Institute for Healthcare Improvement

Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care

ihi.org

Authors

Jeffrey Boord, MD, MPH, Chief Quality and Safety Officer, Parkview Health

Amy Weckman, MSN, APRN-CNP, CPHQ, CPPS, Project Director, Institute for Healthcare Improvement

Natalie Martinez, Project Manager, Institute for Healthcare Improvement

Acknowledgments

The authors extend their deepest gratitude to the expert panel, who contributed their time and expertise to guide this work. The panel was led by advisors Jeffrey Boord, MD, MPH, Chief Quality and Safety Officer, Parkview Health, and Gordon Lipscomb, Director, Office of Threat Management, Memorial Sloan Kettering Cancer Center.

The expert panel included the following members (reflects their roles at the time of the expert panel convenings): Karen Garvey, MPA/HCA, BSN, DFASHRM, CPHRM, CPPS, Vice President, Safety and Clinical Risk Management, Parkland Hospital; Mike Hodges, MA, CHPA, CPP, System Director of Public Safety, Piedmont Health Care; Marybeth Kingston, PhD, RN, FAAN, EVP and Chief Nursing Officer, Advocate Health; Indira Maharaj-Jain, MPA, EHS Director, Network Safety Officer, Hackensack Meridian Health; Tom Mahoney, Associate Director of Police and Security, Mass General Brigham; Bonnie Michelman, CPP, CHPA, Chief Security Officer, Mass General Brigham; Stephen Muething, MD, Chief Quality Officer and Co-Director of the James M. Anderson Center for Health Systems Excellence, Cincinnati Children's Hospital; and Deeba Siddiqui, RN, DNP, CPPS, CPHQ, SVP, Chief Risk Officer, Hackensack Meridian Health.

The authors gratefully acknowledge IHI colleagues Jill Duncan, Marian Johnson, Kate Feske-Kirby, and Val Weber for their valuable contributions and support throughout this project.

IHI also thanks the many individuals that participated in the innovation cycle interviews to share their insights and expertise (see Appendix A).

How to Cite This Document: Boord J, Weckman A, Martinez N. *Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care*. Boston: Institute for Healthcare Improvement; 2025. (Available at ihi.org)

Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI) is a leading, globally recognized not-for-profit health care improvement organization that has been applying evidence-based quality improvement methods to meet current and future health care challenges for more than 30 years. IHI provides millions of people in health care with methods, tools, and resources to make care better, safer, and more equitable; convenes experts to enable knowledge sharing and peer-learning; and advises health systems and hospitals of all sizes in improving their systems and outcomes at scale. IHI's mission is to innovate and lead transformational improvement in health and health care worldwide. Learn more at ihi.org.

Contents

Executive Summary

The Institute for Healthcare Improvement Leadership Alliance convened safety leaders and experts from across the health care industry to create a framework for standardized data collection of workforce violence incidents. The aim was to establish a comprehensive data standard to measure workplace violence events, enabling health care leaders to better understand the impact of their efforts and learn from one another across the industry. By leveraging the power of shared data, this approach supports the assessment of workplace violence prevention programs and interventions and creates a reliable approach to understanding and learning across the industry.

This publication includes:

- A description of the critical need and gap in standardized data collection across the health care industry related to workplace violence incidents;
- A recommended framework for standardized data collection of workplace violence incidents in health care, including critical data elements needed to effectively analyze incidents;
- Data definitions related to workplace violence;
- Considerations for collecting data; and
- Practical examples for visualizing collected data.

The standardized data collection framework offers organizations a valuable tool to enhance their ability to predict, prevent, and analyze workforce violence incidents within their own health care settings. Additionally, the use of a more standardized workforce violence data collection structure across the health care industry will enable organizations to collaborate more effectively and facilitate data-driven approaches to keeping the workforce safe from harm. These initial recommendations, informed by expert panel and industry partner input, lay the foundation for future efforts to test, refine, and expand the framework for broader industry implementation.

Introduction

The Institute for Healthcare Improvement (IHI) Leadership Alliance is a dynamic collaboration of health care executives from approximately 60 health care systems across the United States. IHI Leadership Alliance members share a goal to work with one another and in partnership with patients, workforces, and communities to deliver on the full promise of the IHI Triple Aim.[1] The Leadership Alliance offers a variety of opportunities for members to learn from one another, transform and innovate together, and use their collective voice to drive improvements in health care quality and safety. One such opportunity, Leadership Alliance Accelerators, enable members to advance the field of health care improvement in a specific topic area by incubating emerging theories of change or by developing testable innovation models.

For several years, the IHI Leadership Alliance has been dedicated to fostering opportunities for collaboration aimed at improving the safety of the health care workforce. In 2018–2019 the IHI Leadership Alliance Workforce Safety Workgroup developed and tested a theory of change to reliably identify and address workforce safety issues, focused on five foundational pillars:

- An explicit strategic goal focused on reducing workforce injuries;
- A process for senior leadership to review workforce safety data in real time, as close as possible (at least monthly);
- A robust injury review and reporting process;
- Multiprofessional teams chartered to improve workforce safety; and
- A means by which to share with and learn from other health care organizations.

These foundational pillars offered the framework for nearly three years of Leadership Alliance member-to-member learning based on sharing data specific to workforce harms. This workgroup came together again in 2021–2022 to collaborate on the topic of workforce violence and produced a toolkit focused on preventing verbal and physical violence across the health care workforce.[2] The toolkit provides recommendations and case studies to offer system-level strategies within equity, inclusion, and belonging; prevention and prediction; prioritization and measurement; system designs, leadership, and policy; and community partnerships and strategic relationships.

In 2023, IHI Leadership Alliance members expressed the need for ongoing efforts around workforce violence prevention due to its persistent and growing impact within their organizations and across the industry. To address this, the IHI Leadership Alliance convened the *Keeping Our Workforce Safe from Harm Accelerator* with a goal to advance the health care field by convening organizations and experts to clarify key drivers of workplace violence prevention, develop theories of change, and create testable innovations that enhance prevention and mitigation efforts.

Through collaborative efforts and shared expertise, this Leadership Alliance Accelerator has driven meaningful progress toward identifying, creating, and sharing best practice recommendations around workforce violence data collection and measurement to assist in predicting and preventing events as well as informing effective interventions to decrease

workplace violence incidents in the health care setting. This publication highlights the findings and recommendations from the IHI Leadership Alliance *Keeping Our Workforce Safe from Harm Accelerator*, including a Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care.

