de-escalation efforts, one being a dysfunctional risk management culture. In this view, the fear of any violence occurring is managed by a rigid application of rule systems without consideration to situational context and cultural norms. In today's hospital environment, signage touting zero tolerance for violence abounds, and although it is reasonable to address many of the behaviors that will not be tolerated, the overarching message is that violence will trigger a security or police or eviction response. Authoritarian responses to violent behavior that involve strict institutional consequences, such as discharge, may actually undermine workplace safety, as they exacerbate the patient's sense of powerlessness, which can fuel violent behaviors.[40,78] In one review of the charting on 775 violent hospital incidents, the authors noted that 23% involved security teams whose presence seemed to exacerbate the violent incident, inadvertently provoking patients who were angry.[41] As Daigle[79] points out, what makes sense from a security perspective to manage disruptive or threatening behavior (ie, physical force or security) may not be an ethical or effective approach. It also relies on external control rather than understanding behavior. Thus, as in psychiatry, a risk-averse environment also legitimizes practices that are ineffective and eclipse meaningful treatment partnerships.[80]

A risk-averse environment also relies heavily on risk management and risk identification instruments, including the identification of patients with a history of aggression or who pose an imminent threat.[81] These risk tools have a role to play when used as broad initial assessments and also to alert staff to violence potential as patients move across systems. But when repeated daily, the data may narrow staff views and prime nurses to look at patients only in terms of those characteristics.[82] As Daguman et al[83] point out, risk-related data reporting may come to dominate how patients are defined and understood and restrict consideration of contextual factors at play in aggressive incidents. As use of these tools enters nonpsychiatric settings,[84] nurses need to be aware that an individual's risk level for violence and the individual's circumstances can change over time. Static tools may not account for these changes and may lead to stigmatization or labeling[85] and, for some populations, the emergence of challenging behaviors.[44]

Importantly, a risk-averse environment that emphasizes risk identification or strict nontolerance policies overlooks the organizational structures that have been consistently identified as risk factors for workplace violence, including inadequate staffing and resources to meet patient demands, long patient wait times, and poor organizational support for staff.[86] Indeed, many of these risk factors have been identified in psychiatry as substantial barriers to risk mitigation[87] and have been isolated in select reviews of risk in medical units.[12] Thus, although understanding risk is important, dialogue should address the dangers of developing a risk-averse environment, particularly its impact on organizational culture and policies that are barriers to staff engagement.

Integration and Synthesis of the 5 Factors

Workplace violence in health care continues to escalate, placing both patients and clinicians at risk while undermining the stability of the nursing workforce. Traditional reliance on

Table 2: Five Topics in Workplace Violence Prevention: Core Challenges and Strategies

Domain	Core Challenges	Proposed Strategies
Evolving scope of professional responsibilities	Role boundary tensions; perception of workplace violence as "outside scope"; underreporting; psychological stress	Reframe minimizing workplace violence as part of duty to care; role clarification; debriefing; support systems for reporting
Ethical tensions and competing priorities	Moral distress; balancing safety versus patient care; stigma toward certain patient groups, eg, persons who use drugs	Ethics training; reflective debriefing; structured support for ethical decision-making; policy review for equity
Engagement as a proactive practice	Underuse of therapeutic communication; retreat from escalation; taking patient anger personally	Trauma-informed communication training; narrative practice; active listening; presence-focused interventions
Organizational constraints	Task-driven culture; silos; missed care; insufficient staffing/time for engagement; lack of teamwork	Promote team-based care; adjust staffing models to allow engagement; strengthen safety culture; increase peer support
Unintended consequences of a risk-averse environment	Over-reliance on zero tolerance/security; labeling and stigmatization via risk-management tools; exacerbation of patient powerlessness	Balanced risk management; context-sensitive safety planning; de-escalation prioritized over coercion; cultural shift from punitive to collaborative safety practices

de-escalation training, while necessary, has proven insufficient to address the complexity of aggression in medical settings. The 5 areas outlined here mutually reinforce one another; specifically, presence is supported by calm, which is fostered by situational awareness, which is embraced when WVP assessment and interventions are integrated into a professional skill set. These skills are cultivated in an organization that values their development and allows for the time to discuss the situations that prompt conflict or tension (see Table 2). Staffing formulas often account for patient acuity and associated nursing tasks. Optimally, staffing formulas should also include time for building trust and rapport and debriefing violent incidents. No one should believe violence or physical assault is just part of the job. However, we may also consider that zero tolerance for emotional or cognitive dysregulation under life-altering situations, like hospitalization, may not be the answer to the environment we seek to create.

