MASSACHUSETTS Health & Hospital ASSOCIATION

GUIDELINES *for* HEALTHCARE SAFETY *and* VIOLENCE PREVENTION

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FOREWORD

In response to the increased risk of violence in healthcare settings, the Massachusetts Health & Hospital Association (MHA) formed a Healthcare Safety and Violence Prevention (HSVP) Workgroup composed of a diverse group of healthcare professionals, including, but not limited to, healthcare security/public safety professionals, clinical leadership from psychiatry/behavioral health, and members of emergency medicine, nursing, risk management, and legal counsel. In 2019, the workgroup developed a guidance document to help healthcare facilities use evidence-based practices to create effective healthcare violence prevention programs. Over the last few years, the workgroup's accomplishments include adopting and reporting on a standardized data collection tool, creating a united set of principles for patient-visitor codes of conduct, providing regular education opportunities to disseminate safety and violence prevention strategies from local and national leaders, and advocating for federal and statewide policy changes related to healthcare worker protections. Taken together, these efforts have helped make Massachusetts a recognized national leader in healthcare safety and violence prevention and prompted collaboration and publications with colleagues across the country.

Additionally, healthcare organizations across Massachusetts have expanded their strategies and approaches to safety to include implementing new training opportunities for all staff, expanding risk assessments in compliance with new regulatory changes such as national standards from the Joint Commission, promoting patient and visitor codes of conduct, incorporating behavioral health resources into safety responses, and integrating trauma-informed care into their everyday work.

As such, this *Guidelines for Healthcare Safety and Violence Prevention* offers newly revised strategies for a comprehensive approach to healthcare safety and violence prevention across healthcare facilities, including emergency departments, inpatient settings, outpatient clinics, mobile health services, and home healthcare. It also recognizes that because every healthcare organization has its own unique needs, structures, economics, patient populations, and workforce environments, each entity's response to workplace violence will be different. There is no one single way to implement a workplace violence strategy for a healthcare setting, but these collected strategies can assist.

Contextual Changes Since the 2019 Guide Was Published

Much has changed since this guide was initially published in early 2019. The world has experienced a pandemic that claimed more than seven million lives; growing economic instability for many; a heightened awareness of racial and ethnic systemic inequities; increases in both pediatric and adult mental/behavioral health crises, leading to record levels of emergency department boarding; obstacles to LGTBQIA care across the U.S.; severe restrictions on reproductive freedoms for patients and providers across many states; and a workforce shortage crisis, leaving many healthcare organizations understaffed and workers strained. All these factors have contributed to a rise in tensions and violence in healthcare settings.

Many of these challenges have been documented in detail in other MHA reports, including a 2023 report on the increase of violence in hospitals. In response to the rise in violence, Joint Commission (JC) issued new Workplace Violence Prevention Standards that went into effect in January 2022. JC also compiled many resources for organizations to incorporate into their safety plans. Effective in January 2026, Joint Commission will launch National Performance Goals for acute care hospitals and critical access hospitals. These are not new requirements; rather they are existing requirements under one goal, "The hospital maintains workplace and patient safety," to more clearly show the components supporting workplace violence prevention.

The purpose of this MHA document is to provide additional and expanded strategies that have emerged over the past few years to support member organizations with maintaining a safety culture, reducing risk of violence, and improving wellbeing and outcomes for patients, providers, and staff.

2025 Updates to this Guide

- ✓ Adopts a health equity framework
- ✓ Expands the focus to include additional care settings
- ✓ Updates strategies and resources to address caring for special populations, including patients with dementia, those on the autism spectrum, and those with other developmental disabilities or behavioral/mental health conditions/considerations
- ✓ Includes the Joint Commission Workplace Violence Prevention Standards
- ✓ Incorporates principles of trauma-informed care
- ✓ Emphasizes support for victims and a focus on workforce wellbeing

Definitions and Current Regulations

The Joint Commission developed the following definition of "workplace violence" to ensure standardization of how incidents are reported across healthcare settings. This definition of workplace violence includes actions by patients, employees, and visitors (interpersonal and non-interpersonal) and has been modified from the language used by the Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health, and the U.S. Department of Labor.

> *"Workplace violence is 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."*
>
> *– Joint Commission*

Hospitals and healthcare facilities are required under existing state and federal laws and regulations, as well as accreditation requirements, to develop general policies regarding violence prevention for healthcare workers. These include the following:

- In Massachusetts, Chapter 151 of the Acts of 2010 puts into place enhanced penalties (not less than 90 days nor more than 2.5 years in House of Correction; a fine of $500 - $5,000, or both. MGL 265 s. 13I) for an assault or an assault and battery on a healthcare provider while treating or transporting a patient in the line of duty.
- In 2015, the Executive Office of Health and Human Services (EOHHS) issued regulations (101 Code of Massachusetts Regulations 19.00), pursuant to state law (Section 30 of Chapter 3 of the Acts of 2013) that requires any program that provides direct services to clients and is operated, licensed, certified, or funded by a department or division of EOHHS to have a workplace violence prevention and crisis response plan, updated at least annually, for social workers, human services workers, volunteers, and all other employees. Programs are required to provide a copy of the current plan to any employee of the program upon request.
- The Joint Commission, as part of the hospital accreditation program and routine survey, requires hospitals to meet various standards regarding the development of workplace violence prevention policies and services. In response to the rise in violence, JC issued new and revised workplace violence prevention standards for all Joint Commission-accredited hospitals and critical access hospitals that went into effect in January 2022 (R3 Report Publication Issue 30, June 18, 2021). Three new and one revised workplace violence prevention requirements for all Joint Commission-accredited behavioral healthcare and human services organizations went into effect in July 2024 (R3 Report Publication Issue 42, December 20, 2023). Two new and one revised workplace violence prevention requirements for all Joint Commission-accredited home care organizations went into effect in January 2025 (R3 Report Publication Issue 45, July 23, 2024). The National Performance Goals, one of which is focused on workplace and patient safety for acute care and critical access hospitals, will be launched by the Joint Commission in January 2026. This new chapter of National Performance Goals will replace the former National Patient Safety Goals®.

The Five Pillars of Healthcare Violence Prevention Efforts

The foundation of effective violence prevention in healthcare settings rests on several interconnected pillars that must exist in harmony to create sustainable safety cultures.

1. **Support from leadership** is imperative in creating a lasting violence prevention program that is embedded in a facility's culture. Leadership can guarantee the long-term sustainability of this work by allocating adequate resources to the effort. Leadership can also set the tone from the top-down that violence and incivility, in all forms, are not acceptable and leaders can instead foster a supportive, healthy work environment for all staff, patients, and visitors.

2. **Education and training** serve as the framework of prevention efforts, ensuring that all healthcare personnel—from direct care providers, public safety/security, and risk managers to administrative staff—possess the knowledge, skills, and competencies necessary to recognize, de-escalate, and respond appropriately to potentially unsafe or violent situations. This training-and-education framework must be comprehensive, ongoing, and tailored to the specific roles and responsibilities of different healthcare team members.

3. **Robust data collection and reporting** systems are central to evidence-based violence prevention efforts. Organizations should establish comprehensive mechanisms for documenting, analyzing, and reporting violent incidents, near-misses, and safety concerns. This data infrastructure should capture not only the frequency and severity of incidents, but also their underlying causes, contributing factors, and outcomes. Effective reporting systems provide benchmarks, encourage transparency, support learning from adverse events, and enable organizations to identify patterns and trends that inform targeted interventions.

4. **Integration of violence prevention into key clinical operations and physical design/layout of facilities** ensures that safety considerations are woven into the fabric of daily healthcare delivery. This includes embedding safety protocols into admission processes, care planning, medication administration, discharge procedures, and transitions of care. Careful considerations should be made when designing or renovating both public spaces and patient care areas to ensure the availability of quick and easy exits by staff when needed and that furnishings and other objects cannot be used as weapons. By aligning safety measures with clinical workflows and facility design/layout organizations can create more efficient and effective prevention strategies that healthcare workers can implement consistently without disrupting patient care.

5. **Interdisciplinary collaboration** represents another critical element of successful safety and violence prevention programs. The complex nature of healthcare delivery requires seamless coordination among clinicians, social workers, security personnel, health equity leaders, behavioral/mental health professionals, and administrative leaders. Each discipline brings unique perspectives, expertise, and intervention strategies that, when integrated effectively, create a more robust and responsive safety infrastructure. This collaborative approach ensures that violence prevention is not relegated to a single department or individual, but rather becomes a shared responsibility embedded throughout the organization.

Central to all safety and violence prevention efforts is an unwavering commitment to equity and the elimination of bias in safety practices. Healthcare organizations serve diverse populations with varying cultural backgrounds, socioeconomic statuses, abilities, and healthcare needs. Prevention strategies must acknowledge and address the ways in which systemic inequities, implicit bias, and discriminatory practices can contribute to or exacerbate violent incidents.

MHA's *Guidelines for Healthcare Safety and Prevention* provides healthcare organizations with a comprehensive framework for strengthening and sustaining effective violence prevention programs. It recognizes that creating safe healthcare environments requires ongoing commitment, adequate resources, and the engagement of all organizational stakeholders. By addressing each of these critical components—training and education, data collection and reporting, clinical operations integration, interdisciplinary collaboration, equity and bias prevention, and continuous evaluation—healthcare organizations can continue to evolve robust safety cultures that protect everyone within their care environments while maintaining their fundamental mission of providing compassionate, high-quality healthcare services.

