LHA TRUST FUNDS

Workplace Violence Prevention 2026 Training & Discussion Guide

Drawing from scenarios presented at the 2026 LHA Trust Funds Workplace Violence Symposium, this guide outlines realistic situations that may arise in your healthcare work environment and offers structured prompts to support planning and discussion. Use these sample scenarios and discussion questions in relation to your organization's workplace violence and safety plan, customizing the conversation to reflect your own specific policies, procedures, and risk profile.

Group Discussion Scenario 1

Hospital-Law Enforcement Disagreement

Setting

A busy urban hospital with an Emergency Department (ED), Behavioral Health Unit, and a Level II Trauma Center.

It is 7:45 PM on a Friday night. ED volume is high, security coverage is stretched, and law enforcement is frequently in and out of the department.

Scenario Overview

Local law enforcement officers bring in a 32-year-old male patient, Mr. R., who was found unconscious in a parking lot. On arrival:

- The patient has head trauma, is confused, and is intermittently combative.
- Officers report he is a suspect in a burglary investigation.
- The patient denies wrongdoing, but seems disoriented and unable to answer simple questions.
- The ED physician orders a CT scan and other diagnostics.

During the visit, a disagreement arises between hospital staff and law enforcement about custody, restraints, and access to the patient.

Key Conflict Points

1. Custody vs. Clinical Necessity

Officers insist on remaining inside the patient's room at all times, citing risk of escape.

However, clinical staff argue that:

- The patient's cognitive status is altered.
- Police presence is escalating his agitation.
- The patient requires privacy for assessment and mental status evaluation.

The ED charge nurse asks the officers to step out temporarily. Officers refuse.

2. Restraint Usage

Police request that hospital staff place soft, four-point restraints for their safety.

The physician disagrees because:

- The patient is not currently violent.
- Restraints could worsen confusion.
- Alternatives have not been attempted.

Officers argue that handcuffing the patient to the bed is "standard procedure," since he is a criminal suspect.

Hospital policy prohibits handcuffing unless clinically necessary and approved by leadership.

3. Medical Clearance vs. Police Time Pressure

The ED physician determines the patient is not medically stable for release to custody due to:

- Altered mental status
- Need for neuroimaging
- Potential concussion or intracranial injury

Police insist the patient is "fine," and want discharge after vital signs stabilize, stating:

"We can take him to the station; we just need a basic medical release."

The physician refuses and attempts to explain the medical risks.

Tensions rise.

4. Access to Protected Information

Officers request:

- Diagnosis
- Anticipated discharge time
- Copies of lab results
- Statements from the patient

Staff inform them this falls under HIPAA protections, unless certain criteria are met.

Officers respond that they "have a right to all information concerning a suspect."

Complicating Twist

While the discussion is ongoing:

- The CT scan returns showing a small subdural hematoma, confirming the patient needs to be admitted for observation.
- The patient becomes more agitated and attempts to get out of bed.
- The officers become increasingly frustrated and threaten to file a complaint against the hospital for "interfering with an investigation."

Hospital security arrives, adding another layer of tension.

Discussion Questions

Clinical & Ethical Considerations

1. What is the priority in this situation: the patient's medical needs or law enforcement's investigative needs?
2. How should the team balance safety, patient rights, and law enforcement requests?
3. At what point does the patient's altered mental status affect their ability to participate in questioning?

Legal & Compliance Considerations

4. What information can be shared with law enforcement under HIPAA?
5. What are the hospital's obligations around custody when a patient is medically unstable?
6. How should staff respond when officers request actions that conflict with hospital policy?

Communication & De-Escalation

7. Who should take the lead in communicating with law enforcement?
8. What de-escalation or conflict-resolution steps might help in the moment?
9. What role does hospital security play?

Policy & Process Improvement

10. Should the hospital create clearer procedures for when law enforcement accompanies patients?
11. What collaborative expectations should be established between the hospital and local law enforcement agencies?
12. Should training be developed for staff about interacting with officers?