Background

Workplace violence in health care settings continues to be a growing concern, posing significant impacts to the safety and well-being of health care workers, patients, and families. According to the US Bureau of Labor Statistics, health care workers are five times more likely to experience workplace violence than those in other private industry sectors in the United States, with more than 72 percent of cases occurring among health care and social assistance workers.[3] Among health care workers, nurses are particularly vulnerable to this risk, with almost half reporting having experienced physical violence at work.[4] Violent incidents are even more pronounced within emergency departments, with two out of three emergency department physicians polled in 2022 reporting having been verbally or physically assaulted in the prior year, 24 percent of whom were assaulted multiple times per week.[5]

Definition of Workplace Violence

The Joint Commission defines workplace violence[6] as:
"An act or threat occurring at the workplace that can include any of the following:

- Verbal, nonverbal, written, or physical aggression
- Threatening, intimidating, harassing, or humiliating words or actions
- Bullying
- Sabotage
- Sexual harassment
- Physical assaults
- Other behaviors of concern involving staff, licensed practitioners, patients, or visitors"

The increasing frequency of workplace violence in health care is alarming. A 2022 Press Ganey report indicates that in the US more than two nurses are physically assaulted every hour, or an estimated 57 assaults per day. The number of assaults to nurses increased by 5 percent between 2022 and 2023.[7] The impact of violent incidents in health care is significant, with 69 percent of violent incidents resulting in days away from work and over 30 percent requiring job transfer or restriction.[8]

A common misperception is that the escalation in workplace violence in health care started with the COVID-19 pandemic; however, data show that violent incidents were on the rise prior to the pandemic. According to the US Bureau of Labor Statistics, there was more than a 60 percent

increase in the rate of workplace violence to health care workers from 2011 to 2018.[9] In 2018, health care workers accounted for 73 percent of all nonfatal workplace injuries due to violence.[10]

Regulatory Landscape

Multiple regulatory agencies and health care professional organizations recognize that workplace violence is a fundamental concern for the safety of patients, health care workers, and families and caregivers in the health care setting.

The Occupational Safety and Health Administration (OSHA) is the agency within the US Department of Labor that is responsible for oversight of worker safety and health protections for most private sector workers and their employers. OSHA offers a variety of tools and resources to assist health care and social service organizations in developing effective workforce violence prevention programs.[11,12] The development of an OSHA standard for prevention of workplace violence in health care and social assistance is currently under consideration, but has yet to be implemented.

In 2022, The Joint Commission created new workplace violence prevention standards that include 1) leadership oversight, 2) policies and procedures, 3) reporting systems, 4) data collection and analysis, 5) post-incident strategies, and 6) education and training.[13] The Joint Commission Workforce Safety and Well-Being Resource Center offers resources to assist organizations in creating and enhancing workplace violence prevention systems.[14]

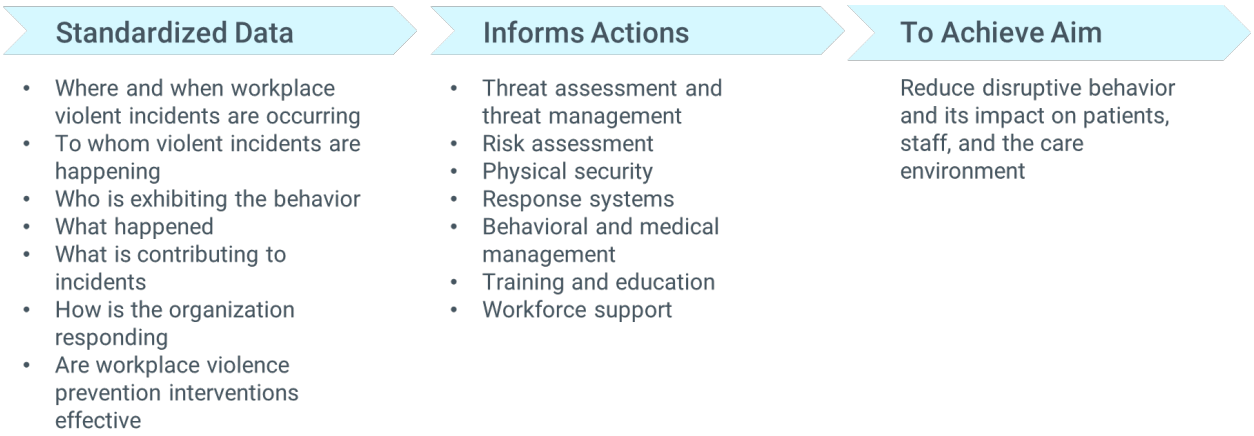
The US Centers for Medicare & Medicaid Services (CMS) enforces regulatory expectations that hospitals provide a safe environment for both patients and staff, including requirements around patient risk assessment, environmental safety analysis, and staff training.[15] Beginning in 2025, CMS will also require hospitals to complete attestation reporting on the Patient Safety Structural Measure (PSSM),[16] including having an action plan with improvement activities, metrics, and trends addressing issues such as workplace violence.

While OSHA and CMS guidelines provide the foundation for workplace violence regulation in hospitals and other health care settings, states such as California, Ohio, Illinois, Minnesota, and Oregon have enacted legislation to require health care employers in these states to implement workplace violence prevention plans, conduct risk assessments, provide staff training, and provide a reporting system for incidents of violence.[17] These state-level requirements often include mandates for collecting and reporting workplace violence incident data. The California OSHA Health Care Workplace Violence Prevention regulation requires health care employers to record information about every workplace violence incident, including response and investigation.[18] The Ohio Health Care Workplace Safety Act, enacted in January 2025, requires each hospital system to establish a workplace violence incident reporting system and utilize workplace violent incident data to develop a security plan for preventing workplace violence.[19]

The Need for Data Collection Standards in Health Care

The use of standardized data frameworks and detailed, comprehensive data collection systems in health care have been instrumental to advancing patient safety across a range of different safety outcomes. According to OSHA, risks of workplace violence assaults can be minimized or even prevented if risk factors can be identified and appropriate precautions taken.[20] The Joint Commission emphasizes that data is critical for a proactive approach to workplace violence prevention in health care, highlighting the importance of incident tracking and trending data over time to prioritize strategies and address risks.[21] The Joint Commission further notes the lack of nationally standardized measurement systems for reporting workplace violence incidents and recommends the adoption of standard processes for collecting and reporting data on workplace violence incidents to allow for more accurate benchmarking of violence prevention programs and promote modifications to reduce events.[22] Figure 1 outlines the importance of standardized data collection to inform the actions needed to reduce health care workforce harm.