Chapter One: Organizational Approach and Training

LEADERSHIP and OVERSIGHT COMMITTEES

Healthcare organizations will ideally have a dedicated, interdisciplinary team or committee to oversee the security and safety of staff and patients. This group assesses risk, safety, and operations with the goal of designing, evaluating, and implementing healthcare safety and violence prevention policies, programs, and practices for the facility or organization. Examples of departments that could be represented on this team include (but are not limited to):

- Security/public safety
- Risk management, patient safety, and quality improvement
- Diversity, health equity, and inclusion
- Human resources/occupational health
- Psychiatry/behavioral health
- Emergency medicine
- Emergency management
- Clinical operations/staff and leaders
- Spiritual care and chaplaincy
- System police (if applicable)

The committee's efforts ideally extend to all areas of the enterprise, including outpatient clinics, mobile services, and at-home care to ensure that safety programs are effective and accessible to all facility employees, patients, and visitors. This work may consist of, but is not limited to, providing input on the redesign of the built environment and facilities, enhancing policies and procedures, and ensuring a comprehensive process is in place for training, data collection, reporting, and ongoing evaluation.

There are a number of effective and sustainable strategies and policies that healthcare organizations can implement to keep staff and patients safe, such as:

- Having a dedicated security and safety team that may or may not include law enforcement;
- Designing facility layouts in accordance with best practices for safety;
- Restricting access where appropriate;
- Using technology within medical record systems to flag patients who are known to be high risk or repeat antagonists of violence;
- Employing alerts and panic buttons for staff;
- Installing signage detailing patient and visitor codes of conduct and consequences for violations;
- Creating crisis/emergency/behavioral health response teams;
- Ensuring supports are in place for victims of violence, including incident debriefing and peer support; and
- Imposing search and weapons policies.

Providing Direction: A Dedicated Committee

Developing an effective and sustainable workplace safety program usually begins with creating a dedicated group to provide direction for the program. This involves strong and consistent support from senior leadership, cross-departmental collaboration, and an ongoing commitment to maintaining internal improvements and policies, including targeted resources for interventions and tools.

STEP 1

Ongoing Leadership Support

Senior leadership should allocate adequate resources to support a designated committee in conducting comprehensive risk assessments across all locations. This includes support for/development of a standardized process for reporting events of workplace violence, allowing for thorough review and analysis. In addition, organizational leadership should ensure that a clear and accessible workplace violence prevention statement or code of conduct is publicly posted. (See more on code of conduct below.)

Such signage clearly articulates the organization's stance on incidents of violence and outlines the consequences for such behavior.

STEP 2

Collaboration Across the Healthcare System

When developing and evolving policies and procedures, it is critical to include representation from all relevant departments, personnel, and organizations that can contribute to internal review and drive changes based on the findings of the internal risk assessment. Additionally, the committee should consider engaging the organization's Patient and Family Advisory Council to incorporate the patient and designated support person perspective into the violence prevention process.

STEP 3

Sustainability of Improvement through Dedicated Resources

The committee responsible for workplace safety and violence prevention should consider leveraging internal safety event reports to evaluate current operations, identify areas of risk, assess the need for safeguards, and recommend targeted operational changes and resource allocations. The organization should also explore appropriate technology investments to track the effectiveness of implemented measures. Finally, designated committee members should consider presenting findings, including event reporting trends and proposed operational improvements, to the senior management and, when appropriate, to the organization's governing body.

EDUCATION and TRAINING

Education and training are critical components of a comprehensive workplace safety and violence prevention program. They ensure that staff are aware of relevant policies and procedures and are equipped with the tools needed to safely manage aggressive or violent behavior from patients, visitors, and others entering the facility.

Education must address both prevention and response, and account for variations in service areas, clinical operations, and facility geography. Training plans are ideally tailored to the unique needs of each department and role, based on risks identified through formal workplace violence risk assessments.

Leadership and Supervisory Training

Supervisors and managers play a pivotal role and receive specialized training that enables them to:

- Recognize early warning signs of escalating behavior;
- Confidently manage violent or high-risk situations;
- Conduct initial intake when an employee reports an incident; and
- Refer employees to services post-incident as necessary.

High-Risk Area Staff Training

Employees working in high-risk areas of the organization ideally receive focused training designed to:

- Prevent, respond to, and recover from violent events;
- Manage patients exhibiting behavioral health challenges;
- Apply de-escalation techniques and trauma-informed care principles; and
- Safely apply physical interventions or restraints when appropriate.

Because there is no one-size-fits-all training approach that suits all departments, healthcare facilities are strongly encouraged to collaborate with their security leadership and their workplace safety and violence prevention committee to assess departmental risks and determine appropriate training content and frequency.

Core Elements of a Workplace Safety & Violence Prevention Training Program

Effective training programs consider a range of modules, which may be delivered based on job function, department risk level, and organizational need. Common elements include one or more of the following:

Prevention and Incident Management

- ❑ Overview of workplace safety and violence prevention program policies and procedures
- ❑ OSHA workplace training
- ❑ Risk factors for workplace violence
- ❑ Active shooter preparedness and response training

Patient Management and Response Trainings

- ❑ Trauma-informed care principles
- ❑ Recognizing early signs of behavioral escalation
- ❑ De-escalation and effective communication strategies
- ❑ Restraint application and safety techniques training

Training Delivery and Frequency

It is recommended that healthcare facilities identify which trainings can be:

- Provided to all new hires during on-boarding
- Required annually for all employees
- Delivered on-demand or at regular intervals for staff in high-risk departments
- Provided in response to a workplace violence event and as part of a risk review process
- Included components of self-defense and behavioral health treatment

To support learning and maximize engagement, a blended learning approach is recommended, incorporating e-learning, simulation, instructor-led sessions, and scenario-based training when possible.

Funding and Resource Allocation

While there may be opportunities to secure external funding, such as through insurance carriers or federal and state grant programs, organizations can proactively plan and budget for staff training. The workplace safety and violence prevention program plays a key role in determining how best to allocate internal and external resources.

Examples of external funding sources include:

- Organization of insurance carriers (umbrella or risk-specific policies)
- Federal or state grant opportunities, such as the Susan Harwood Training Grants Program

Organizations in Massachusetts are using a variety of training resources to support workplace violence prevention efforts. These resources, listed below in alphabetical order, reflect a range of educational tools and vendor-supported programs commonly used throughout the state:

- Alert Lockdown Inform Counter Evacuate (ALICE) training
- HDTS training
- AVADE training
- Crisis Prevention Institute (CPI)
- Management of Aggressive Behavior (MOAB)

ORGANIZATIONAL RISK and THREAT ASSESSMENT

As of 2022, all organizations accredited with the Joint Commission are required to conduct annual risk and threat assessments, and even those not JC accredited are strongly urged to do the same. These assessments include a comprehensive review of physical and material security tools and equipment of all areas under the organization's license or domain. Assessments ideally will actively engage employees in the review process and may include a comprehensive security survey. The goal is to identify and analyze the risk of violent incidents by gathering data that answers the "who, what, where, when, how, and why" of the organization's current safety and security operations.

Records Review

Healthcare organizations should consider reviewing relevant data sources, determine what relevant reports are available, and identify what types of information are currently collected and maintained. Recommended sources of information include records from security leadership, risk management/patient safety, employee health, and human resources departments. (Care should be taken not to permit inappropriate access to sensitive or privileged records without the input of legal counsel.)

Examples of useful data include potential risk areas or incidents. Information and resources to consider including are:

- ✓ Safety event reports, including near-miss reports (including verbal threats, attempted or completed physical assaults whether intentional or unintentional)
- ✓ Threat assessments
- ✓ Workers' compensation claims related to workplace violence
- ✓ OSHA-required injury and illness reports
- ✓ First reports of injury filed with insurance and malpractice carriers
- ✓ Police reports
- ✓ Other daily operational logs deemed appropriate

Procedures

A review of current safety processes and procedures is encouraged. When possible, facilities can analyze current site operations and procedures to determine whether they contribute to potential risk for violence-related hazards. This includes:

- ✓ Conducting an environmental scan of tools and equipment locations, access to equipment, and other infrastructure, as well as the relationship between employees and employee codes of conduct, and/or job roles.
- ✓ Examining task-specific duties and the tools/resources used.
- ✓ Reviewing environmental factors within the workplace.

Employee Engagement and Culture of Safety

Organizations can use employee survey data, rounding, and staff meetings to bring frontline perspective into the organizational risk and threat assessment process. This includes:

- ✓ Developing a plan to engage employees before and after operational or policy changes related to workplace safety.
- ✓ Tailoring staff communications and engagement to site-specific concerns for groups of employees, including size, structure, and environment of each healthcare facility or specific care setting.
- ✓ Using employee feedback to understand risk perception. Some hospitals and health systems may use routine surveys, while others may benefit from in-person methods such as staff meetings and leadership rounding. The goal is to gather frontline insights on safety concerns and the effectiveness of current practices and training. These opportunities reinforce an organizational philosophy toward violence prevention and safety and the shared goal of making a safe and therapeutic work environment.