Group Discussion Scenario 2

ICE Officers Arrive to Apprehend a Hospital Patient

Setting

A busy community hospital with a diverse patient population. It is Tuesday evening around 6:30 PM. The Emergency Department (ED) is full, staffing is tight, and security is already attending to other situations in the facility.

The hospital has no formal, written process for responding to immigration enforcement requests.

Scenario Overview

A 27-year-old patient, Mr. Alvarez, presented to the ED earlier that afternoon with:

- Fever and severe abdominal pain
- Vomiting
- Evidence of dehydration
- A suspected appendicitis (awaiting surgical consult)

He is alert and oriented, but anxious.

At 6:32 PM, two ICE officers arrive at the ED security desk and state:

"We are here to take custody of a patient under an active federal warrant. We need access to his room immediately."

They do not voluntarily present a judicial warrant but state they have "authority to detain him."

The officers request:

- The patient's location
- His medical status
- Confirmation that he is currently receiving treatment
- Immediate access to the bedside

ED staff and security are caught off-guard.

Key Conflict Points

1. Access to Protected Patient Information

ICE officers insist staff provide:

- Patient name confirmation
- Diagnosis and treatment plan
- Estimated discharge time

Staff are unsure:

- Whether immigration officers qualify for exceptions under HIPAA
- Whether verbal confirmation of a patient's presence is permitted
- What authority the officers have without a judicial warrant

The charge nurse and registration clerk disagree about what can be disclosed.

2. Entry Into Patient Care Areas

ICE requests immediate access to the ED treatment bed.

Nursing staff express concerns:

- The patient is in pain, vulnerable, and mid-evaluation.
- ICE presence may escalate the patient's distress or impede care.
- Immigration enforcement in clinical areas may create fear among other patients and families.

Staff ask the officers to wait in a private office. Officers refuse, stating:
"We can't delay our enforcement action. He is a priority risk."

3. Impact on Clinical Decision-Making

The surgical consultant arrives during the discussion and recommends urgent imaging and probable surgical intervention.

ICE responds:
"We need him released into custody as soon as you can clear him medically."

The physician pushes back:

- The patient is not yet medically stable.
- Surgery may be required.
- The patient's condition could deteriorate.

Tension builds as ICE interprets the delay as resistance.

4. Patient Rights & Informed Discussion

The patient overhears part of the conversation and becomes visibly distressed.

He asks:

- "Am I being arrested right now?"
- "Can they take me while I'm sick?"
- "Do I have a right to talk to someone?"

Staff are unsure what they are legally allowed to say.

5. Confusion Among Hospital Departments

The ED charge nurse calls:

- Security
- The house supervisor
- Risk management voicemail (after hours)

No one is certain:

- Who has final authority
- Whether ICE can enter clinical areas without a judicial warrant
- How to balance care obligations with federal agency requests

This delays care and heightens anxiety.

Discussion Questions

Clinical, Ethical & Human Considerations

1. How can staff prioritize patient safety and dignity while responding to enforcement requests?
2. Should ICE be permitted at the bedside during active clinical care?
3. How might the patient's fear or emotional distress impact medical evaluation and outcomes?

Legal & Compliance Considerations

4. What information can be released to ICE officers without a judicial warrant?
5. What is the difference between an ICE administrative warrant and a judicial warrant in healthcare settings?
6. Are staff obligated to facilitate patient apprehension?
7. How should the hospital balance HIPAA obligations with federal law enforcement activity?

Operational & Security Considerations

8. Who should lead communication with ICE—security, nursing leadership, legal counsel, or risk management?
9. How should frontline staff respond if ICE officers insist on entering restricted care areas?
10. What are the appropriate steps to prevent disruption to other patients or staff?

