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Critical Care Work Environments and Personal Safety

Kristen W. Springer

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Critical Care Work Environments and Personal Safety: Preventing Workplace Violence

Kelsey Springer MSN, RN, CCRN Bozeman Montana

Please refer all correspondence to Kelsey Springer MSN, RN, CCRN

Kelsey.springer27@gmail.com

**Mailing Address:
83 Talon Way Unit A
Bozeman, MT 59718**

Synopsis

Workplace violence (WPV) in healthcare, especially in high-stress environments like ICUs, is rising and often underreported. Nurses are the most affected, facing both patient-initiated violence—often due to delirium—and interpersonal aggression such as bullying. WPV leads to burnout, job dissatisfaction, turnover, and compromised patient care. Despite the high costs, there are no national mandates for prevention. Evidence supports a multifaceted approach including OSHA, NICE, and RNAO guidelines, focused on policy changes, staff training, and supportive workplace culture. Reporting mechanisms and leadership accountability are key to improving safety and reducing the prevalence and impact of WPV.

Introduction/Background

Workplace violence in healthcare has become an increasingly urgent issue, with a notable rise in its incidence in recent years. The Occupational Health and Safety Administration (OSHA) defines workplace violence as “any act or threat of physical violence, harassment, intimidation, or other threatening behavior that occurs at the work site.” This form of violence is the third leading cause of non-fatal occupational injuries in the U.S.¹ According to the U.S. Bureau of Labor Statistics, 72.8% of all nonfatal workplace violence cases in the private sector occurred within the healthcare and social services sectors during 2021-2022. Only law enforcement workers experience higher rates of workplace violence.² Given the staggering frequency of such incidents, it is evident that healthcare workers endure significant strain, not only in terms of physical safety but also regarding mental health and job satisfaction.

While workplace violence is commonly associated with patient or family member assaults on healthcare workers, it also frequently manifests as interpersonal violence among staff, whether lateral or hierarchical. This form of violence remains underreported and often overlooked, despite its potential to cause significant harm.³ Although research specific to the ICU setting is limited, existing studies consistently demonstrate that workplace violence contributes to increased burnout, diminished job satisfaction, higher turnover rates, and negative impacts on patient care.⁴ These findings emphasize the growing prevalence of workplace violence and underscore the need for improved prevention strategies to ensure the safety and well-being of healthcare workers, particularly in high-stress environments like the intensive care unit (ICU).

Key Terms

- Workplace Violence
 - Healthcare
 - Critical Care
 - Nurse
 - Guidelines
 - Healthy work environments
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Search Terms Used

A comprehensive search for the phrase “workplace violence in healthcare” was conducted across multiple scholarly search engines and limited to the years 2015-2025, yielding 6,970 results. This search was then narrowed to include the term “nurse,” producing 3,315 results. Adding the term “ICU” further refined the search and resulted into 215 articles. A second search, focusing on “guidelines for prevention of workplace violence in healthcare,” yielded 174 results. These results were further narrowed to current OSHA and National Institute for Occupational Safety and Health (NIOSH) guidelines, which produced five scholarly articles and two government websites. These articles were then reviewed, and pertinent studies and reviews were used to write this article.

Key Points

- There is a high prevalence of workplace violence in healthcare work environments.
- Nurses who are most proximate to patient care are at the highest risk for experiencing workplace violence.

- Chronic underreporting of violence leads to underestimation of actual rates.
 - A multifaceted approach to prevention is considered best practice.
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Abbreviations

- ICU: Intensive Care Unit
 - WPV: Workplace Violence
 - HWPV: Horizontal Workplace Violence
 - OSHA: Occupational Safety and Health Administration
 - NIOSH: National Institute for Occupational Safety and Health
 - PTSD: Post Traumatic Stress Disorder
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Review of Literature/Current Evidence

See Table 1 for general information regarding studies included in this review of evidence.