Questions that may guide employee engagement include:

- How safe do you feel working in this setting?
- How confident are you in the safety of this setting?
- What are the safety strategies you use while working?
- What daily activities or aspects of your job do you feel may expose you to the greatest risk of an incident of violence?
- What daily tasks or aspects of your job make you feel unprepared to respond to an incident of violence?
- How has a change in a patient's routine affected the precautions you take to prevent violence?
- What improvements to the safety and violence prevention training you receive would help you better identify and manage potential risks?
- What tools and resources would be most helpful to support your safety at work?

Security Assessment

Thoughtful practice for evaluating the physical environment includes conducting walk-through assessments of all areas of the organization with a focus on high-risk departments and units, including but not limited to psychiatric units, emergency departments, geriatric care units, admissions, maternal and child health, and waiting rooms.

These assessments also include review of an organization's grounds, building perimeters, points of entry, and egress parking areas. As part of this process, evaluation of existing security measures such as lighting, access control, surveillance cameras, duress alarms, and other emergency alert systems should be included to identify gaps and areas for improvement. The walk-through can incorporate ligature risk assessment and staff knowledge checks (i.e., emergency code response procedures). The assessment could also include an evaluation of the facility's location (e.g., urban v. rural v. suburban) and known crime activity in the area. A consideration of the types of services provided as a result of the location (e.g., higher psychiatric or trauma case load) can be generated from a review of the population the organization serves.

PATIENT FEEDBACK

When forming patient-facing policies, procedures, and practices, it is best practice for healthcare organizations to solicit input of patients and families through patient surveys, focus groups, interviews, and evidence-based research. Additional research can ensure equitable representation of individuals who may be affected by the changes. Partnering with existing groups such as Patient and Family Advisory Councils also builds and strengthens trust between healthcare organizations and the populations they serve, thereby contributing to a shared culture of safety within healthcare settings.

Examples of standard tools available to assist organizations in these efforts include:

- American Society for Healthcare Risk Management Workplace Violence Toolkit
- ASIS Healthcare Security Council
- International Association for Healthcare Security and Safety (IAHSS) Guidelines
- Public Services Health and Safety Association (PSHSA) Workplace Violence Risk Assessment Toolkit for Acute Care
- The WAVR-21 Violence Threat Assessment AppOSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- Security Vulnerability Assessment (SVA) — available through multiple vendors

CODE OF CONDUCT

It is the goal of every healthcare organization to foster an environment that prioritizes the safety of all people, including staff and patients, while also ensuring that operational practices, technologies, and the physical environment do not restrict access to medically necessary care.

Assaults, verbal threats, harassment, and other aggressive or threatening behavior undermine a safe work environment. Healthcare leaders are working daily to create safer work environments for employees. These efforts are only as effective as the support their organizations receive from everyone who enters their facilities – including patients and visitors. The significant rise in incidents within healthcare organizations prompted MHA members to issue a strong, unified message to the general public about the expectations of treating workers with civility and respect. In doing so, MHA members established a set of code of conduct principles to be adopted across each of their organizations. These principles are shown below.

MHA Member United Code of Conduct Principles

Approved by the Board of Trustees on January 26, 2023

Promotion of a Safe and Respectful Environment

I. Healthcare organizations are committed to uphold a code of conduct to maintain a safe, inclusive, equitable, and respectful environment for patients, staff, and visitors.
II. Healthcare organizations commit to the creation of policies and practices that promote the protection of staff, patients, and visitors.
III. A safe environment promotes patient, visitor, and staff safety.
IV. Offensive, abusive, or discriminatory language or behavior undermines the safety of patients and staff.

Code of Conduct Violations Could Include, but Are Not Limited to:

I. Disrespectful, aggressive, abusive, or violent behaviors or actions towards staff, patients, and visitors.
II. Threatening, discriminatory, bullying, disrespectful, or offensive language towards staff, patients, and visitors.
III. Possession of weapons or firearms.
IV. Disruption of other patients' care or experience.
V. Taking photos or videos of patients, visitors, and/or staff without permission.

Potential Consequences

All violations will be addressed by hospital staff per the organization's policies and procedures.

I. Patients violating the code of conduct may be asked to continue their care plan elsewhere and their future ability to obtain non-emergent care at the facility may require further review.
II. Anyone found violating the code of conduct may be asked to leave and future visits may be restricted.
III. The hospital may report violations of personal conduct to appropriate authorities.

Maintenance of Code of Conduct

I. Alert members of your care team if you witness or are a victim of behaviors or actions that violate the code of conduct.
II. Retaliation for reporting a violation is prohibited.
III. Staff will report all observed or experienced violations of the Code of Conduct to the appropriate individual or offices per the organization's violence prevention policy.

Organizations may alter the language and include additional items as appropriate for their individual facilities but agree to uphold the principles outlined on the previous page as a united, baseline standard. Taken together, these principles make clear that patients and their visitors must treat caregivers with respect at all times. And those who engage in abusive behavior will be subject to consequences, as dictated by the individual facility and review of the incident.

It is recommended that healthcare organizations not only expand upon this united set of principles but also establish clear escalation processes and procedures for handling violations of the code of conduct, and train staff on how to implement it. It is important for staff to understand the escalation path and when to request assistance from management and/or security. It is also important for staff to understand what kinds of behavior may or may not result in terminating future non-emergent care, and also how best to continue to provide necessary care to patients engaging in behavior that violates the code of conduct.

To ensure awareness, the code of conduct can be prominently displayed throughout the facility, particularly in high-traffic areas, using signage that incorporates visual symbols and plain language to communicate behavioral expectations.

Ideally, codes explicitly state that:

- ❑ The organization is a **weapon-free facility**
- ❑ Treatment (except in emergencies) may be delayed if a weapon is known to be present and poses a risk to the care environment
- ❑ **Video recording or photography** of healthcare staff or patients is prohibited without express permission from both the individual and the organization

These provisions are essential in deterring acts of intimidation, stalking, and other disruptive behaviors.

EMPLOYEE SUPPORT and RESOURCES

Employees and patients who experience or are witnesses to incidents of violence need to be provided with a comprehensive support system. This includes offering both medical and behavioral health treatment as appropriate, as well as information on the resources available to help the employee following an incident of violence.

Following an incident of violence, staff should receive immediate support, both physical/medical and psychological, as appropriate. Incidents should be documented in accordance with the organization's policies and procedures. When possible, the staff member should be removed from the immediate work environment to a safe space where they can decompress and receive initial emotional support from trained personnel or employee assistance program counselors if desired.

The staff member's manager should be informed of the incident and check in with and monitor the staff member's recovery as appropriate/needed. Depending on the severity of the incident, employees may need to take time off or modify their schedule, duties, or assignments on a temporary basis. Staff and management should discuss these options, as appropriate, with the organization's human resources and/or occupational health offices. Should an employee need time off or alternate work arrangements temporarily, the organization/management should have a reintegration plan that addresses the staff member's comfort level and any ongoing concerns about safety.

Organizational policies to support an employee's return to work following incidents of violence should be consistent with federal and state requirements. In addition, some organizations may have collective bargaining agreements with additional processes to consider; attention should be paid to those issues.

Resources and supports that may be considered, as appropriate, include:

- Employee Assistance Programs (EAPs)
- Occupational/employee health services
- Leave of absence
- Peer support
- Crisis debriefing
- Chaplain services
- Office of Clinical Support/Psychiatry
- Workers' compensation program
- Assaulted Staff Action Programs (ASAP) for psychological support
- Outside law enforcement, if there is a need for criminal action

Organizations should also consider policies that support staff should they choose to pursue legal action against those who commit violence. These policies could consider related time off requests to meet with police, attorneys, or appear in court; use of the hospital's address for related documents/mail rather than using their home address; and other relevant factors.

Chapter Two: Data Collection and Reporting

Data collection and reporting are foundational to any effective healthcare safety and violence prevention strategy. Without reliable and comprehensive data, organizations cannot fully understand the scope, frequency, or underlying drivers of safety incidents, including workplace violence, provider safety skills, patient factors, or behavioral emergencies. Collecting disaggregated data by race, ethnicity, language, gender identity, disability status, and social determinates of health factors is critical to identifying disparities in who experiences incidents and how interventions are applied. Transparent reporting not only supports accountability and regulatory compliance, it also advances a culture of safety, trust, and inclusion. When data are used proactively, they become evidence-based tools driving safer outcomes while ensuring interventions are dynamic and responsive to the needs of the provider and patient community.

POST-INCIDENT INVESTIGATION and REPORTING

Conducting thorough post-incident investigations is critical to ensuring effective safeguards are implemented to prevent future occurrences. Systematic, multidisciplinary, and timely investigations are key. The following steps are recommended as part of a comprehensive post-incident review process.

1. Reporting Requirements

Determine who needs to be notified internally and externally when an incident occurs. This includes identifying:

- Mandatory internal notifications (department leaders, senior executives, risk management, safety committees, or the board);
- External reporting requirements (law enforcement, DPH, Boards of Registration, Joint Commission); and
- Timelines for reporting.

2. Employee Involvement

Engage staff who were present or work regularly in the area where the event occurred. Their firsthand knowledge can offer valuable insight into causes, contributing factors, environmental considerations, and prevention solutions.