Figure 1. Standardized Data Collection Informs Actions to Achieve Aims to Reduce Health Care Workplace Violence



To provide the foundation for understanding and mitigating workplace violence risks, the health care industry needs to implement standardized data reporting taxonomies, data definitions, and formats that allow for accurate classification, analysis, and aggregation of specific violence events. For example, a standardized taxonomy for analyzing medication errors and classifying the severity of patient harm related to the error has been in place since 1996;[23] these medication error report data are then collected and analyzed within health care organizations and shared across organizations for learning, risk assessment, and process improvement.[24,25]

One challenge is that health care workplace violence data are generally fragmented across multiple data and reporting systems within health care organizations, including safety/risk management incident reporting systems, electronic health records, police and security reporting systems, and employee injury/employee health record systems. Data fragmentation makes it difficult to create a synoptic view of workplace violence incidents across an organization's care delivery enterprise. The lack of a common data framework also makes it difficult for health care

organizations to aggregate and share data internally and externally for learning, process improvement, and governance of workplace violence prevention programs.

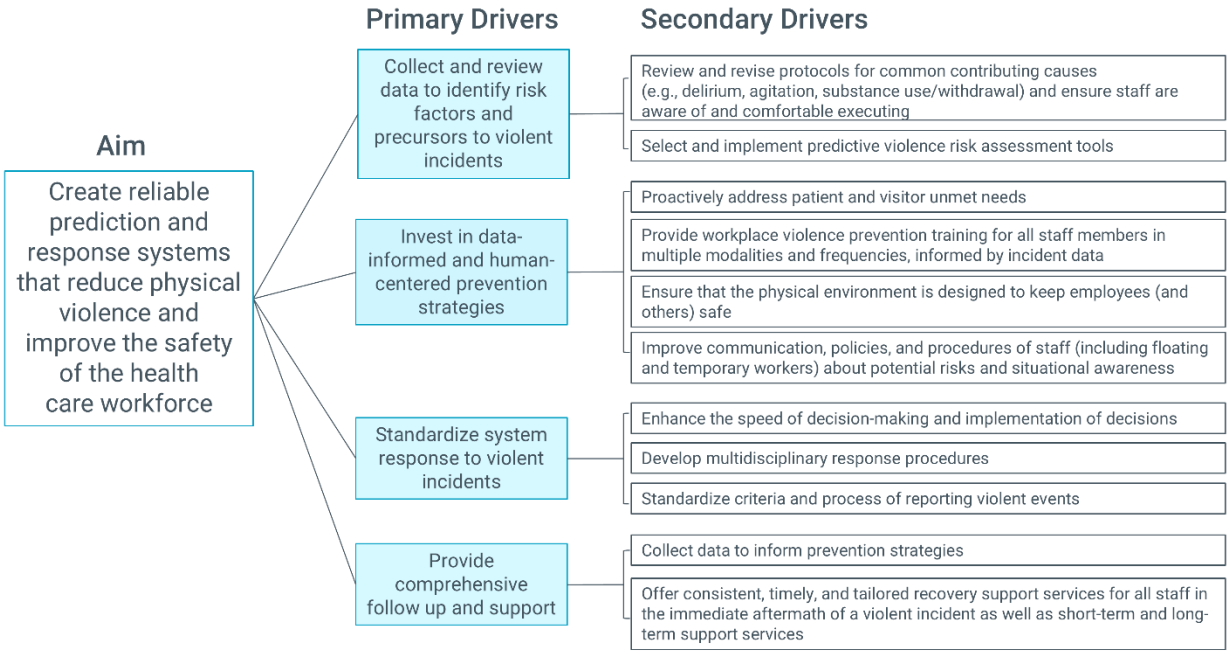
Methods

The data framework described in this publication was informed by a robust process that included an IHI innovation cycle, engagement with an expert panel, and collaboration with industry partners to collect data and gain insights into best practices.

Innovation Cycle

In October 2023, the IHI Innovation team conducted a 90-day innovation cycle[26] that included a comprehensive review of the literature and more than 30 interviews with health care safety experts across 19 organizations (see Appendix A). This cycle explored existing workplace violence prevention approaches and frameworks, identified best practices, and uncovered opportunities for improvement, which resulted in the development of a driver diagram (see Figure 2).

Figure 2. Driver Diagram for Health Care Workplace Violence Prevention



Expert Panel

An expert panel that included respected health care safety leaders from across the US reviewed the findings from the innovation cycle. The panel convened three times throughout 2024, determined a need to address and prioritize the gap in standardized practices and best practice

recommendations around workplace violence data collection, and guided the development of a draft standard data collection framework.

Industry Review

The IHI Leadership Alliance Accelerator workgroup gathered data from several leading US health care organizations and industry partners to gain a deeper understanding of current and best practices regarding specific metrics and approaches to workplace violence incident data collection and benchmarking. The group used surveys to gather, analyze, and rank data elements, helping to identify the most critical pieces of information needed to effectively understand and mitigate workplace violence incidents. Additional interviews with industry partners (see Appendix A) provided secondary reviews and further validated the standard data collection framework and data element recommendations.

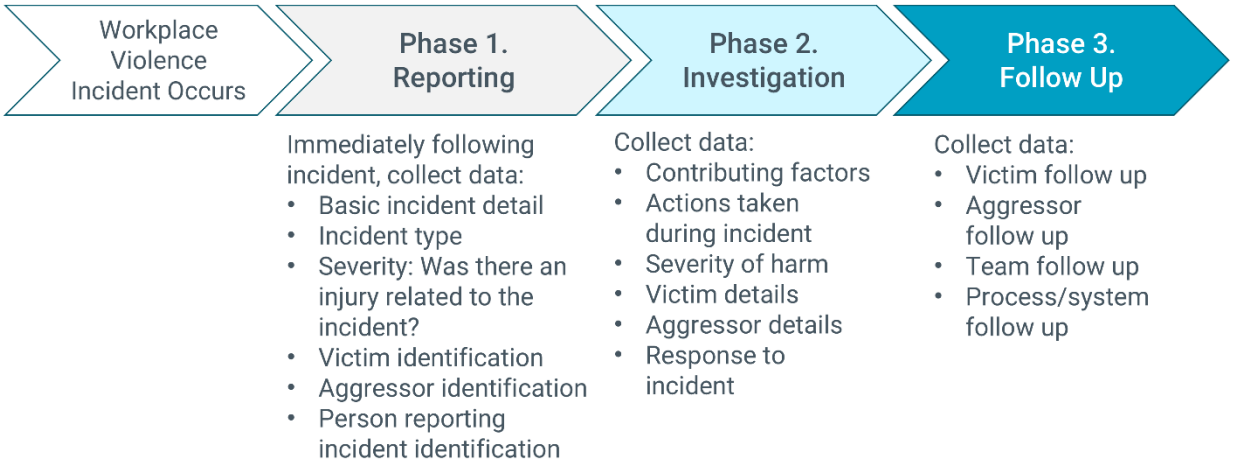
Framework for Standardized Data Collection of Workplace Violence Incidents

Figure 3 outlines the Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care, including key data elements to collect in three phases: 1) Reporting, 2) Investigation, and 3) Follow Up. This framework enables a structured and effective approach to collect and analyze data that is aligned with when and how information will be used to inform actions and next steps.