Prevalence of Workplace Violence in Healthcare and the ICU

Workplace violence in healthcare is a longstanding issue, and recent data shows an alarming increase in its prevalence. Workplace violence encompasses physical assaults, threats, intimidation, and other forms of aggressive behavior. Defined by OSHA, workplace violence includes any act or threat of violence, whether actual or implied.¹ Notably, events are still considered violent even if the threat is not carried out, such as when a patient threatens harm but does not follow through with physical action. Regrettably, many healthcare workers fail to report incidents that do not result in physical injury, often because they do not recognize them as violence. As previously discussed, healthcare and social service workers experience nearly 75% of all workplace violence incidents in the private sector, making this sector the second most

affected after law enforcement.² These statistics likely underestimate the true extent of the problem due to widespread underreporting.

Global data reveals that the estimated median rate of workplace violence among healthcare workers is 61.9% over a 12-month period, according to 78 studies.⁵ Berger et al.⁶ (2024) found that 54% of ICU staff experienced some type of WPV at some point in their career. In a 2023 survey, National Nurses United⁷ reported that 81.6% of nurses had encountered some form of workplace violence, with physical violence reported by 21% to 43% and verbal violence by 77%. Nurses face the highest rates of workplace violence, with an average exposure rate of 59.2%, followed by physicians at 56.8% and other healthcare workers at 44.4%.⁵ Regardless of which study you read, it is clear that workplace violence is highly prevalent and a growing problem for healthcare workers globally.

Although specific data on workplace violence in the ICU is limited, especially when compared to emergency departments or psychiatric settings, available studies suggest that up to 80% of violence in the ICU is attributed to patients experiencing delirium and other medical conditions.⁶ This lesser data is likely due to underreporting which is further exacerbated by the ICU culture, where nurses often view violent behavior from patients as part of the inherent responsibilities of their role, thus neglecting to report these incidents.⁷

Inter-Professional Violence and Incivility in Healthcare Settings

Inter-professional violence, including bullying and incivility, is another significant issue in healthcare settings. This type of violence can occur laterally (between peers in similar roles) or vertically (between individuals with different roles). The Joint Commission defines this form of violence as repeated mistreatment of individuals, which may involve verbal abuse, intimidation,

or work interference, ultimately leading to harm.⁸ Workplace bullying is especially prevalent among nurses, with reported rates ranging from 26% to 77%.⁹ In high-pressure environments like the ICU, the occurrence rates are even higher, ranging from 42.7% to 75%.³ The unique demands of the ICU, such as high stress, emotionally taxing patient care, and complex team dynamics, contribute to this elevated prevalence.

The culture of bullying is often ingrained in healthcare, with the phrase “nurses eat their young” reflecting the systemic acceptance of such behavior. Studies have shown that a range of 38% - 80% of healthcare workers in the U.S. have experienced psychological harassment^{10,11} a rate much higher than the 15% reported in non-healthcare settings.¹² Factors contributing to lateral violence include organizational culture, leadership styles, power dynamics, and strained interpersonal relationships.³ The formation of subgroups within nursing teams and jealousy toward high-performing colleagues further exacerbate tensions, leading to an environment where bullying can thrive.^{13,14} Research by Kenneth Oja, RN, PhD, found that nurses who reported less incivility within their teams had a stronger sense of professionalism and a more positive work environment.¹⁵

Impact of Workplace Violence on Nursing and Patient Care

Workplace violence, whether physical or verbal, patient-initiated or interpersonal, has significant consequences for both healthcare workers and patient care. Bullying and lateral violence can lead to physical symptoms, including headaches, sleep disturbances, and depression.³ In addition, these experiences contribute to burnout, reduced job satisfaction, and a heightened intention to leave one’s position. Chronic exposure to violence can also result in post-

traumatic stress disorder (PTSD) and substance abuse.¹⁶ The financial impact of bullying is also substantial; in 2011, the estimated cost of incivility was \$11,582 per nurse per year due to reduced productivity. Given inflation and increased turnover, this cost is likely much higher today.¹⁷ Allen et al ¹⁸(2014) conducted a quantitative study in which they found a positive correlation between bullying and burnout in nurses and that psychological detachment did not offer moderation for this correlation. A systematic review found that even in the simulation environment, a mild sense of incivility leads to markedly decreased team performance and patient care outcomes. Young nurses and new-to-practice nurses reported the negative effects of incivility more frequently, shining a light on the vulnerability that new nurses have and likely contributing to the increase in turnover amongst new-to-practice nurses.¹⁹ Another consequence of incivility is the potential for distraction; one study highlighted the shift in focus that staff can experience when trying to de-escalate a heightened team member rather than focusing on their patients, resulting in poor patient outcomes.²⁰