3. Review of Related Documents

Depending on the nature of the event, investigators may review records and documentation that can shed light on contributing conditions such as the involvement of hazardous materials or external threats. These documents may include:

- Staff training;
- Equipment maintenance logs;
- Safety inspections and audits; and
- Past incident reports or patterns.

4. Investigation of Near-Misses

Near-miss events — where acts of violence are threatened but not completed — are caused by the same conditions that can produce more serious outcomes, and signal that some hazards are not being adequately controlled or that previously unidentified hazards exist.

5. Post-incident Notification

Victims should receive notice that the investigation has been completed, any conclusions if allowable or appropriate, and a list of resources to assist the individual with follow-up steps.

6. Environmental Assessment

Following an incident, determine if there are changes that need to be made to objects and/or operational structures to prevent their future use as a weapon or as a barrier to a point of entry or exit (for staff, patients, visitors).

7. Classification of Incidents

Healthcare facilities are encouraged to adopt a standardized internal system for classifying incidents of workplace violence. This classification process may, when possible, consider whether a patient intended to cause actual harm or whether the patient was not competent at the time due to their medical or psychiatric condition, medication side effects, or cognitive impairment.

Organizations can decide whether clinical input or medical notes are necessary for classification purposes on a case-by-case basis. Classification of incidents can help the appropriate staff investigate gaps in systems that could decrease the risk of such incidents in the future and inform plans of care for individuals with known behaviors of concern. Incorporating clinical information allows identification of patient populations or diagnoses that may require additional staff training or variations in system designs. Examples include identification of risk patterns among patients on the autism spectrum, pediatric patients, and patients with dementia/delirium as a foundation for specific interventions.

Healthcare facilities are encouraged to leverage their existing safety event tracking system(s) to document and monitor workplace violence-related events. Integrating these events into existing systems allows for consistent documentation, streamlined data collection, and coordinated analysis along with other safety and quality events. This approach also supports trend identification, risk mitigation, and the development of targeted interventions. Commonly used incident tracking systems in healthcare settings include both security incident management software and healthcare safety and quality reporting systems:

- Perspective Security Software
- RLDatix
- Quantros
- Omnigo Security Software
- Guardtek Security Software
- Midas

When configured appropriately, these systems can capture critical details such as the type of event, location, parties involved, contributing factors, and follow-up actions, which enables a comprehensive approach to workplace violence prevention and response.

COMMUNICATION ACROSS SYSTEMS and the CARE CONTINUUM

It is important to consider how information related to violent or high-risk patient behavior is communicated across settings. Effective care coordination ensures relevant risk information is available to care teams as patients move through inpatient, outpatient, and community-based services.

This approach supports continuity of care while allowing staff to prepare appropriately and implement safety measures that protect both patients and workers.

Instituting standardized processes for flagging risk, documenting behavioral alerts, and facilitating handoffs across departments/ care settings is essential for maintaining safety throughout the care continuum.

REPORTING SYSTEMS

Having a system in place for staff/employees to report incidents of violence is important, and is also a component of Joint Commission standards. The system should be easily accessible and simple to use. While most organizations use a computer-based electronic reporting system, other innovations can support additional reporting. In the ideal design, workplace violence event reports are received by dedicated staff in real time, including the employee's manager/supervisor, which allows a team to check in and provide any necessary support for affected staff. A strong culture of reporting for *all* incidents of violence, including both verbal and written and/or those deemed "minor," is critical to accurately assess the volume of incidents over time and ensure that policies, procedures, and training are adequately addressing the needs of staff.

CONTINUOUS MONITORING and EVALUATION

Following completion of the annual workplace violence prevention worksite analysis, organizations can leverage the data collected to evaluate current practices, implement targeted improvements, and monitor the effectiveness of workplace violence prevention efforts. The following are examples of internal strategies healthcare facilities can consider. These are not prescriptive nor exhaustive, and each facility will need to determine which practices are appropriate based on its specific needs, resources, and types of incidents experienced.

A. Review of Healthcare Organization Policies

Healthcare organization policies regarding safety and violence prevention are ideally reviewed and modified where appropriate on an annual basis. Policies are informed by current violence prevention standards (e.g., those from CMS-Approved Accrediting Organizations), findings from annual worksite safety analyses, current laws and regulations, and effective practices from research literature and subject matter experts. Policies should also be reviewed through a lens of equity to ensure that they are not overtly or inadvertently promoting bias against any groups of people.

B. Data Collection and Reporting

Healthcare organizations work to make the process of reporting incidents of violence (verbal and physical) as quick and easy as possible. Key components include ensuring that electronic forms are easily accessible, simple to complete, and submitted to a dedicated person or team who review all submissions. Ideally the review teams follow up with affected individuals to see if they need any treatment, support, or if more information about an incident is needed. Patients and staff need to know that their experiences are being taken seriously and that, when warranted, appropriate actions are taken in response. A lack of response could lead to a decrease in reporting if employees feel that incidents are not going to be addressed.

It is important that reports are reviewed regularly to look for patterns or areas where security or safety can be improved. For example, data could show that certain areas of a facility may need more security staff, or certain times of the day require more frequent rounding.

Other uses for data include, but are not limited to, the following strategies:

- Establishing a standardized violence reporting system for all staff and conducting regular reviews of submitted reports;
- Engaging frontline staff regularly to understand their experiences with hostile or aggressive behaviors in the workplace;
- Reviewing input from safety and security discussions during team or department meetings to identify emerging concerns or patterns;
- Analyzing trends in workplace violence incidents, including illness, injury, or fatality rates, and comparing them to baseline or prior years' data;
- Measuring progress by tracking changes in frequency and severity of events involving healthcare violence;
- Assessing trends around security involvement to determine any possible conscious or unconscious bias against certain groups of individuals;
- Assessing impact of staff training such as de-escalation and self-defense by reviewing assault or attempted assault rates among trained versus untrained staff or departments;
- Maintaining detailed records of administrative and operational interventions, and periodically evaluating their effectiveness in preventing violence;
- Conducting pre- and post-implementation staff surveys when introducing changes within a facility (e.g., installing security equipment or altering workflows) to assess perceived effectiveness;
- Tracking and follow-through on committee recommendations, ensuring proposed changes are implemented and sustained in practice;
- Staying informed about emerging strategies and industry best practices in healthcare and social service violence prevention;
- Evaluating new security or operational measures after implementation to determine their role in reducing or preventing incidents in targeted departments or locations; and
- Requesting periodic external assessments, such as reviews from law enforcement or workplace safety consultants, to gather fresh perspectives and expert recommendations on improving staff safety.

These practices, when implemented thoughtfully, can help ensure a data-informed, proactive approach to reducing violence and enhancing safety across the healthcare environment.

Chapter Three: Clinical Operations

It is best practice to have safety and violence prevention policies, programs, and practices extend to *all* healthcare settings, including emergency departments, inpatient units, outpatient clinics, community-based settings, and mobile or at-home services. Special considerations apply to each care setting.

BEHAVIORAL EMERGENCY RESPONSE TEAMS

Healthcare organizations are increasingly implementing Behavioral Emergency Response Teams (BERTs) to manage acute behavioral crises and enhance the safety and wellbeing of patients and staff. BERTs are multidisciplinary groups trained to respond swiftly and effectively to escalating behavioral situations, particularly those involving aggression, agitation, or potential violence. Evidence suggests that BERTs significantly reduce the incidence of workplace violence, use of restraints, and rates of injury among staff and patients. Their presence also reassures staff and patients, fostering a safer therapeutic environment. BERTs also enhance staff confidence in handling challenging situations, which contributes to a safer, more supportive workplace.

Key elements of a successful BERT include:

1. **Multidisciplinary Composition**

   BERTs typically include behavioral health disciplines, security personnel, nursing staff, and administrators, including those with de-escalation expertise.

2. **Clear Activation Criteria**

   Healthcare organizations define when and how to activate BERTs and staff must know when and how to call the team, which is generally based on observable behavioral cues such as yelling, threatening language, pacing, or staff concern about escalating interactions.

3. **Rapid, Coordinated Response**

   Once activated, BERTs should arrive promptly and work collaboratively to stabilize the situation using verbal de-escalation techniques, clinical assessment, and trauma-informed engagement. The BERT's primary function is to provide consultation and guidance to a patient's primary caregivers who will be continuing to provide care and intervention once the BERT clears the call for assistance. This may include the development of a standardized plan of care and response to behaviors of concern.

4. **Training and Simulation**

   Regular team training, including simulation exercises, ensures readiness. All staff should receive education on recognizing behavioral escalation and how to access BERTs. BERTs are ideally grounded in trauma-informed care, recognizing that many patients exhibiting behavioral distress have histories of trauma. Interventions must promote emotional and physical safety; avoid re-traumatization through respectful, non-coercive, and collaborative engagement; and use calming techniques, clear communication, and patient-centered approaches to ensure patient and provider safety to prevent further escalation.

SPECIAL POPULATIONS

Workers caring for individuals with intellectual and developmental disabilities (e.g. autism spectrum disorder, attention-deficit/hyperactivity disorder, Down syndrome), acute behavioral health conditions, or dementia must be equipped with both clinical insight and safety strategies to ensure compassionate care and maintain provider and patient safety. Understanding the unique characteristics of these populations is a critical first step.