The standardized data collection framework uses an incident-based approach as the fundamental unit of analysis and data collection. Incident-based data includes specific details about workplace violence occurrences, including (but not limited to) information about victims, aggressors, times, locations, and the offenses involved. The advantages of using an incident-based unit of analysis include:

- Consistency with patient safety reporting;
- Ability to capture context for each occurrence of workplace violence; and
- Alignment of the framework with law enforcement incident-based reporting when workplace violence incidents involve criminal conduct.

Figure 3. Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care



Phase 1. Reporting

After a workplace violence incident occurs, it is important to collect key details, either from those involved in the incident or unit leaders, to inform immediate response while also keeping the data collection simple enough to encourage reporting. Essential data includes a brief description of the incident, the incident type (e.g., physical, verbal), severity of the incident, and basic identification information for the victim, aggressor, and person reporting the incident to know with whom to follow up. Table 1 includes a detailed list of recommended data elements to collect in the reporting phase, immediately following the incident.

Table 1. Reporting Phase Recommended Data Elements to Collect

Data Element	Detailed Data to Collect
Basic incident detail	• Date • Time • Location (department, building, unit) • Visit type (in person, phone, video, written) • Brief factual description
Incident type	• Physical assault • Verbal incivility: threat, harassment, intimidation • Damage or destruction of property • Inappropriate sexual behavior • Other disruptive behavior
Severity: Was there an injury related to the incident?	• Basic level of physical injury (none, minor, moderate, major, death) • If physical injury occurred: Who was injured? • Was a weapon used by the aggressor in the incident?

	(Categories adapted from National Database of Nursing Quality Indicators[27])
Victim identification	• Name of each victim • Victim type (patient, staff, visitor, other) • Provide an option for anonymous reporting
Aggressor identification	• If patient: Name/medical record number • Identity/name of aggressor(s) • Aggressor type (patient, visitor, staff, other)
Person reporting incident identification	• Name • Contact information • Role • Provide option for anonymous reporting

Phase 2. Investigation

During the investigation phase, more comprehensive data is collected to better understand what happened during the workplace violence incident. This information can be gathered by safety, security, quality, or operations teams following an incident. Identifying individual, situational, or environmental factors that may have contributed to the incident are important to understand the context and prevent future, similar incidents from occurring.

Detailed information regarding the actions taken during and following the incident — including who responded, de-escalation efforts, and whether the response was effective — are also essential to help inform future training and education, processes, and response systems. Gathering more detailed demographic information on both the victim and aggressor will help a health care organization understand patterns and identify individuals or groups at risk. By assessing factors such as age, gender, role, and other demographic information, organizations may be able to detect trends to help develop violence prevention strategies and ensure that resources are directed to areas of greatest need.

Table 2 includes a detailed list of recommended data elements to collect in the investigation phase.

Table 2. Investigation Phase Recommended Data Elements to Collect

Data Element	Detailed Data to Collect
Severity: Was there an injury related to the incident?	Severity categories (select one): • No harm • Emotional harm • Minor injury (first aid only) • Medical treatment beyond first aid* • Significant injury requiring emergency department visit, surgical procedure, or hospitalization for treatment*

	• Loss of consciousness* • Restricted work or transfer to another job* • Days away from work* • Death* (*Indicates OSHA-recordable injury criteria[28])
Victim detail	• Victim identification • If staff: Job title/role and department • Age • Sex • Race • Ethnicity • Primary language • Provide option for anonymous reporting
Aggressor detail	• If staff: Job title/role and department • Age • Sex • Race • Ethnicity • Primary language • Previously flagged for violent behavior (Y/N) • Workplace Violence Type** (select one): ○ Type 1: Criminal intent Aggressor has no association with the workplace or employees ○ Type 2: Patient/client Aggressor is a patient, client, or visitor and is violent toward employee(s) ○ Type 3: Worker on worker Aggressor is a current or former employee ○ Type 4: Personal Relationship Aggressor has a personal relationship with an employee, none with the organization (**Types adapted from National Institute for Occupational Safety and Health[29])
Contributing factors	Aggressor: • Under legal custody • Confusion/altered mental status • Alcohol/drug intoxication • Alcohol/drug withdrawal • Serious mental illness • Medical condition affecting behavior • Current tobacco/vaping use

	• Experiencing homelessness • Bias/discrimination (age, gender/sex, disability, race, religion) Process based: • Wait time/delay in care • Perceived needs not met • Staffing/resourcing • Policy/protocol related (e.g., visitor policy) • Personal belongings (e.g., access to contraband) • Communication (e.g., language barrier)
Actions taken	• Physical restraints used on aggressor? • Medication administered to aggressor for behavior? • De-escalation efforts? • Law enforcement involved?

Phase 3. Follow Up

Finally, collecting data on follow-up actions for the victim, aggressor, and the health care team(s) involved is important to assess the effectiveness of the response and identify areas for future improvement. For the victim, it's important to identify whether immediate support was provided, what physical and emotional support services were provided, and what additional resources were utilized. For the aggressor, it is important to track whether a debriefing occurred and what, if any, actions were taken to mitigate future incidents. It is also helpful to evaluate any follow-up actions for frontline health care teams and at an organizational level to reduce workplace violence incidents, such as workplace violence prevention education and training, process improvements, or safety reviews. Collecting this data helps organizations evaluate the most effective actions, identify gaps, and enhance strategies for preventing and responding to future workplace violence incidents.

Table 3 includes a detailed list of recommended data elements to collect in the follow up phase.