Workplace violence also undermines the quality of patient care. Nurses who experience or witness bullying often report diminished performance, which can include making mistakes, failing to clarify unclear orders, or performing tasks they aren't comfortable doing due to fear of retribution.²¹ A systematic review by Johnson and Benham-Hutchins ²²(2020) confirmed that bullying in healthcare settings contributes to increased medication errors, patient falls, and poor communication, all of which can lead to serious medical errors. Johnson and Benham-Hutchins did note that there were limitations on the extent to which patient care is affected by horizontal hostility and highlighted the need for further research in this area, especially with the high prevalence of nurses experiencing this hostility.

The financial implications of workplace violence are also significant. In an article published in the Joint Commission Journal on Quality and Patient Safety Judith Arnetz²³ (2022) included that the cost of non-fatal workplace violence in a single hospital system could range from \$109,000 to \$330,000 annually. These costs include the cost of treatment of the physical injury as well as related costs such as insurance co-pays, travel, and hotel stays. This number doesn't include the broader costs associated with staff turnover, job dissatisfaction, and the disruption caused by such incidents.²³

Workplace Violence Reporting in Healthcare

A study by Wang et al ²⁴ (2022) found that 57% of ICU nurses surveyed did not report incidents of workplace violence. Common reasons for this underreporting included the belief that nothing could be done about the incident, the perception that the violence was not serious enough to report, or concerns about causing discord among staff members. Nurses also reported avoiding reporting incidents involving delirious patients or co-workers mishandling situations. Berger et al⁶ (2024) also found that lack of reporting systems and the feeling of failure that led to the violent incident were also common reasons that healthcare workers did not report. When these events are underreported, the data fails to capture the true risk that healthcare workers are facing at work every day. While it is not a national standard, some states have implemented workplace violence programs that include mandatory reporting of violent events from the hospital system to the state, but no mandates are ensuring that nurses report these events themselves. This leaves a significant gap of events that the nurse might encounter on their own and never report to a higher authority.

In a qualitative study, Thomas et al ²⁵(2021) identified a theme of underreporting WPV, largely attributed to a lack of follow-up and perceived commitment from organizational leadership. This absence of accountability contributed to a workplace culture that normalized violence and fostered a belief among staff that reporting was futile—only considered worthwhile in cases involving physical injury resulting in time off work. Participants conveyed that unless an incident resulted in significant harm, it was not seen as worth reporting, particularly given the consistent lack of follow-up.

Conversely, participants who experienced a cultural shift within their organizations to a focus on employee wellbeing, where leadership emphasized the importance of reporting all WPV incidents, reported increased engagement in the reporting process. They described a noticeable difference when managers actively listened and demonstrated genuine interest in their experiences, which, in turn, encouraged more frequent and comprehensive reporting. The study concluded that managerial follow-up is essential to staff well-being and plays a critical role in fostering a positive safety culture around WPV.²⁵

This emphasis on leadership accountability and reporting culture is strongly supported by several professional organizations. The Joint Commission, in its updated 2022 guidelines, underscores the responsibility of leadership in creating and sustaining a culture of safety, which includes robust reporting mechanisms and timely follow-up.²⁶ Similarly, both the American Association of Critical-Care Nurses (AACN)²⁷ and the Emergency Nurses Association (ENA)²⁸ have published position statements emphasizing that institutions and their leaders are responsible for establishing and maintaining a safe work environment. This includes implementing clear reporting pathways and providing leadership support following WPV incidents ^{27, 28}

Evidence Based Workplace Violence Prevention in Healthcare

Currently, there are no national mandates for workplace violence (WPV) prevention in healthcare settings in the United States. However, several guidelines and evidence-based practices are available to help healthcare institutions mitigate the risk and impact of WPV. A scoping review identified three key guidelines: two published in 2015— the Occupational Safety and Health Administration (OSHA) guidelines²⁹ and the National Institute for Health and Care Excellence (NICE) guidelines³⁰— and a third published in 2019 by the Registered Nurses Association of Ontario (RNAO).³¹ It is also important to place a focus on the prevention of delirium in the ICU as a strategy to reduce WPV in that setting.

