

Injury to None

Preventing Workplace Violence to Protect
Health Care Workers and Their Patients



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INTRODUCTION

As the Covid-19 pandemic has reminded us all too often, when nurses and other health care workers are not safe — patients and our communities are not safe. Long before SARS-CoV-2 emerged, nurses and other health care workers had already been experiencing a different epidemic — workplace violence.

As the largest union and professional association representing registered nurses in the United States and with more than 170,000 members — both nurses and other health care workers — providing direct care across the country, National Nurses United (NNU) has been tirelessly advocating for workplace violence prevention laws to protect health care workers and patients.

The risk of workplace violence is a serious occupational hazard for nurses and other health care workers. Countless acts of assault, battery, aggression, and threats of violence that routinely take place in health care settings demonstrate a frightening trend of increasing violence faced by health care workers throughout the country. This occupational hazard has serious ramifications for patient safety; when nurses and health care workers are at risk of experiencing violence on the job because their employers have not ensured a safe workplace, patients are also at increased risk. In addition to innumerable anecdotal and media accounts, several national surveys document the prevalence of violence committed against health care workers.

As a persistent and growing workplace hazard for our members and all health care workers across the country, NNU has advocated for occupational health and safety standards to require employers to prevent violence in health care settings. Our efforts have resulted in the establishment of some of the most comprehensive state-level standards on preventing and reducing violence in the workplace for our members and all health care workers in those states. Where state-level standards have not been established, NNU and our state affiliates have won strong protections for our members through collective bargaining.

Only a federal OSHA standard on preventing workplace violence in health care will ensure that all nurses and other health care workers are protected.

But despite these strides, protections for nurses and other health care workers across the country will remain piecemeal in light of the Occupational Safety and Health Administration's (OSHA) exclusive jurisdiction in 24 states making a state OSHA standard impossible in those states. Only a federal OSHA standard on preventing workplace violence in health care will ensure that *all* nurses and other health care workers are protected.

NNU has identified the necessary standards and other protections to ensure the effectiveness of workplace violence prevention laws. We know from the research literature and nurses' direct care experiences that, in order to effectively prevent and mitigate workplace violence hazards, the inclusion of certain elements in employers' workplace violence prevention plans is critical. To ensure the effectiveness of employers' workplace violence prevention plans, it is equally as important that worker protection agencies, particularly OSHA, engage in robust enforcement of minimum standards for workplace violence prevention.

With members who work as direct care professionals in every state in the nation, NNU believes that we need the Workplace Violence Prevention for Health Care and Social Service Workers Act, which was introduced by U.S. Rep. Joe Courtney (D-Conn.) and U.S. Senator

Tammy Baldwin (D-Wis.), to protect nurses, other health care workers, and their patients from workplace violence. The Workplace Violence Prevention for Health Care and Social Service Workers Act would create a federal OSHA standard that would require health care and other specified employers to create, implement, and maintain effective workplace violence prevention plans. Under this bill, such a standard would include all the elements that NNU has learned are necessary to effectively protect nurses and other health care workers.

This issue brief provides an overview of what workplace violence is, reviews the leading literature on rates of workplace violence for nurses and other health care workers, and discusses the impacts on nurses and other health care workers of experiencing violence on the job. Then it examines the essential elements for workplace violence prevention plans and summarizes the leading research on workplace violence prevention. And finally, this brief summarizes work for state-level workplace violence prevention laws, discusses the need for a federal OSHA standard, and describes how the Workplace Violence Prevention for Health Care and Social Service Workers Act includes the necessary elements to prevent workplace violence on the job for nurses and other health care workers.



WHAT IS WORKPLACE VIOLENCE?

Workplace violence is an occupational hazard that occurs frequently in health care workplaces. When we say, “workplace violence,” we mean any act of violence or threat of violence that occurs within the worksite or while an employee is doing their job. Workplace violence includes »

- » Incidents of physical violence such as hitting, kicking, scratching, or spitting.
- » Threats of physical violence that cause an employee to fear for their physical safety.
- » Incidents where a firearm or other weapon is threatened or used, including where common objects are improvised into weapons.

The definition of workplace violence is not contingent upon a physical injury occurring. The impacts of workplace violence are varied — from serious physical injury and death to emotional and psychological impacts. Any act of workplace violence can impact nurses and health care workers’ health; therefore, it is an occupational hazard that must be addressed by the employer.

Importantly, the definition of workplace violence includes not just incidents where physical force is used, but also incidents where threats of violence are made. Threats of violence can have damaging psychological impacts on nurses and health care workers who experience them, causing fear and anxiety.