Patients with intellectual and developmental disabilities (I/DD) may have limited communication abilities, sensory sensitivities, and difficulty understanding complex instructions, which can lead to fear, frustration, or mistrust. When patients with I/DD are non-speaking or have limited verbal expression, their actions, behaviors, and other non-verbal expressions are often their primary ways of communicating. They may express themselves through gestures, vocalizations, and/or alternative/augmentative communication devices. When distressed, ill, or in pain, they may express this discomfort through aggressions, self-injurious behavior, or bolting. For example, an individual with autism and gastrointestinal dysmotility may express abdominal pain caused by severe constipation by self-injury of banging their head against an object or hitting a caregiver. It is important for staff to be aware that these behaviors can be a means of communication and be as proactive as possible in their encounters to learn about how the patient communicates. Family, support persons, or other trusted caregivers are an invaluable resource for input on how to interpret and support the patient's communication and access to medical care.

Individuals with behavioral health conditions — such as psychotic disorders, severe depression, or personality disorders — may also have limited communication abilities, sensory sensitivities, and/or heightened affective states due to acute psychosis, including impulsivity or heightened reactions to stress.

Patients with dementia often experience progressive cognitive decline, resulting in confusion, paranoia, wandering, or aggression, especially in unfamiliar or overstimulating environments.

A key component of safety and violence prevention is conducting a thorough patient risk assessment upon admission and ensuring the environment is as therapeutic as possible to minimize overstimulation. This includes reviewing the patient's clinical history, how the patient communicates and expresses pain, and their trauma history, and then identifying triggers or effective calming strategies. Developing individualized care plans, ideally created with input from the patient, family members, and an interdisciplinary care team, help guide staff in responding appropriately to each patient's specific needs and behaviors. The use of clearly identified trigger warnings — such as known sensitivities to touch, noise, or changes in routine — can serve as an effective prevention tool by alerting staff to conditions that may provoke distress or escalation.

Healthcare workers can use calm, respectful, and simple language, avoiding medical jargon or abstract instructions. Allowing extra time for processing, providing clear choices, and maintaining a non-threatening posture can help patients feel safer, build trust, and prevent confrontations. Verbal de-escalation techniques, such as acknowledging emotions, redirecting attention, and offering reassurance, are essential skills for all frontline staff. In certain cases, involving mental health professionals or security personnel early can prevent situations from becoming unsafe (See more in *Appendix: Resources for Communication*.)

HOME HEALTHCARE

Home health and home care workers provide important services in environments that differ significantly from clinical or facility-based settings. The home environment is not under the organization or agency's control and can vary widely in terms of safety, cleanliness, and interpersonal dynamics. As a result, organizations and agencies must take proactive steps to support the safety and wellbeing of their staff while providing care.

Worker safety in the home setting requires both organizational policy and individual situational awareness. Agencies typically address home safety through training, risk assessment, communication protocols, and escalation procedures. These efforts are essential in preventing harm, supporting staff retention, and promoting a culture of safety.

Key strategies and practices include:

- **Environmental and Physical Safety**
  Staff are trained to identify environmental hazards during visits, such as cluttered walkways, blocked exits, poor lighting, loose rugs, or unsanitary conditions. These risks may pose a danger not only to staff but also to patients and should be reported and documented according to agency protocols.
- **Personal Safety and Situational Awareness**
  Agencies commonly incorporate training on situational awareness, de-escalation techniques, and boundary setting. Staff are encouraged to trust their instincts and leave a home if they feel unsafe. Clear policies around when and how to end a visit due to safety concerns are essential.
- **Pre-Visit Risk Screening**
  Some home health agencies conduct pre-visit safety assessments based on referral information or known patient history. This may include reviewing the address against the Massachusetts Sex Offender Registry and noting any prior incidents or warnings from referring facilities or case managers.
- **Communication and Check-In Protocols**
  Agencies may implement systems that require staff to check in and out of visits, especially for first-time or high-risk patients. Some use mobile applications with GPS tracking or panic buttons, while others have internal escalation protocols to respond quickly to staff concerns.
- **Collaborative Safety Planning**
  In situations where there are known or suspected safety risks, agencies may involve families, other providers, or law enforcement in planning care. This may include scheduling visits in pairs, adjusting timing, or creating written safety agreements.

By addressing home safety systematically, providers can create a work environment that supports staff confidence and reduces the risk of harm — both physical and psychological. As the population ages and the home care landscape expands, thoughtful planning around worker safety remains a foundational element of high-quality care delivery.

ADDRESSING ENVIRONMENTAL FACTORS

The healthcare environment itself may be modified to promote calm and reduce risk. This could include removing unnecessary equipment or potentially dangerous objects, minimizing noise and lighting, and using clear signage to support orientation. Ensuring staff have a clear path to exit the room and encouraging a "buddy system" when working with high-risk patients can enhance team safety.

Addressing common triggers proactively can mitigate patient distress that could lead to escalation.

Examples include:

- Providing frequent and preferred meals or snacks and drinks to avoid hunger and thirst;
- Providing warm blankets or bedside fans for temperature regulation;
- Addressing toileting needs proactively and promptly;
- Facilitating sleep by minimizing interruptions, such as avoiding overnight vital signs unless medically indicated;
- Implementing cluster care to provide periods of rest, and when possible providing clustered care during periods of calm;
- Ensuring any assistive devices, such as glasses, hearing aids, and comfort items are within reach; and
- Ensuring access to support persons outside of visiting hours; these are trusted individuals whose support positively affects the patient's clinical outcomes, including risk of violence.

Ongoing staff training in trauma-informed care and behavioral crisis response is critical, as is embedding trauma-informed care principles in the delivery of care.

Chapter Four: Healthcare Security and Safety Operations

SECURITY and LAW ENFORCEMENT

Healthcare facilities should allocate appropriate resources and provide comprehensive training to prevent and respond to workplace violence. Security professionals play an essential role on the healthcare team, helping to maintain a safe environment for patients, workers, and visitors.

Training

Security professionals should ideally receive regular, specialized training in the following areas:

- ❑ De-escalation techniques to safely manage potentially volatile situations;
- ❑ Proactive and reactive patrol, searches of rooms and property, contraband and weapons management, environment-of-care safety, self-defense, control and restraint, and incident response protocols, including internal policies and procedures related to workplace violence events and safety searches;
- ❑ Safety event reporting to ensure accurate and timely document of events;
- ❑ Where possible, training/drills in mixed groups of clinical and security staff to enhance professional relationships and collaboration; and
- ❑ Appropriate use of mechanical restraints applied only as a last resort and in accordance with organization policy and patient rights.

Several training programs and systems are available to support these efforts, some of which are highlighted in *Chapter One: Organizational Approach and Training*.

Security Technology

Healthcare facilities should thoughtfully evaluate and implement security technologies as appropriate, based on their unique geographic, demographic, and operational characteristics, current security controls in place, and existing risk assessments. Security technology may be custom designed to fit the risks inherent in the organization, using the leadership of staff who are objective and not employed by a security technology supplier.

Law Enforcement

Healthcare facilities are encouraged to maintain an ongoing relationship with local law enforcement agencies and to designate a facility liaison to coordinate safety coordination efforts. Facilities may consider routinely engaging police departments or independent consultants to review potential security risks, using data from past incidents both on-site and in the surrounding community.

Furthermore, healthcare organizations can establish a clear set of processes and expectations with external emergency response partners if and when it is necessary to rely on law enforcement assistance in managing a violent incident, as well as when an employee wishes to pursue criminal charges as a result of a violent event. This proactive approach supports the collaboration between the internal and external security/safety professionals.

SPACE DESIGN, ACCESS SYSTEMS, and REPORTING

Space Design

Organizations have implemented a variety of engineering controls to mitigate the risk of violence toward employees, patients, and visitors. The following examples illustrate commonly adopted practices in healthcare settings. However, it is understood that not all organizations will have the capacity to implement every recommendation due to limitations in physical infrastructure, available resources, or service-specific constraints.

Facilities should evaluate and prioritize engineering controls based on factors such as available resources, the culture and environment of specific service areas, the types of treatments provided, and the characteristics of the patient population served. Tailoring these controls to the unique needs and risks of each setting can help ensure their effectiveness and sustainability.

Good practices include training all employees in the use of the emergency duress system(s); these may include stationary or mobile panic buttons that alert internal emergency responders. Silent panic buttons may be placed in strategic locations such as team stations, concierge desks, registration desks, pharmacy, and nursery, and used as a discrete means to alert for help in an emergency. Mobile panic buttons can be used in similar ways and locations but offer the advantage of moving with the employee, typically affixed to or worn with a name tag or security badge.

Patient rooms are ideally designed to provide staff the ability to "own the door," meaning the ability to directly exit a patient room as needed. When staff are not able to maintain a clear exit from a room, it is recommended that multiple staff be present at the bedside for safety purposes. All staff are encouraged to increase awareness regarding egress routes in all locations to effectively exit rooms, departments/units, floors, and buildings.

Barrier Protection

Organizations may consider installing barriers such as windows or deep counters in places where staff interact with the public/patients. This could include nursing stations and check-in desks. They may also consider locking doors for staff and treatment rooms from the public side, and using technology such as keyless entry systems.

Patient and Client Areas

To the extent possible, waiting areas and treatment areas should be designed in such a way to provide space to limit the spread of agitation amongst patients and visitors. Areas should also be identified for people to de-escalate when necessary. Effort should be given to reducing the level of noise in an area to the extent possible.