Table 3. Follow Up Phase Recommended Data Elements to Collect

Data Element	Detailed Data to Collect

Victim follow up	• Immediate victim support provided
	  ○ Physical care (Y/N)
	  ○ Emotional support (Y/N)
	• Debrief with victim occurred (Y/N)
	• Employee Assistance Program referral made (Y/N)

Aggressor follow up	• Debrief with aggressor occurred (Y/N) • Aggressor placed under arrest (Y/N) • Criminal charges filed (Y/N)

	If aggressor was a patient:
	• New violence risk banner/flag added to electronic health record (Y/N)
	• Clinical care plan adjusted (Y/N)
	• Corrective actions taken (define)
	  ○ Current encounter ended (when possible)
	  ○ Warning letter/notification
	  ○ Therapeutic restrictions implemented
	  ○ Non-emergent care services terminated

Frontline team(s)/ organization follow up	• Debriefing for team(s) provided (Y/N) • Root cause analysis completed, if appropriate (Y/N) • Incident report submitted to regulatory agency (e.g., OSHA, state department of health, accrediting agency), if applicable (Y/N)

Additional Data Considerations

Data Definitions

Creating clear and consistent definitions for workplace violence incidents is critical to ensuring standardization within health care organizations and across the industry. Establishing a common language enables staff and organizations to have a clear understanding of what each data point represents, leading to more accurate and reliable insights. Aligning definitions throughout the health care industry will make it easier to evaluate and utilize workplace violence incident data more effectively. Consistency in data definitions also enhances the accuracy, quality, and integrity of the data.

Utilizing picklists for data collection can further improve compliance while also simplifying and streamlining the data collection process. A list of health care security incident data definitions can be found in the 2022 International Association for Healthcare Security and Safety (IAHSS) Council on Guidelines Glossary of Terms.[30] See Appendix B for additional data definitions related to workplace violence incidents.

Use Cases for Workplace Violence Data

Workplace violence data can be used in multiple ways to enhance safety and operational efficiency within and across health care organizations. Some use cases for workplace violence data include the following:

- Conduct worksite analysis and risk assessments;
- Inform threat assessment and threat management;
- Develop and evaluate workplace violence prevention programs;
- Share learning and benchmark across facilities, health systems, and the health care industry;

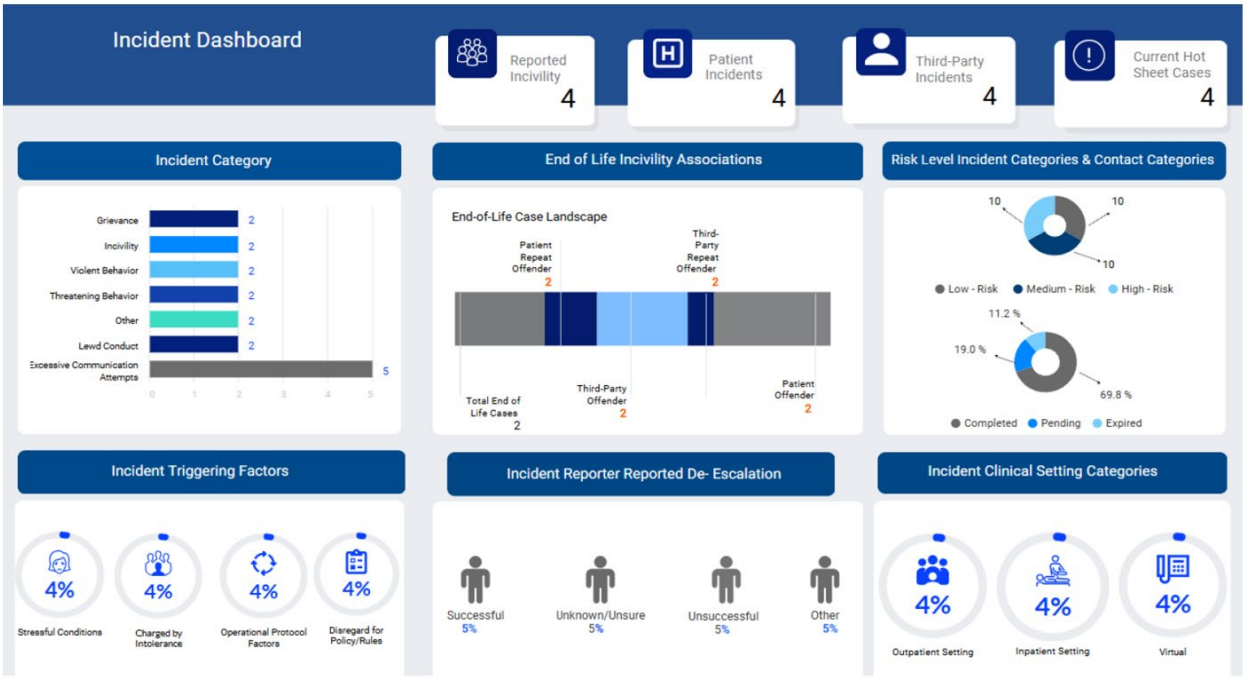
- Meet regulatory standards (Joint Commission, CMS, OSHA, state health department);
- Advance research and innovation to prevent workplace violence;
- Visualize trends for operational oversight and reporting of workplace violence incidents; and
- Standardize reporting to boards for organizational governance of workplace violence prevention programs and response systems.