The OSHA guidelines underscore the necessity of a comprehensive, organization-wide written program to effectively address workplace violence (WPV). The success of this program relies on the active commitment and collaboration of both management and staff in adhering to established protocols. A key component of the guidelines is conducting a thorough worksite analysis, which includes maintaining detailed records, performing hazard assessments, and gathering feedback from both employees and patients.²⁹

In terms of hazard prevention and control, the guidelines highlight the importance of implementing engineering controls—such as metal detectors, panic alarms, and secure door locks—to regulate access to high-risk areas.²⁹ Additionally, administrative controls are emphasized, including the development of a formal WPV policy or plan, systems for incident reporting and tracking, standardized employee uniforms, and structured post-incident debriefings.²⁹ Equally important is the implementation of a comprehensive safety and health training program for all personnel—not limited to nurses and security staff. This training must be regularly evaluated to ensure its effectiveness. The final component of the OSHA guidelines

involves rigorous record-keeping and ongoing evaluation of the entire WPV prevention program. Continuous improvement through data-driven analysis is essential for maintaining a safe and secure work environment.²⁹

The NICE guidelines focus on the anticipation and reduction of aggressive and violent behaviors. Key strategies include de-escalation practices, post-incident debriefing, and the differentiation of aggression management strategies depending on the department, particularly emphasizing emergency departments over primary care settings. De-escalation is a central principle of the NICE guidelines, and all staff are encouraged to be trained in recognizing early signs of agitation and aggression, with the goal of preventing situations from escalating into violence.³⁰

The RNAO guidelines share similarities with the OSHA and NICE recommendations but also include specific strategies for addressing incivility, whether in the form of lateral or horizontal violence. These guidelines advocate for recognizing and addressing such behaviors to further improve workplace safety.³¹

Fricke et al³² (2023) conducted a review of 33 systematic reviews examining workplace violence (WPV) and prevention strategies across various healthcare settings. Their findings indicate that multicomponent programs, which incorporate organizational change alongside training initiatives, are effective in preventing violence against nurses. Additionally, strategies aimed at addressing incivility, which include educational, administrative, and learning interventions, were also found to be successful. Other noted interventions include simulation-based training, the establishment of response teams, formal support following violent incidents, de-escalation training, and environmental awareness and modification.³² However, a significant gap in the literature exists regarding the evidence supporting WPV mitigation strategies, with

most studies focusing on specific care areas, such as emergency departments or psychiatric settings.

In a 2023 article published by the Agency for Healthcare Research and Quality, Jones et al³³ discuss various methods to address workplace violence (WPV). The article highlights the updated standards from The Joint Commission, released in 2022, regarding WPV. While not all hospitals are accredited by The Joint Commission, these standards are evidence-based and provide valuable guidance. One key aspect of the updated standards encourages institutions to address barriers to reporting, emphasizing that it is not the responsibility of staff to handle violent incidents. Instead, it is the institution's duty to take appropriate action.³³ However, employees are responsible for reporting such events, as the institution cannot effectively address issues it is unaware of.

When addressing workplace violence (WPV) in the intensive care unit (ICU), it is essential to recognize the significant role that delirium can play as a contributing factor. Implementing effective delirium prevention strategies is a critical component in reducing the incidence of WPV. One such comprehensive approach is the ABCDEF bundle (also referred to as the A-F bundle), which provides a structured framework for holistic patient care in the ICU.³⁴ This evidence-based bundle includes pain assessment and management, spontaneous awakening and breathing trials, careful selection of sedation, routine delirium assessment and prevention, early mobilization, and active involvement of family members in the patient's care.³⁴ While this bundle tends to lean more towards the intubated patient, many of its components can be applied to all critically ill patients and assist with delirium prevention.