Furniture, Materials, Maintenance

Good practice includes an environmental survey for items that could be used as weapons, such as furniture, supplies, and equipment. Where possible, items should be secured to prevent their use as a weapon as appropriate to the setting. Examples of proactive environmental surveillance include replacing or refurbishing items with sharp corners or placing padding over them to reduce the risk of injury. Consideration can also be given to limiting other protrusions, such as the use of continuous hinges on doors, or recessing equipment into the wall.

Travel Vehicles

If patients will be transported, the organization should ensure that the vehicle is properly maintained and checked at regular intervals to ensure it is in good working order. Good practice includes ready access to a communication device for staff during transport and a process for base/organization staff to remain oriented to their location at all times, should they need to call for help while on the road. An organization may also wish to subscribe to a GPS service to help locate mobile staff while on duty. Ideally, vehicles should also have a barrier in place between the patient and driver. Protocols can also be put into place to inspect the passenger compartment before and after each use for any items of concern that may be present.

Access Control Systems

Best practice encourages organizations to ensure a systematic and consistent approach to the deployment of access control systems, with such systems designed based on assessments of the facility with consideration given to life/fire safety code. When evaluating access control processes, organizations can:

- ❑ Identify what areas will be secured and how (e.g. all medication rooms and doorways separating public spaces from patient care areas will be secured via card access).
- ❑ Identify who should receive card access and how that access is requested and approved.
- ❑ Ensure that access is provided to only those areas necessary.
- ❑ Ensure staff have the means to allow access and screen the patients/clients prior to doing so (e.g. intercoms and door releases).

Most access control systems will include capabilities for monitoring door status alarms (held open, forced open). The organization should establish processes for identifying which door alarms are monitored, how and by whom, and how alarms are responded to.

Organizations should also establish clear processes for the regular inspection of equipment and auditing of access lists, and clear processes for resolving issues.

Space Design, Access Systems and Reporting Considerations

Security/Silenced Alarm Systems

This category includes fixed and mobile panic buttons, paging systems, or personal alarm/duress devices that can be worn or easily accessed by employees to summon assistance. Issues to consider when implementing a panic/silent alarm system include:

- ❑ **Processes for monitoring the alarm system and receiving alerts by security or response personnel, and acknowledging receipt of an alarm**
- ❑ **Ensuring that all alerts/alarms clearly identify their location for the person receiving**
- ❑ **For wireless alarm systems, ensuring the organization and employees understand the accuracy of location reporting**
- ❑ **Clear response protocol and steps to be followed in the event of an activation**
- ❑ **Processes for the regular, frequent testing of devices to ensure they are in good working order**
- ❑ **Security silenced alarm systems**
- ❑ **Blue light phones in parking lots**

Egress Routes	❑ Two exits for certain examination rooms, if applicable, and when not, furniture placement that allows clear and close exit routes, allowing the caregiver to be closer to the door ❑ Safe rooms for employees to shelter during emergencies ❑ Marked "safe" doors, i.e., those that cannot be opened from outside if locked, with nondescript stickers or other marker that employees will recognize
Monitoring Systems & Natural Surveillance	❑ Closed circuit video inside and outside the facility ❑ Curved mirrors used in patient rooms and hallways to assist with full visual range prior to physically entering a space ❑ Placement of nursing stations to allow for visual screening of areas ❑ Glass paneling in doors and walls ❑ Employee knowledge of whether video monitoring is in use and whether someone is always monitoring the video ❑ For employees, avoiding turning their backs to public/patient spaces ❑ Staff video surveillance monitoring systems in team stations or other staff/patient facing locations — with privacy screens ❑ Crime prevention through environmental design, when possible ❑ Flags or markings for rooms of patients identified to be high risk for violence so all staff members are aware prior to entering
Assessment Tools	❑ Violence risk assessment tools to better identify patients at risk of violence (e.g., Brøset Violence Checklist, DASA, ABRAT)
Barrier Protection	❑ Deep counters at nursing stations and registration desks ❑ Controlled access to team station behind locked door ❑ Plexiglass and enclosed team station ❑ Locking entry doors to units with controlled access/intercom system ❑ Locked doors for staff and treatment rooms ❑ Keyless entry systems
Patient and Client Areas	❑ Private areas for patients and clients to de-escalate ❑ Comfortable waiting areas to reduce stress ❑ Divided waiting areas to limit spreading agitation among clients and/or visitors

Furniture, Materials, Maintenance	❑ Securing of furniture and other items that could be used as weapons ❑ Replacement of open hinges on doors with continuous hinges ❑ Locks on drawers containing supplies that can be used as a weapon ❑ Padding or replacement of sharp-edged furniture ❑ Noise reduction in certain areas ❑ Recessed handrails, drinking fountains, and other protrusions to protect against ligature risk ❑ Safe chairs in behavioral health settings ❑ Removal of potentially weaponized items from the rooms of high-risk patients (including but not limited to food trays, extra chairs, IV poles, clocks, medical equipment, etc.)
Lighting	❑ Bright, effective lighting inside and outside the facility, parking areas, and walkways ❑ While lighting should be effective, it should not be harsh or cause undue glare ❑ Dimmers where appropriate
Travel Vehicles	❑ Physical barrier between driver and patients ❑ Proper maintenance of vehicles at all times
Access Control Systems	❑ Systematic and consistent approach for the facility regarding access control systems, designed based on vulnerability and other assessments of the facility ❑ Security escorts for employees in dark/evenings walking to vehicles

SEARCHES of PATIENTS and VISITORS for DANGEROUS ITEMS

Healthcare organizations should establish a standard policy and practice for searches across settings that include information on obtaining patient and/or visitor consent for participation, how and why searches for dangerous objects or illicit substances may be performed, how dangerous objects and illicit items are handled, and how the search and results are documented within internal records and incident reports.

The policies should also outline the clinical and/or safety reasons for conducting a search of the patient or visitor as well as of their belongings, gifts/food brought to patients, and/or patient room upon admission, as well as upon the patient returning from leave of absence/interrupted stay. This policy should include leaves for the day or shorter periods where a patient's clinical condition changes unexpectedly following their return to their inpatient level of care. Healthcare organizations are encouraged to develop a specific process for determining when a search is appropriate, including a policy and procedure that would allow a search without patient consent if there were an identified immediate risk that warrants such a search. In particular, there needs to be a documented reason that would allow for a search, including significant suspected risk by the healthcare staff (clinical and administrative) that illegal, dangerous, or potentially harmful items are being brought into the healthcare organization's facility and/or property.

Examples of the items that could pose reasonable suspicion and that could be included in a policy may include:

- Medication or drugs that the healthcare organization clinical staff has not prescribed.
- Illegal, dangerous, or potentially harmful objects or intoxicating substances.
- Unauthorized property that poses a risk of harm to self, staff, or another patient.
- Information that the healthcare organization has maintained that a patient, visitor, or other individual has a recent history of overdose or self-harm behavior or violent events involving a weapon or other dangerous item.
- Demonstrating behavior (e.g., combative, threatening, verbally abusive, or aggressive) that risks harm to the patient, staff, or another patient.
- Unexplained change in clinical condition such as somnolence, signs of intoxication, etc.
- Documented past history of possession of illegal, dangerous, or potentially harmful objects or intoxicating substances.

Healthcare organizations should strive to provide information and resources to patients and visitors in their preferred language to explain the reason and implications of the search. Staff conducting the search should ask for consent from patients and visitors throughout the search, including when the search may require physical contact. For patient searches, the patient must be informed as to the reason for the search in a voluntary and non-forcible manner and when possible and appropriate, be present during any search of their belongings, packages, gifts, and/or room. Exceptions for consent may occur in emergency circumstances when there is an immediate risk of harm to patients and/or staff. For searches that occur in an emergency circumstance and for which the patient may not be present during the search of their belongings and/or property, the patient should be informed as soon as possible. Consistent with best practice of trauma-informed care, before conducting the search, staff should gather relevant information on trauma and sexual assault history to minimize any distress to the patient or visitor.

Note that CMS considers unconsented-to searches as a restraint and seclusion, and as such will need to be supported by a provider's order, consistent with other forms of restraint and seclusion. Patient searches should be conducted by trained public safety/security personnel as directed by the clinical/administrative team.

Research has shown that patients from historically marginalized racial and ethnic communities, low-income backgrounds, and/or whose preferred language is not English are more likely to be searched in healthcare settings. It is important to recognize that searches conducted without significant suspected risk may result in an allegation of discriminatory practice as well as leaving patients feeling stigmatized, which may lead to patient-requested discharge despite ongoing care, contributing to poor health outcomes.

When conducting searches for patients with substance use disorders who may have illicit substances in their belongings, healthcare organizations are encouraged to maximize interventions to address reasons for use, including aggressive management of withdrawal symptoms for opioid use disorder medications as clinically indicated. Similarly, care teams ideally manage pain if present, and provide social and recovery supports if available. When possible, a recovery coach or licensed substance use counselor may discuss with the patient their reasons for in-hospital use. For example, the counselor may clarify if the patient is experiencing undertreated withdrawal, pain, craving, boredom, or distress. This will help destigmatize symptoms associated with untreated substance use disorder and minimize patient escalation while providing a safe treatment environment.

