NCLEX 2026 · PSYCHOSOCIAL INTEGRITY · SAFETY & INFECTION CONTROL

MENTAL HEALTH

Workplace Violence *in Nursing Practice*

CARE & TEACHING
HIGH-YIELD
PRIORITY TOPIC

1 Definition & Overview

- **Workplace Violence (WPV)** = any act or threat of physical violence, harassment, intimidation, or disruptive behavior occurring at the work site.
- **4 Types (OSHA):** Type I = criminal intent · Type II = *patient/client-on-staff (most common in healthcare)* · Type III = worker-on-worker (lateral violence) · Type IV = personal relationship.
- **Why it matters:** Healthcare workers face violence at *5× the rate* of other industries. Underreporting is the #1 barrier to prevention.

75% of nonfatal workplace assaults occur in healthcare & social services

2 Escalation Cycle & Risk Factors

PHASE 1	→	PHASE 2	→	PHASE 3	→	PHASE 4
Triggering		Escalation		Crisis		Recovery
↑ anxiety, stressor		defensive, loud		acting out · violence		tension reduction

Patient Risk Factors: psychosis · dementia · delirium · substance intoxication or withdrawal · TBI · pain · hypoxia · hypoglycemia · history of violence.
Environmental Triggers: long waits · understaffing · isolated rooms · poor lighting · 24/7 access · weapons in ED.

3 Warning Signs — Recognize Before Crisis

EARLY / MILD — DE-ESCALATE NOW

- **Verbal:** raised voice, demanding tone, sarcasm, profanity, repetitive questions
- **Behavioral:** pacing, restlessness, fidgeting, clenched jaw & fists
- **Physical:** flushed face, dilated pupils, rapid breathing, sweating
- **Cognitive:** mumbling, paranoid statements, blaming, refusing care

LATE / SEVERE — CODE & WITHDRAW

- **Direct threats** "I'm going to hurt you"
- **Throwing objects** or breaking property
- **Weapon** in possession or referenced
- **Lunging**, hitting, biting, spitting, scratching
- **Sudden calm** after agitation (may signal an attack)

📌 **STAMP Mnemonic — Early Warning Signs of Violence:** Staring/eye contact · Tone & volume of voice · Anxiety · Mumbling · Pacing

4 Priority Nursing Interventions

1. **ENSURE SAFETY FIRST** — maintain 2 arms' length distance; never turn your back.
2. **POSITION** yourself **nearest the exit**; never let the patient block the door.
3. **CALL** for help/security *before* entering an escalating situation — never go alone.
4. **USE** a **calm, low, slow voice**; one nurse speaks (one-voice rule).
5. **REMOVE** triggers, audience, and any objects that could become weapons.
6. **OFFER** choices & verbal de-escalation *before* any chemical/physical restraint.
7. **ADMINISTER** PRN per protocol if verbal de-escalation fails (see §5).
8. **APPLY** restraints only as **LAST resort** — need MD order within 1 hr; reassess q15 min.
9. **DEBRIEF** with team & patient after; **document & report** every incident.

5 Emergency PRN Pharmacology

DRUG	KEY CONSIDERATIONS
Haloperidol Haldol · FGA	EPS, NMS, *prolonged QT*. Monitor ECG. Hold if QTc > 500.
Lorazepam Ativan · BZD	Sedation, *respiratory depression*. Have flumazenil & O_2 ready.
Olanzapine Zyprexa IM · SGA	↓ BP, sedation. Do *NOT* give IM with parenteral BZD (cardiopulm depression).
Diphenhydramine Benadryl	Treats EPS from haldol; anticholinergic effects.

"B-52" COCKTAIL
Benadryl 50 mg + Haldol **5** mg + Ativan **2** mg IM —

ABC PRIORITY: Personal safety → Patient safety → Team safety → Therapeutic care

common ED chemical restraint combo.

6 NCLEX Test Traps

- ⚠ ~~Apply restraints first~~ → verbal de-escalation FIRST; restraints last.
- ⚠ ~~Approach alone & reassure with touch~~ → call team; NO touch on agitated pt.
- ⚠ ~~Stand between patient and door~~ → YOU stay closest to the exit.
- ⚠ ~~Argue or correct delusion~~ → acknowledge feeling, redirect.
- ⚠ ~~PRN every 4 hrs scheduled~~ → PRN = as needed for behavior, not routine.
- ⚠ ~~Restraint order good for 24 hr~~ → adult max 4 hr · age 9–17: 2 hr · <9: 1 hr.
- ⚠ ~~Sudden calm = improvement~~ → may signal planned attack — stay alert.
- ⚠ ~~Don't report co-worker bullying~~ → lateral violence IS workplace violence; report.

7 Patient, Staff & Self Teaching

PATIENT/FAMILY

- Identify personal triggers
- Coping skills: deep breathing, time-outs, grounding
- Anger management referral
- Medication adherence reduces relapse
- Safety plan for home/community

STAFF / SELF

- Complete CPI / nonviolent crisis training annually
- Know unit alarms, panic buttons, exit routes
- Buddy system — never alone with high-risk pt.
- Trauma-informed care · debrief after events
- EAP & counseling for secondary trauma / PTSD
- **Report every incident** — silence enables WPV.

8 Memory Boosters & Mnemonics

STAMP

EARLY SIGNS OF VIOLENCE

- **S** — Staring / prolonged eye contact
- **T** — Tone & volume of voice
- **A** — Anxiety
- **M** — Mumbling
- **P** — Pacing

CALM

DE-ESCALATION APPROACH

- **C** — Communicate calmly, low voice
- **A** — Acknowledge feelings
- **L** — Listen actively
- **M** — Maintain safety & space

4 R's

POST-INCIDENT ACTIONS

- **R** — Recognize the event
- **R** — Respond (safety + clinical)
- **R** — Report (chart + incident form)
- **R** — Review (debrief + prevention)

SAFE

ENVIRONMENT CHECK BEFORE ENTRY

- **S** — Scan room for hazards/objects
- **A** — Assess patient cues
- **F** — Find exit, position near door
- **E** — Engage team — never solo

2 ARMS

PERSONAL SPACE RULE

- Stay **2 arm-lengths** from an escalating patient
- Doubles to **4 arms** if weapon present
- Approach **diagonally**, not face-to-face
- Hands **visible, open**, at waist height

B-52

EMERGENCY CHEMICAL RESTRAINT

- **B** — Benadryl 50 mg IM
- **5** — Haldol 5 mg IM
- **2** — Ativan 2 mg IM
- Verbal de-escalation must fail first