Data Visualization

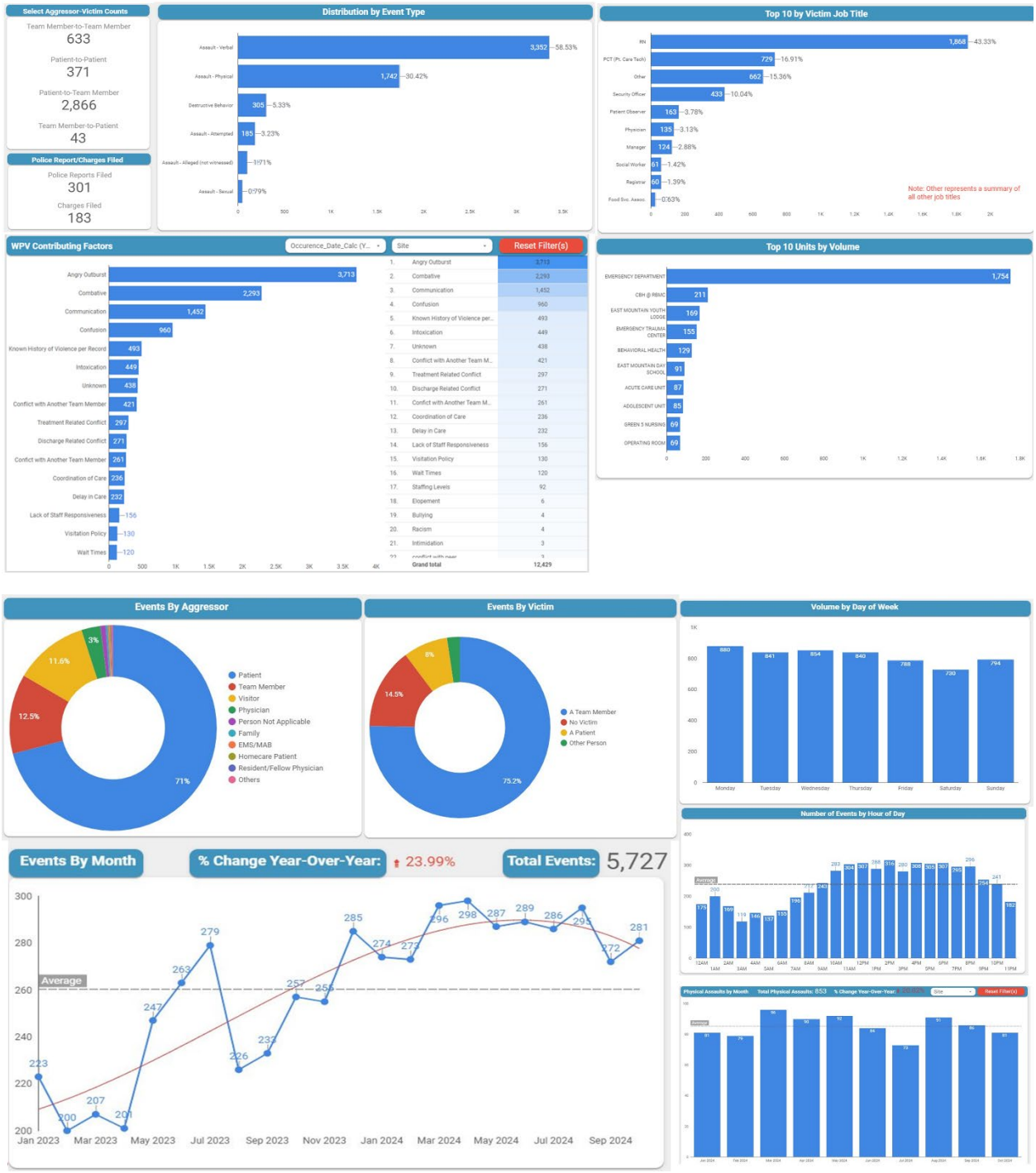
Data visualization plays a crucial role in effectively analyzing workplace violence incidents by transforming raw data into clear, actionable insights. Even small data sets can be effectively displayed to identify patterns and trends to promote data-informed decision-making. Figure 4 includes examples of workplace violence incident data dashboards from Memorial Sloan Kettering Cancer Center and Hackensack Meridian Health, showing a variety of formats in which data can be displayed and analyzed.

Figure 4. Example Workplace Violence Incident Data Dashboards

Illustrative example from Memorial Sloan Kettering Cancer Center (does not represent actual data).



Illustrative example from Hackensack Meridian Health (does not represent actual data).



Conclusion

Implementing a structured data and measurement system for workplace violence incidents in health care is essential for identifying potential patterns and informing future prediction and prevention response strategies. This publication presents a Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care that serves as a guide for organizations in collecting the data needed to better understand violent incidents, track trends, and evaluate the effectiveness of violence prevention interventions.

A standardized approach enhances data collection and analysis within organizations and also enables comparison of data across organizations, providing a foundation to work together to tackle workplace violence throughout the health care industry. By adopting a data-driven approach, organizations can build proactive and informed systems to ensure the safety of the health care workforce and those they serve.

Appendix A: List of Interviewees

Experts Interviewed During Innovation Cycle

- Johany Acebal, Public Safety Director, Nicklaus Children's Health System
- Alan Bennet, Associate Principal, Strategic Consulting Services, Press Ganey
- Linda Bergonzi-King, System Workplace Violence Prevention Coordinator, Yale New Haven Health System
- Jeffrey Boord, Chief Quality and Safety Officer, Parkview Health
- Thomas Brennan, Senior Manager, Health Care Finance and Data Analysis, Massachusetts Health & Hospital Association
- Keri Cross, Quality Specialist, Billings Clinic
- Jill Duncan, Vice President, Institute for Healthcare Improvement
- Karen Garvey, Vice President, Safety and Clinical Risk Management, Parkland Hospital
- Jennifer Goba, Senior Manager of Investigations, Mass General Brigham
- Dawn Hartfield, Deputy Registrar and Hearings Director, College of Physicians and Surgeons of Alberta
- Jill Hodge, Vice President, Security Services, Hackensack Meridian Health
- Mike Hodges, System Director of Public Safety, Piedmont Health Care
- Keziah Imbeah, Senior Research Associate, Institute for Healthcare Improvement
- Edmund Jacobs, Head of Health, Safety and Security, London Ambulance Service
- Mary Beth Kingston, EVP and Chief Nursing Officer, Advocate Health
- Gordon Lipscomb, Director, Office of Threat Management, Memorial Sloan Kettering Cancer Center
- Mathieu Louiset, Deputy CEO and Head of Improvement Services, PAQS
- Navneet Marwahal, Senior Vice President, Chief Medical Officer, and Chief Quality and Patient Safety Officer, Northern Light Health
- Bonnie Michelman, Chief Security Officer, Mass General Brigham
- Stephen Muething, Chief Quality Officer and Co-Director of the James M. Anderson Center for Health Systems Excellence, Cincinnati Children's Hospital
- Pat Noga, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association
- Jeff Rakover, Director, Innovation, Institute for Healthcare Improvement
- Jeff Salvon-Harmon, Vice President, Safety, Institute for Healthcare Improvement
- John Schallenkamp, Chief Quality Officer, Billings Clinic
- Amar Shah, Chief Quality Officer, East London NHS Foundation Trust
- Deeba Siddiqui, SVP and Chief Risk Officer, Hackensack Meridian Health
- Kimberly Stevenson, Director, Workforce and Clinical Affairs, Massachusetts Health & Hospital Association

- Arianna Urquia, Vice President and Chief Financial Officer, Nicklaus Children's Health System
- Janice Yanez, Director of Patient Safety, Nicklaus Children's Health System