Some facilities provide distraction tools for coping with boredom and distress like books or magazines, crafts, or word puzzles. It is preferable to give patients the option to take what they need from their belongings — such as their phone, clothes, toiletries — and then offer to securely store the rest of their belongings rather than searching those belongings if not clinically necessary. If there is concern about substance use, providers should talk about it in a transparent and non-accusatory manner. For example, say, "I am concerned that you seemed extra sleepy this afternoon and not like yourself."

Toxicology testing is a clinical test and in many settings would be used only if it could change clinical management. If a toxicology result would not guide medical decision making, it may lead to bias when used as a basis for activities such as searches.

There is a significant increased risk of death after "against medical advice" (AMA) discharges, so it is important to balance the risk of in-hospital use against the risk of a patient leaving prematurely. When patients feel accused, judged, or surveilled or when their withdrawal/craving/pain is not managed, they are more likely to leave AMA.

Hospitals should establish a standard policy outlining the circumstances under which patients and visitors may be searched for dangerous items. This policy should include:

- ❑ Criteria for initiating a search.
- ❑ The need for patient participation and, when possible, consent.
- ❑ Procedures for handling, storing, returning, or destroying dangerous items.
- ❑ Guidelines for documentation in internal records and safety event reports.

Again, searches should only be performed when staff identify a credible safety concern.

Visitor searches should be consistent with the standard policy and practice for patient searches. However, additional considerations for visitors may include the concern that they may possess dangerous objects or illicit substances that pose immediate risk of harm to patients and/or staff, or that there was a sudden change to a patient's clinical condition following visitation.

For visitors to behavioral health settings, including locked inpatient psychiatric units, packages from visitors should be checked in with a nurse or security professional first to ensure the safety of the patient and employees. Patients should also be made aware of this search.

Where possible, visitors should be provided notice of items that are prohibited – such as illicit substances, or non-prescribed opioids. The organization may wish to post notice of the potential for search upon entering the facility. This may be accomplished through the organizational code of conduct outlined previously.

The organization should outline a process for managing situations where visitors refuse to consent to searches, including steps to remove them from the premises and revoke visitation privileges. This process should be well planned and incorporated into staff training.

Physical and/or property searches should only be used as a measure to protect the safety of employees and patients when there is significant risk identified by healthcare staff or patients. Searches must not be more intrusive than necessary to accomplish the goal of protecting the patient and staff. Healthcare settings must balance patient rights against larger safety issues. In many organizations, the public safety or security staff conduct the search. Further, best practice includes conducting searches with at least two staff present, one of which is a healthcare organization's public safety or security professional. Consider contacting law enforcement for support in visitor situations where there is a lack of cooperation and/or extreme concern for safety.

Documentation of Searches

Healthcare organizations require documentation of searches that are conducted. Documentation as part of an incident report or through other internal records allows these instances to be easily reviewed by appropriate staff and/or regulators if requested. This documentation ideally includes:

- ❑ The nature and reasons for a search; if it was for an emergency circumstance, then document the specific nature of the emergency.
- ❑ The names of the staff involved in the decision making to conduct a search, as well as who conducted the actual search.
- ❑ If the search is being done as part of the admission, an inventory and documentation of patients' belongings should be completed pursuant to healthcare organization policy for admissions.
- ❑ The results of such a search, would include but not be limited to:
    - ❑ A description of any objects found.
    - ❑ Disposition if the object was harmful or dangerous to the patient, staff, or others.
    - ❑ If the patient was not present during the search, the reasons for not being present.

HANDLING DANGEROUS OBJECTS and ILLICIT SUBSTANCES

Healthcare organizations are encouraged to develop standard policy and procedures for managing, handling, and securing dangerous objects and illicit substances in consultation with their public safety and security professionals. Such policies should include guidance for handling any illicit substance or dangerous drug use item that presents a risk to staff, such as used needles, and smoking and/or inhaling paraphernalia. Items or substances that present a safety concern to the patient and/or others should be removed and stored in a secure area until the patient is discharged pursuant to healthcare organization policies for storing patient possessions, or destroyed if the substance poses a safety concern to the patient, staff, and/or other patients and visitors. Organizations protect staff safety by establishing a policy and process for the handling, storage, securing, and disposal of illicit items that may be encountered, such as illegal drugs or weapons, including contacting local law enforcement for appropriate disposition.

All searches require documentation of participants/witnesses to allow for review. Documentation includes identity of the parties involved, the specific reason for the search, steps taken, and inventory of contraband found and its disposition.

Staff conducting contraband searches require training and need to be equipped for safety. Use of safety search tools such as needle stick-proof gloves, eye protection, masks and other PPE, safety search sticks, flashlights, and transport bags and boxes should be part of the training provided.

REMOVAL of CLOTHING

Healthcare organization policies regarding clothing removal need to be consistent with policies, procedures, and practices of physical searches. Policies regarding removal of patient clothing also include:

a. Patients' right to refuse removing their clothing; and
b. Clinicians' need to request the removal of clothing if appropriate to conduct a medical screening examination.

Organizations are encouraged to develop resources and/or communication materials that outline the organization's policy on removal of clothing/searches for patients, including the patient's right to refuse and requirement to consent. If a physical search is conducted, which may also include the removal of any clothing, one of the two staff present must be a clinician. These searches must be conducted in a private or secure location. All clothing should be returned to the patient as soon as is reasonable. Staff of the same gender should be present during physical search or removal of clothing to support trauma-informed care principles.

Healthcare organization policies regarding clothing removal apply equally to all patients seeking treatment in the healthcare setting. Policies that focus on clothing removal or pat downs for targeted patients (such as those being admitted for mental health or substance use disorder treatment) may demonstrate bias and may affect patients' legal rights. Organizations may wish to review personal search policies with both clinical resources and legal counsel within their organizations to ensure the rights and safety of patients and staff are maintained. Providers should be culturally competent when engaged in any encounter with patients involving personal autonomy and modesty. Some cultural traditions have limitations on physical touching, particularly of the opposite gender. Providers are encouraged to work with their social services and related professionals to receive proper training on such issues.

It is well recognized that removal of clothing may be necessary to enable an appropriate medical screening examination for the identification of an emergency medical condition. Another reason to request the removal of clothing is to protect oneself or others against potentially harmful substances or weapons that might be hidden on a patient's person. Forced removal of clothing is a form of physical restraint, and as such, all alternatives to this action must be used before forced removal of clothing. Therefore, compelling clinical information indicating imminent risk to self or others is necessary to prompt forced removal of clothing. A provider's order is necessary to forcibly remove a patient's clothing, consistent with all other forms of restraint.

WEAPONS POLICY

Healthcare organizations are strongly encouraged to develop a policy and practice that informs providers, patients, visitors, and others (for example, law enforcement not acting within their jurisdiction) that the healthcare facility is a weapon-free facility and weapons and other dangerous items of any kind will not be allowed. The only exception should be provided for law enforcement officials who are acting in their official capacity.

Weapons of any kind that are identified or surrendered must be secured by the healthcare organization's security personnel in a designated secure area and returned when appropriate and legal to do so, provided that the individual is lawfully able to possess it. Healthcare organizations must require that only licensed personnel are allowed to handle weapons, particularly firearms, given the need for training in safe handling and the removal of ammunition. Healthcare organizations should develop an operational protocol for staff to secure weapons, including:

1. When and how to notify hospital security leadership or other appropriate leader(s) within the organization.
2. The process for involving local law enforcement if internal security is not available or properly trained or licensed to handle a firearm. In the case of firearms:
    i. Identifying staff who possess a firearms license, validating the license is and remains active;
    ii. Identifying what to do if a licensed staff person is unavailable (contacting local law enforcement, what to do with the item, etc.);
    iii. Ensuring that those licensed staff that will be authorized to assist with firearms possess an adequate level of training and competency for the task, and that this training and competency is validated at regular intervals;
    iv. Ensuring the organization has an appropriate area and equipment for the safe clearing and legally compliant storage of weapons (trigger locks, safes, and clearing stations); and
    v. Training staff to call security leadership to assist with securing and removing weapons. Staff should also be aware of the process for contacting local law enforcement, if there is a weapon and internal security leadership cannot be contacted.

Weapons Detection Systems and Screening

If an organization considers implementation of weapons detection (metal detectors), it is recommended that the use of this technology should be based on organizational risk assessment with input from qualified security and design professionals due to the investment of resources and responsibility assumed when deploying this risk mitigation approach. Key areas for consideration include:

- Where and at what entrances will the technology be deployed (e.g., emergency department, outpatient building, main campus)?
- Who will be screened?
- What is the organization screening for and what is its risk tolerance? Most technologies have variable sensitivity settings. Higher sensitivity will hit positive for more types of items but will increase false positives and slow access into the facility. Lower sensitivity will allow quicker access but will hit only on larger/denser items (like long guns or some handguns) but might miss knives and some handguns.
- Which type(s) of detectors are most effective/efficient and in what locations/for what uses? Full walk-through models, or smaller wands? There are many options that should be explored and may serve different purposes.
- Environmental design is key. For example, when deploying at an emergency department (ED), organizations should limit or eliminate any means of access into the ED that circumvents the screening check point(s). Similarly, weapons detection should not be installed in a main entrance while other means of entry to the campus are available for use by the public where screening is not in place.
- Ensuring design, staffing, and equipment are deployed in a manner that can support the amount of foot traffic.
- In the emergency department, the Emergency Medical Treatment and Active Labor Act (EMTALA) considerations for patients needing urgent treatment and avoiding potential delays apply.