Policy & Preparedness Considerations

11. Should the organization develop a formal immigration enforcement response policy?
12. What training should staff receive to handle future events?
13. How might the hospital partner with local or federal agencies to clarify expectations and reduce conflict?

Group Discussion Scenario 3

Enhancing Staff Safety Through Panic Alarms & Badge Access Controls

Setting

A mid-sized hospital system is reviewing its workplace violence prevention measures after several recent safety incidents. The organization currently uses stationary panic buttons in high-risk areas, has piloted wearable panic alarms for some departments, and is expanding badge access zone controls throughout the facility.

You are part of a multidisciplinary safety task force convened to evaluate gaps and make recommendations.

Characters in the Discussion

- **Nurse Manager (Lisa):** Represents inpatient nursing units.
- **Security Director (Marcus):** Oversees system-wide safety & security technologies.
- **ED Physician (Dr. Singh):** Provides perspective from emergency and behavioral health encounters.
- **Facilities Manager (Jamal):** Manages the physical environment and badge access infrastructure.
- **Risk Consultant (You):** Facilitates the discussion and helps identify risk reduction strategies.
- **CNA (Tanya):** Provides frontline staff insight about real-time risk exposure.
- **IT Analyst (Rachel):** Supports system integration for alerts and automation.

Scenario Overview

During the past 60 days, the hospital has experienced:

- Aggressive visitor incident in an inpatient unit

  A visitor became verbally abusive toward staff; they hesitated to press the stationary panic button because they weren't sure if the alarm would trigger a silent or audible response.
- Physical assault in the Emergency Department

  A patient struck a nurse. The assigned wearable panic alarm failed to activate properly due to a dead battery.
- Unauthorized entry into a medication room

  A former employee tailgated into a badge-access-only area without being challenged by staff.

Your task force must assess what happened, why, and what changes are needed.

Discussion Prompts

1. Stationary Panic Buttons

- Are staff aware of location, function, and response protocols for stationary buttons?
- What training is needed to ensure staff feel confident using them?
- Should panic buttons provide silent alarms, audible alarms, or both, depending on the setting?
- Are current placements (nurse stations, triage rooms, reception areas, psych-safe rooms) sufficient?
- How quickly does security respond, and are they properly notified with location details?

2. Wearable Panic Alarms

- Are they assigned to individuals or shared by shift?
- What processes ensure battery life, testing, and readiness?
- Which roles benefit most—clinical staff, techs, sitters, social workers, environmental services?
- How should alerts be routed (security, team lead, overhead code)?
- What policies should define when staff activate them?

3. Badge Access Controlled Areas

- How do we prevent tailgating and unauthorized access?
- Should more areas be restricted (e.g., medication rooms, OB units, pediatrics, ED entrances)?
- Do staff understand expectations for visitor management and challenging unbadged individuals?
- How do we balance security with workflow efficiency?
- Do access logs support incident investigation adequately?

Scenario Twist: A New Incident During the Meeting

Midway through your group discussion, the command center notifies the team:

"Security just received a panic alert from the cardiology clinic. Staff report a patient became agitated over wait times."

However, reports conflict:

- Some staff say they used the stationary panic button, but no alert appeared in the electronic security dashboard.
- Others claim someone tried to use a wearable device, but the location pin was inaccurate, and security arrived at the wrong suite.

Group questions:

- What steps should the team take immediately?
- How do you verify which system malfunctioned?
- What communications need to go to clinic leadership now?
- How should the organization conduct a post-event review?
- Does this incident change your previous recommendations?

Deliverables for the Group

Your discussion should end with:

1. Top five recommendations

(E.g., upgrade panic alarm infrastructure, standardize training, periodic testing cycles, expand badge access zones, enhance visitor management)

2. Suggested policy updates

Including roles, responsibilities, and activation procedures.

3. Training and communication plan

To ensure staff confidence in using alarms and enforcing access controls.

4. Technology or workflow improvements

Such as dashboards, analytics, automation, audit logs, or maintenance schedules.