Industry Partners Interviewed

- Alan Bennett, BSIE, MBA, CPPS, LSSBB, PMP, Associate Principal, Strategic Consulting, Press Ganey Associates
- Thomas M. Brennan, Senior Manager, Healthcare Finance and Data Analysis, Massachusetts Health & Hospital Association
- Melissa Campbell, MBA, CPPS, Senior Director, Safety and Reliability Delivery, Press Ganey Associates
- Jamel Cato, Network Director of Data Management and Systems for Enterprise Risk Management, Team Health, and Safety, Hackensack Meridian Health
- Tejal Gandhi, MD, MPH, CPPS, Chief Safety and Transformation Officer, Press Ganey Associates
- Christina Jones, MS, CIH, Director, Office of Outreach Services and Alliances, Directorate of Cooperative and State Programs, Occupational Safety and Health Administration
- Christina Morgan, MPH, Safety and Occupational Health Specialist, Office of Outreach Services and Alliances, DCSP, Occupational Safety and Health Administration
- Patricia M. Noga, PhD, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association
- Angela Pascale, PhD, Research Analyst, Press Ganey Associates
- Anu Puri, Executive Director, Chief Data Officer, Massachusetts Health & Hospital Association
- Ethan A. Swartz, BA, Senior Healthcare Data Analyst, Massachusetts Health & Hospital Association
- Dan Snyder, MSN, RN, LNCC, Enterprise AVP, Public Safety – Risk Mitigation, Advocate Health
- Kimberly Stevenson, MS, Director, Workforce and Clinical Affairs, Massachusetts Health & Hospital Association
- Jason P. Stopyra, MD, MS, Enterprise VP, Public Safety, Emergency Management and Business Continuity, Advocate Health
- Kelly Vance, Workplace Violence Prevention Program Director, Veterans Health Administration
- Lynn Van Male, PhD, CTM, Senior Director, Threat Management, Kaiser Permanente National Security Services
- Nora Warshawsky, PhD, RN, NEA-BC, FAAN, Nurse Scientist, Press Ganey Associates

Appendix B: Data Definitions for Workplace Violence Incidents

Term	Definition
Active Shooter	A situation involving a person who has or is threatening to use a firearm and may be moving from one location to another on campus.[31]
Aggravated Assault	An unlawful attack by one person upon another wherein the offender uses a dangerous weapon or displays it in a threatening manner or the victim suffers obvious severe or aggravated bodily injury, or where there was a risk for serious injury/intent to seriously injure.[32]
Assault	Attempt by one person to cause serious bodily harm to another person.[31]
Bullying	Repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipient.[33]
Destruction of Property	To willfully or maliciously destroy, damage, deface, or otherwise injure any public or private property without the consent of the owner or the person having custody or control of it.[32]
Domestic Violence	Crime of violence committed by a current or former spouse or intimate partner of the victim; by a person with whom the victim shares a child in common; by a person who is cohabitating with, or has cohabitated with, the victim as a spouse or intimate partner; by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred; or by any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred.[31]
Duress Alarm	An activation device placed covertly and accessible which is intended for security situations where silent notification is appropriate. Typical locations include cash handling areas, pharmacy, reception, and administration. See also Panic Alarm.[31]
Employee Assistance Program (EAP)	A professional assessment, referral, and short-term counseling service available to all employees and, in some situations, to their family members to help with personal problems such as substance abuse, financial pressures, job stress, and family dysfunction which may be affecting work performance. EAP services are voluntary, confidential, and provided at no cost to the employee.[34]
Harassment	Behavior that involves an intent to annoy, harass, or alarm another in person, by telephone, computer, other communication device, or by touching another person in an offensive manner.[31]
Incivility	One or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them.[33]

Intimidation	Unlawfully place another person in reasonable fear of harm through the use of threatening words and/or other conduct without displaying a dangerous weapon or subjecting the victim to an actual physical attack.[32]
Less-Lethal Weapon	Weapons, devices, and munitions that continue to pose a great risk of lethal injury, but the intent is not to cause death or bodily harm and do not measure up to the definition of "likely" in a court environment.[31]
Mitigation	Actions taken to reduce the exposure to and impact of a hazard.[31]
Murder	The killing of one human being by another.[31]
Panic Alarm	An activation device placed overtly and accessible which is intended for security situations where silent notification is not required. Typical locations include ICU, Behavioral Health, ED, and parking areas. See also Duress Alarm.[31]
Property Damage	To willfully or maliciously destroy, damage, deface, or otherwise injure real or personal property without the consent of the owner or the person having custody or control of it.[31]
Safety Risk Assessment (SRA)	A focused approach to safety within health care facilities developed by the Facilities Guidelines Institute. It is a multidisciplinary, documented assessment process intended to proactively identify hazards and risks and mitigate underlying conditions of the built environment that can contribute to adverse safety events. These adverse events include infections, falls, medication errors, immobility-related outcomes, security vulnerabilities or breaches, and musculoskeletal or other injuries. The Security Vulnerability Assessment is required for each new construction and renovation project.[31]
Security Assist	A range of incident or daily activity types completed by security staff for various groups supporting the health care facility to include patients, visitors, staff/volunteers, vendors, and contractors.[31]
Sexual Abuse/ Assault (including Rape)	Nonconsensual sexual contact, including oral, vaginal, or anal penetration or fondling of the individual's sex organ(s) by another individual.[31]
Targeted Violence	A situation where an individual, individuals, or group are identified at risk of violence, usually from another specific individual such as in cases involving domestic violence.[31]
Threat	Any verbal or physical conduct or situation that conveys, or could be implied or perceived to convey, an intent to threaten safety, negatively impact physical or psychological well-being or damage an organization's property.[31]
Use of Force	The amount of physical effort used to compel cooperation and compliance beyond a guiding touch.[31]
Weapon	Any instrument that can be used to injure, kill, or destroy. This includes, but is not limited to, firearms, knives, clubs, electrical weapons, and self-defense chemical sprays.[31]

Workplace Violence	An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.[31]
Workplace Violence Typology	Defines incidents using five Workplace Violence Types:[35] • Type 1: Perpetrator has no association with the workplace or employees. • Type 2: Perpetrator is a customer or patient of the workplace or employees. • Type 3: Perpetrator is a current or former employee of the workplace. • Type 4: Perpetrator has a personal relationship with employees, none with the workplace. • Type 5: Ideological violence directed at a health care facility, its people, and/or property for ideological, religious, or political reasons. Such violence is perpetrated by extremists and value-driven groups justified by their beliefs.

References

[1] Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. *Health Affairs*. 2008 May/June;27(3):759-769.