Discussion

The rising prevalence of workplace violence in healthcare settings, particularly in high-stress environments like the intensive care unit, presents a complex and urgent challenge for healthcare organizations.^{2,5-7} As noted, healthcare workers, especially nurses, face significantly higher rates of violence compared to other sectors, with incidents often underreported due to fears of retaliation or disbelief that anything can be done.^{6,24} This underreporting further obscures the true extent of the issue, making it difficult to implement effective and data-informed interventions. Given that the impacts of workplace violence extend far beyond physical injuries, contributing to burnout, mental health issues, job dissatisfaction, and negative patient outcomes, it is crucial that healthcare institutions adopt a proactive approach to address this issue.^{3,16,18-22}

The data presented highlights the prevalence of both patient-initiated violence, often linked to delirium or other medical conditions⁶, and interpersonal violence among healthcare staff, including lateral and hierarchical bullying. The latter, though less frequently discussed, has equally damaging effects on staff morale, teamwork, and patient care. A culture of incivility, often rooted in high-stress environments and poor organizational dynamics, exacerbates the problem.^{8-11,13-15} Addressing interpersonal violence and fostering a culture of respect and professionalism in healthcare settings should be as central to violence prevention as addressing patient-related aggression.

Moreover, the impact of workplace violence on patient care cannot be underestimated. Nurses subjected to violence may experience diminished performance, increased stress, and emotional exhaustion, all of which impair their ability to provide high-quality care.^{21,22} The financial burden of workplace violence—through costs related to turnover, reduced productivity, and healthcare outcomes—further underscores the need for systematic change. With an estimated

cost of up to \$330,000 annually per hospital system for a single non-fatal workplace violence incident, addressing this issue is not only a matter of safety but also an economic issue.²³

In terms of prevention, evidence-based strategies from various guidelines (OSHA²⁹, NICE³⁰, RNAO³¹) point to the effectiveness of multifaceted approaches. These include organizational policy changes, training programs on de-escalation and recognizing early signs of aggression, post-incident debriefings, and creating safe reporting channels. Additionally, focusing on addressing interpersonal violence and creating supportive work environments are critical elements for long-term prevention. Although the literature suggests that interventions tailored to specific healthcare settings (e.g., ICUs, emergency departments) are needed, there is clear consensus that a collaborative, organizational commitment to reducing violence is key.²⁹⁻³²

Summary

Workplace violence in healthcare is a pervasive issue that has far-reaching consequences for both healthcare workers and the quality of patient care. Despite its high prevalence, particularly in the ICU and other high-stress environments, workplace violence remains underreported and often inadequately addressed. The negative impacts of violence, including burnout, diminished job satisfaction, increased turnover, and compromised patient safety, underscore the need for healthcare organizations to adopt a comprehensive, proactive approach to violence prevention.

Evidence-based guidelines emphasize the importance of a multifaceted strategy, incorporating training, policy changes, environmental modifications, and a shift in organizational culture. To effectively mitigate workplace violence, healthcare institutions must prioritize both the physical and emotional well-being of their staff, while fostering an environment where violence, in all its forms, is not tolerated. By addressing the root causes of violence—whether from patients or staff—healthcare organizations can improve their workforce's safety, morale, and performance, ultimately leading to better outcomes for both workers and patients.

In conclusion, workplace violence in healthcare is not only a serious safety issue but also a critical factor in maintaining a healthy, effective workforce and ensuring the quality of care provided. Healthcare organizations must implement comprehensive violence prevention programs, focusing on immediate and long-term solutions, to protect their employees and improve the overall healthcare environment.

Clinics Care Points

Prevalence of Workplace Violence:

- Global data shows high rates of workplace violence among healthcare workers, especially nurses.
- Patient-initiated violence in the ICU is often due to delirium or medical conditions, and is underreported due to the feeling that this is the nature of the job.
- Inter-professional violence, including bullying and incivility, is widespread and can lead to high turnover rates, especially among new nurses.

Impact on Nursing and Patient Care:

- **Physical and Mental Health:** Bullying and violence can lead to headaches, sleep disturbances, depression, PTSD, and substance abuse.
- **Job Outcomes:** Exposure to workplace violence contributes to burnout, job dissatisfaction, and a higher likelihood of leaving the profession.
- **Patient Care:** Workplace violence leads to poor patient outcomes, including medication errors, communication failures, and reduced performance by healthcare staff.