Current WVP efforts often emphasize discrete techniques such as de-escalation training, behavioral response teams, or security involvement. There is certainly a place for behavioral response teams when the demands of a situation exceed available staff resources. However, although these interventions remain valuable, they are insufficient when used in isolation. A cultural transformation is needed to shift from technique-centric models toward principle-based frameworks such as patient-centered or trauma-informed care. Principle-based interventions prioritize presence, empathy, and ethical reflection over rote application of techniques. For example, nurses equipped with trauma-informed approaches are encouraged to interpret aggression within the broader context of fear, trauma, and distress, which fundamentally changes how they engage with patients and families.[38] Similarly, patient-centered practices ensure that communication strategies are sensitive to patients' lived experiences, reducing the likelihood of misinterpretation or escalation. A principle-based culture requires intentional organizational support. Institutions must create environments where engagement is valued as much as task completion, where staff have the time and training to practice narrative-based communication, and where zero-tolerance policies are balanced with context-sensitive responses. This reframing acknowledges that violent incidents are not isolated disruptions but relational and systemic events shaped by patient vulnerability, staff engagement practices, and organizational culture.

Future Directions

Federal mandates for WVP plans and evolving accreditation requirements represent a pivotal opportunity to drive systemic change in health care organizations. The Occupational Safety

and Health Administration's guidelines[24] and recent Joint Commission standards[88] emphasize that WVP must move beyond voluntary adoption to establishing safety planning, staff training, and postincident debriefing as essential organizational responsibilities. Legislative proposals for mandatory WVP plans further underscore the need for institutions to demonstrate accountability through measurable outcomes.[89] By embedding these expectations into accreditation and regulatory frameworks, health care organizations are compelled to elevate WVP from a discretionary initiative to a core component of operational safety and quality.

Beyond compliance, legislation and accreditation pressures also bring visibility to organizational deficiencies that perpetuate violence risks. Federal reporting requirements and accreditor reviews create a culture of transparency, obligating hospitals to acknowledge the incidence and prevalence of workplace violence and develop actionable strategies for prevention. Policies that standardize reporting protocols, mandate psychological support for staff, and require ethical consideration of safety vs patient rights can mitigate stigma and silence.[90] In turn, these standards generate institutional learning and position WVP as a shared responsibility across all levels of health care delivery.

Although WVP research has grown, literature remains limited regarding developing specific frameworks for situational awareness and presence-building interventions in nonpsychiatric units. Much of the existing work has been extrapolated from psychiatric or emergency department settings, where aggression and agitation are more overtly recognized as clinical challenges. Medical nurses face unique conditions, such as managing patients with critical illness, altered consciousness, or delirium, for which violence risk emerges differently. Current training programs often emphasize general de-escalation techniques without tailoring strategies to medical environments in which physiological instability and complex family dynamics intersect with escalating behavior. This gap restricts the field's ability to generate evidence-based practices that meaningfully address the nuanced realities of nonpsychiatric units.

The experiences of novice nurses also remain underexplored in this discourse. Early-career clinicians frequently encounter violent incidents with limited preparation and support, intensifying feelings of vulnerability and moral distress. Novice nurses often lack the confidence to interpret subtle warning signs of escalation or to balance patient care priorities with personal safety. Although mentoring and preceptorship models are widely used for clinical skill development, few studies systematically evaluate how these approaches support relational competence[25] and situational awareness in the context of workplace violence. As a result, organizational training and WVP strategies risk overlooking the developmental needs of novice nurses, who represent a substantial portion of the workforce and may be particularly vulnerable to burnout and attrition when exposed to violence early in their careers.

Finally, workplace violence is shaped not only by patient acuity and organizational policies but also by cultural expectations regarding authority, communication, and conflict. For example, stigma around substance use, family involvement in care, or norms about expressing emotion can vary dramatically across patient populations and health care systems. Without cross-cultural studies, interventions risk privileging narrow perspectives and neglecting how sociocultural context influences both the manifestation of violence and the strategies that are most effective in addressing it. Addressing these gaps through multicenter and cross-national research is essential to building a robust, inclusive evidence base for WVP in nursing practice.

Conclusion

Medical nurses, situated at the front line of patient care, are uniquely positioned to lead this transformation. Their daily practice requires balancing technical expertise with ethical decision-making and compassionate engagement, making them natural champions of patient-centered, trauma-informed, and culturally responsive interventions. This shift also acknowledges that violence is not solely an individual problem but a systemic challenge shaped by organizational structures, staffing models, and cultural expectations. Ultimately, such a paradigm creates safer hospitals, supports nurse retention, and honors the ethical imperative to provide care in a manner that is safe, compassionate, and just.

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CE Assessment Instructions

This article has been designated for CE contact hour(s). The assessment tests your knowledge of the following objectives:

1. Identify organizational, ethical, and professional role factors that should be included in workplace violence prevention discussions.

2. Describe how dealing with workplace violence can be at odds with prioritizing patient care responsibilities.

3. Explain how to coach nurses on using interpersonal skills to effctively addressss tense and escalating situations.

Contact hour: **1.0**
Synergy CERP Category: **B**

When completing this activity, you will need to identify 3 concepts you have learned by reading this article.

To see CE activity ACC26S1, visit https://aacnjournals.org/aacnacconline/pages/ce-articles. Once the article opens, click the CE Article button to complete the assessment. No CE fee for AACN members. See CE activity page for details and expiration date.