[2] Butkowski O, Duncan J, Martinez N. *Preventing Verbal and Physical Violence across the Health Care Workforce*. IHI Toolkit. Boston: Institute for Healthcare Improvement; 2022. https://www.ihi.org/sites/default/files/2023-10/IHI-Leadership-Alliance_Preventing-Verbal-Physical-Violence-across-Health-Care-Workforce-Toolkit.pdf

[3] Injuries, Illnesses, and Fatalities. Workplace Violence 2021–2022. US Bureau of Labor Statistics. https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022.htm

[4] *Fact Sheet: Workplace Violence and Intimidation, and the Need for a Federal Legislative Response*. American Hospital Association; 2022. https://www.aha.org/system/files/media/file/2022/06/fact-sheet-workplace-violence-and-intimidation-and-the-need-for-a-federal-legislative-response.pdf

[5] *ACEP Emergency Department Violence Poll Results*. Marketing General Incorporated; 2022. https://www.emergencyphysicians.org/siteassets/emphysicians/all-pdfs/acep-emergency-department-violence-report-2022-abridged.pdf

[6] R3 Report Issue 42: Workplace Violence Prevention in Behavioral Health Care and Human Services. The Joint Commission; 2023. https://www.jointcommission.org/standards/r3-report/r3-report-issue-42-workplace-violence-prevention-in-behavioral-health-care-and-human-services/

[7] Healthcare Safety Outcomes Are Improving But Patient and Workforce Experience Paints Mixed Picture, Press Ganey Report Finds. Press Ganey. April 2, 2024. https://www.pressganey.com/news/healthcare-safety-outcomes-are-improving-but-patient-and-workforce-experience-paints-mixed-picture-press-ganey-report-finds/

[8] Injuries, Illnesses, and Fatalities. Workplace Violence 2021–2022. US Bureau of Labor Statistics. https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022.htm

[9] Injuries, Illnesses, and Fatalities. Workplace Violence 2021–2022. US Bureau of Labor Statistics. https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022.htm

[10] Injuries, Illnesses, and Fatalities. Workplace Violence 2021–2022. US Bureau of Labor Statistics. https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022.htm

[11] Worker Safety in Hospitals: Preventing Workplace Violence in Healthcare. Occupational Safety and Health Administration, US Department of Labor. https://www.osha.gov/hospitals/workplace-violence

[12] *Preventing Workplace Violence: A Roadmap for Healthcare Facilities*. Occupational Safety and Health Administration, US Department of Labor; December 2015. https://www.osha.gov/sites/default/files/OSHA3827.pdf

[13] R3 Report Issue 30: Workplace Violence Prevention Standards. The Joint Commission; 2021:6. https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/

[14] Workplace Violence Prevention Resources. The Joint Commission. https://www.jointcommission.org/our-priorities/workforce-safety-and-well-being/resource-center/workplace-violence-prevention/

[15] Center for Clinical Standards and Quality. *Workplace Violence—Hospitals: Memorandum QSO-23-04-Hospitals*. US Centers for Medicare & Medicaid Services; 2022. https://www.cms.gov/files/document/qso-23-04-hospitals.pdf

[16] Patient Safety Structural Measure (Patient Safety). US Centers for Medicare & Medicaid Services. https://qualitynet.cms.gov/pch/measures/safety

[17] Workplace Violence. American Nurses Association. https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/

[18] Richardson LJ, Blanchard-Saiger G. *Healthcare Workplace Violence Prevention: How to Comply with the Cal/OSHA Regulations*. California Hospital Association; January 2017. https://calhospital.org/publications/healthcare-workplace-violence-prevention/

[19] White A, Baker RB. *House Bill 452: Regards hospital violence prevention, training, security plans*. The Ohio Legislature, 136th General Assembly; 2025. https://www.legislature.ohio.gov/legislation/135/hb452

[20] Workplace Violence: Overview. Occupational Safety and Health Administration, US Department of Labor. https://www.osha.gov/workplace-violence

[21] Workplace Violence Prevention: Data Collection. The Joint Commission. https://www.jointcommission.org/our-priorities/workforce-safety-and-well-being/resource-center/workplace-violence-prevention/data-collection/

[22] R3 Report Issue 30: Workplace Violence Prevention Standards. The Joint Commission; 2021:6. https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/

[23] National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). https://www.nccmerp.org/

[24] Institute for Safe Medication Practices National Medication Errors Reporting Program (ISMP MERP). https://home.ecri.org/pages/ecri-ismp-error-reporting-system

[25] Patient Safety Organization (PSO) Program. Agency for Healthcare Research and Quality. https://pso.ahrq.gov/

[26] Martin L, Mate K. *IHI Innovation System*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2018. https://www.ihi.org/resources/white-papers/ihi-innovation-system

[27] *Guidelines for Data Collection and Submission: Assaults on Nursing Personnel Indicator*. Press Ganey; July 2021.

[28] Recording and Reporting Occupational Injuries and Illnesses. 1904 Subpart C: Recordkeeping Forms and Recording Criteria. Standard Number 1904.7: General recording criteria. Occupational Safety and Health Administration, US Department of Labor. https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.7

[29] Types of Workplace Violence. The National Institute for Occupational Safety and Health (NIOSH), US Centers for Disease Control and Prevention. https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit1_5

[30] IAHSS Glossary of Terms. International Association for Healthcare Security and Safety. https://cdn.ymaws.com/www.iahss.org/resource/resmgr/guidelines/guidelines_2022/IAHSS_2022_Glossary_of_Terms.pdf

[31] IAHSS Glossary of Terms. International Association for Healthcare Security and Safety. https://cdn.ymaws.com/www.iahss.org/resource/resmgr/guidelines/guidelines_2022/IAHSS_2022_Glossary_of_Terms.pdf

[32] *2023.0 National Incident-Based Reporting System User Manual*. US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division; 2023. https://le.fbi.gov/file-repository/nibrs-user-manual-063023.pdf/view

[33] Workplace Violence: End Nurse Abuse. *Nursing World*. American Nurses Association. https://www.nursingworld.org/practice-policy/work-environment/end-nurse-abuse/

[34] DOL Workplace Violence Program: Appendices. Office of the Assistant Secretary for Administration and Management, US Department of Labor. https://www.dol.gov/agencies/oasam/centers-offices/human-resources-center/policies/workplace-violence-program/appendices

[35] Types of Workplace Violence. The National Institute for Occupational Safety and Health (NIOSH), US Centers for Disease Control and Prevention. https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit1_5