Financial Implications:

- Workplace violence that leads to physical injury can cost hospitals between \$109,000 and \$330,000 annually, considering turnover, lost productivity, and reduced staff performance.
- Cost of reduced productivity due to incivility can equate to nearly \$12,000 per nurse per year.

Workplace Violence Reporting:

- A significant portion of incidents go unreported, with reasons ranging from the belief that nothing can be done to concerns of retaliation and discord among staff.
- Some states have implemented mandatory reporting of violent events but this is not nationally recognized and does not include reporting of all forms of violence such as verbal threats.

Evidence-Based Prevention Strategies:

- **OSHA Guidelines:** Emphasize the importance of a comprehensive program, including hazard analysis, employee surveys, debriefings, and safety training for all staff.
- **NICE Guidelines:** Focus on anticipating and reducing aggressive behavior, with a strong emphasis on de-escalation practices.

- **RNAO Guidelines:** Address incivility and lateral violence with specific strategies to improve workplace safety in addition to other prevention measures.
- **Multicomponent Programs:** Successful violence prevention involves a combination of organizational change, training initiatives, simulation-based training, and environmental modifications, as well as a formal reporting process.

Table 1			
Authors	Findings	Sample	Research Design
Allen et al., 2014¹⁸	-Bullying has positive association with burnout. - Psychological detachment does not moderate relationship between bullying and burnout.	762 Registered Nurses	Cross Sectional Quantitative Study
Bambi et al., 2018¹¹	- WPV, WPB, and LV had large ranges of prevalence (up to 80% and higher). - PTSD and burnout rates high among those experiencing WPB and LV. - Job efficiency negatively impacted.	79 papers reviewed	Literature Review
Berger et al., 2024⁶	- Median rate of WPV in ICU: 51%. - Up to 97% of healthcare workers experienced verbal violence; up to 82% experienced physical violence. - WPV was under-reported by up to 80%. - High burnout, increased anxiety, and high turnover associated with WPV.	75 studies evaluated across 32 countries	Systematic Review/Meta-Analysis
Fricke et al., 2023³²	- Guidelines and systematic review themes: worksite analysis, hazard prevention and control, de-escalation, post-incident debriefs, formal reviews, WPV prevention programs, safety training, risk assessment. - Comprehensive plans to combat WPV address all staff and nursing students.	Three guidelines and three systematic reviews	Scoping Review of Guidelines and Systematic Reviews
Houck & Colbert, 2017⁹	- Prevalence of bullying rates: 26-77%. - Estimated costs associated with bullying: \$11,582 per nurse per year. - Bullying leads to errors in treatment, delayed care, adverse events, patient falls, inhibited communication, decreased patient satisfaction.	11 studies reviewed	Integrative Review
Lewis, 2023¹⁹	- Incivility has both clinical and psychological effects in healthcare workers. - Incivility can affect patient satisfaction, patient safety, medical and surgical complications, and mortality. - Incivility commonly a systemic institutional issue.	13 studies reviewed	Systematic Review
Oja, 2017¹⁵	- Increased perception of nurse-to-nurse incivility leads to an increased perception of professional comportment.	301 ICU nurses from 14 ICUs	Quantitative, Cross-Sectional, Descriptive Survey

Table 1			
Authors	Findings	Sample	Research Design
Wang et al., 2025 ⁴	Themes Explored: 1. WPV prevalence in the ICU. 2. ICU perception of WPV: emotional distress, empathy. 3. Ripple effect of WPV: avoidance behavior, personal impact, professional burnout. 4. Practical strategies to deal with WPV in ICU: tolerance, acceptance, seeking support, communication, confrontation. 5. Needs when facing WPV in ICU: education, training, psychological counseling, reporting systems. 6. Reasons for not reporting: acceptance of violence as part of the job, fear of retaliation, patient safety prioritized over personal safety.	Six studies	Qualitative Systematic Review and Meta-Synthesis
Zhang et al., 2025 ³	Key Themes: 1. Awareness and understanding of horizontal violence/workplace bullying (LV/WPB). 2. Factors affecting LV/WPB. 3. Impacts of LV/WPB. 4. Strategies to address LV/WPB.	Eight studies: three qualitative, five quantitative	Mixed Systematic Review

Disclosures

This author utilized AI for editing purposes, otherwise no disclosures to report.

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