All personnel must be appropriately trained on how to operate the equipment, conduct a secondary screening, manage positive alerts for weapons, and secure weapons and other dangerous items when necessary. Organizations will need to determine whether weapons screening personnel should be armed or not.

Establishing a process for securing firearms/duty belts for law enforcement officers if they are present as a patient is necessary. Visiting law enforcement officers, either on or off duty, may be able to retain their firearm if they are able to provide proper documentation of employment for a law enforcement agency.

PATIENT SCREENING

Organizations may develop procedures not only to identify patients at risk of committing acts of violence, but also to actively manage and reduce the likelihood of such events. Effective procedures should incorporate:

- ❑ Mechanisms for creating awareness of previous history of violent or assaultive behaviors in healthcare settings.
- ❑ Identification of intent or contributing factors or behavioral triggers in previous incidents.
- ❑ Strategies for developing patient-specific violence prevention plans.
- ❑ Training for staff on effective de-escalation techniques tailored to individual patient profiles.

Technology can play a critical role in enhancing situational awareness and patient risk management. For example, systems may be used to:

- ❑ Alert staff to a patient's known risk history upon registration or arrival.
- ❑ Track movements of identified at-risk patients, communicate the care plan, and notify appropriate staff. Consider using an evidence-based violence assessment tool in the electronic medical record (EMR) to identify patients who may present a greater risk for aggression, violence, and self-harm during a specific episode of care. Awareness flags may be used in both the EMR system and outside of the patient's room (discreet physical signage) to alert staff members of behaviors of concern, and to encourage the use of a team approach.
- ❑ Notify appropriate staff, including security.

Flagging patients at high risk of violence within an EMR is a useful mechanism to alert staff to a history of violent behavior. Many EMRs have capabilities to flag intentional completed assaults, intentional attempted assaults, or threats. "Risk of violence" flags could be used to identify other events such as unintentional aggression or assaults stemming from medical or psychiatric conditions such as autism spectrum disorder, dementia during the post-operative period, postictal seizure state, etc. Flags may include specifics of recent event(s) and staff safety recommendations. Healthcare institutions need to develop a process for reviewing flag content to reduce bias and provide factual information, and to ensure content remains updated over time. A best-practice strategy to decrease bias includes regular multidisciplinary review and creating flags that expire in a patient's chart if behaviors do not continue. Healthcare organizations are encouraged to develop a framework to evaluate ongoing patterns, or to support reporting of particularly noteworthy events even when isolated.

Some organizations use validated violence assessment/screening tools such the Brøset Violence Checklist, which indicates early warning signs of violence and is used to track changes in these signs over time. Some EMRs support embedded tools for ease of use across shifts and care locations. Teams can then use this information to implement interventions that support patient and staff safety and mitigate risk. Organizations should consider how information about prior incidents (including patients who have a known high risk of violence) is communicated throughout the levels of care as the patient accesses inpatient, outpatient, and community-based services if functionality for cross-site/encounter flagging is not utilized.

ENTRY or EXIT PROCEDURES

Managing points of entry and exit is a key aspect of violence prevention. Healthcare facilities can consider implementing procedures that include:

- ❑ Setting clear expectations for patient and visitor conduct while in waiting areas.
- ❑ Structured sign-in procedures and visitor identification processes, including visitor passes.
- ❑ A process for identifying patients, in a non-discriminatory manner, with a history of violence, which can be shared among security, nurses, and admissions personnel.
- ❑ Communication of relevant safety information such as a patient's history of violence (when applicable and nondiscriminatory), to admissions, clinical, and security staff.
- ❑ Identifying the appropriate number and locations of entries and whether or not they will be open to patients/visitors or employees only, or to all.

- ❑ Establishing a procedure for monitoring and screening individuals entering the campus. This may include, to varying degrees, procedures for validating patient appointments, vendor management, employee IDs, and visitor identification.
- ❑ Assessing a schedule for what time frames entrances should be open.
- ❑ Staffing security or other staff at entrances continuously to monitor ingress/egress.

INCIDENT RESPONSE: RESPONSE PLANS and TEAM

Healthcare facilities should create response plans for incidents of violence. These plans should address:

- ❑ Immediate safety measures and containment protocols.
- ❑ How to activate an emergency response.
- ❑ Deployment of immediate de-escalation techniques and trained response teams.
- ❑ Post-event, how to activate the response team, and other actions such as medical care, psychological support, peer support, Employee Assistance Programs, and formal investigation or other actions deemed necessary based on the nature of the event.

CLOSING SUMMARY

These revised and updated *Guidelines for Healthcare Safety and Violence Prevention* represent a comprehensive framework for addressing the escalating crisis of violence in healthcare settings. By following the five foundational pillars outlined in this document—leadership commitment, education and training, robust data collection, clinical integration, and interdisciplinary collaboration—all underpinned by an unwavering commitment to equity and bias elimination in safety practices, healthcare organizations can make strides in ensuring a safe environment for staff and patients.

These guidelines recognize that healthcare organizations operate with diverse needs, structures, and patient populations, and as such, offer a flexible yet evidence-based approach to violence prevention that healthcare facilities can adapt to their specific circumstances. The emphasis on data-driven decision making, continuous evaluation, and multidisciplinary collaboration allows healthcare organizations to create sustainable safety cultures that protect patients, staff, and visitors while maintaining their fundamental mission of providing compassionate, high-quality care. This comprehensive resource serves as both a practical toolkit and a strategic framework for healthcare leaders committed to fostering safe, therapeutic environments in an increasingly challenging landscape.

The Massachusetts Health & Hospital Association would like to thank the many members of its Healthcare Safety & Violence Prevention Workgroup who contributed to this document. Their range of expertise from security and public safety, health equity, behavioral health, emergency medicine, and other clinical expertise have allowed this guidance to remain dynamic and comprehensive. MHA commits to continuing this important work in collaboration with our members and partners across the continuum of care.

APPENDIX: Resources for Communication

Strategies to Support Expression

BE ON THE LOOKOUT FOR	HOW TO RESPOND
Patient responding "yes"/understanding, but difficulty with carryover	Use visual or kinesthetic teaching methods: • Teach-back method to confirm understanding • Pictures, photographs, videos, demonstration • Written instructions or steps Anticipate that patient may require extra opportunities to practice any new learning.
Difficulty with self-advocacy	Offer choices to reduce anxiety. Explicitly ask for input: "As your nurse, it's my job to help you understand what your choices/options are." "What are your worries or concerns?"
Difficulty with eye contact	Sit so that you are at eye level, but at an angle rather than facing the patient directly, to remove any non-verbal expectation that the patient should be making eye contact with you.
Deterioration of patient's ability to express self	Determine urgency of information presented, and if not urgent, stop to allow time for patient to recover to baseline.

Strategies to Support Auditory Processing

BE ON THE LOOKOUT FOR	HOW TO RESPOND
May appear like not listening/hearing you, cover their ears or wear headphones that cancel noise **May have difficulty simultaneously making eye contact while listening**	Offer earplugs/headphones to help reduce noise level. Do not expect continuous eye contact. Reduce environmental noise (turn off alarms, close doors).
May feel distressed when surrounded by a lot of chatter or other noise	Try to limit 1-2 providers in room at a time. Educate patient when multiple providers are typically present (e.g. during an emergency). Designate one point person to communicate when multiple providers present.
When given multiple commands, may only process the last instruction you say	Use visual methods: written steps/lists, pictures, demonstration. Complete one task at a time. Pause to allow patient time to process and respond. Break apart education into smaller sessions across the day.
Stress worsens ability to process information **Nonverbal signs (e.g. body language such as increased restlessness) the person may be under stress**	Advise patient to let you know if they need a break during education. Look for signs of overwhelm and proactively offer to break.

Strategies to Support Interpretation

BE ON THE LOOKOUT FOR	HOW TO RESPOND
Interpreting information literally	Avoid ultimatums (e.g. that a test will occur at 12 PM) unless that is exactly when it will occur. Provide detailed explanations.
Difficulty adjusting to atypical routine	Use whiteboard to write down plan for day. During check in review next steps for the day. Provide step-by-step details on what to expect for unfamiliar tests, medical interventions.
Difficulty with conversations	Recognize patient may need extra time to consider questions. Encourage patient to write down any concerns or questions between check ins.
Heightened awareness of nervousness in others and desire to connect **Difficulty recognizing or understanding social cues/facial expressions** **Misinterpretation of interactions**	Use calm and kind tone of voice and relaxed body language. Avoid "pep talks" (“You're going to be okay") as patient may experience as invalidating., instead validate (“This is hard’). Provide explicit feedback about interactions, "Thank you for telling me XX, it helped me understand you need YY." Consider using masks with clear window.

MASSACHUSETTS
Health & Hospital
ASSOCIATION

GUIDELINES for HEALTHCARE SAFETY and VIOLENCE PREVENTION

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WWW.MHALINK.ORG
500 District Ave
Burlington, MA 01803
(781) 262-6000
info@mhalink.org