Workplace violence occurs without regard to intent. While workplace violence can come from any person present in the workplace, the vast majority of workplace violence that nurses and health care workers experience comes from patients and is most frequently related to their disease/illness or a treatment or medication they are receiving.¹ Regardless of intent, the impact on nurses and health care workers is the same, and employers have a duty to identify and remedy occupational hazards.

The definition of workplace violence does not include acts of self-defense or defense of others.



EXAMPLES OF WORKPLACE VIOLENCE INCIDENTS EXPERIENCED BY NURSES AND HEALTH CARE WORKERS

Workplace violence occurs throughout hospitals and in other health care settings. It is not localized to any one specific unit or area.

During NNU health and safety classes held between February and March 2017, we captured descriptive information on workplace violence as part of a classroom activity called “hazard mapping.” In hazard-mapping activities, worker participants reflect on their experiences of a hazard, identify the location in the workplace, and then visualize or “map” those hazards with others in the discussion group to facilitate a conversation about hazards, prevention of those hazards, and any attendant occupational health and safety rights. Through hazard mapping with our members, NNU captured brief descriptions of violent incidents that nurses experienced or witnessed at work. Listed below are some descriptions of workplace violence incidents collected through NNU’s hazard mapping, as well as the hospital unit in which the incident occurred.

EMERGENCY DEPARTMENTS (INCLUDING ENTRANCES)

- » Patient punched my chest and spit on my face while trying to sedate him in the ER.
- » A nurse was punched in the jaw by a patient while the nurse was inserting an IV into his arm.
- » An alcoholic patient experiencing withdrawal became combative and attempted to attack staff.
- » Parent became verbally combative when told of need to perform lumbar tap and check temperature rectally of the child.
- » Patient became verbally combative and hit the counter when became impatient waiting for a room and to be examined by staff.

- » Patient grabbed an ink pen and tried to stab staff.
- » Husband threatened staff when he was not allowed to see his wife. The husband brought his gun to the ER and threatened staff.
- » Staff member attacked by patient and was cut with the staff member’s scissors.
- » Staff member was struck from behind by patient. Staff member suffered head trauma.
- » We were in the ER by ourselves and the ER was isolated with no code buttons at the time and with no other way to get help quickly. Another pregnant nurse had to run to get help while I held the patient from behind.
- » Patient had psychotic episode, grabbing a nurse and digging her nails into the nurse’s arm.
- » Patient pulled a knife on a nurse upon arrival.
- » A patient grabbed my hair, swung me around, and broke my nose.

MEDICAL/SURGICAL UNITS (INPATIENT)

- » Patient threw a metal pill crusher at staff and through the hospital window, which broke.
- » A nurse was kicked in the back of the neck by an elderly patient with dementia, resulting in a vertebral fix.
- » Patient choked nurse with her stethoscope. Nurse was severely injured.
- » Patient with dementia dislocated my finger.

- » Husband wanted staff to give his wife a shower. But the unit was short staffed that day so the staff promised a shower the next day. The husband got upset and threatened to go get his gun.
- » Patient refused his medication, stating if you ask one more time, I will hit you.
- » Patient hit staff.
- » Confused patient recovering from overdose spat, yelled at, and scolded the nurses.
- » Patient hit staff and injured them. Patient needed specialized psychiatric care but was placed by hospital in general medical/surgical unit without specialized training for staff.
- » Patient threatened to strangle a nurse.
- » Nurse struck in head with telemetry box.
- » Patient's husband grabbed nurse's neck and flung her during a code.
- » Patient headbutted me when we were transferring him back to bed.
- » Confused patient tried to kick us when we were cleaning and turning him.
- » Patient pulled a knife on a nurse.
- » Patient bit nurse who was trying to hold the patient in bed.
- » Patient going through alcohol withdrawal became combative and tried to enter another patient's room. Nurse tried to stop him and was elbowed in the face, fracturing her mandible.
- » Patient threw phone, IV pole, and chairs at staff from inside the room.
- » Confused elderly patient pinched me and pulled my hair while I was trying to take her vital signs and do the patient assessment.
- » A patient threatened to get his gun and shoot all the staff on the floor.
- » A patient bit the nurse while the nurse was feeding the patient.

INTENSIVE OR CRITICAL CARE UNITS (INPATIENT)

- » Newly intubated patient struggled with the nurse while the patient attempted to extubate himself. The nurse tried to keep the patient from falling out of bed and extubating himself. In the struggle, the nurse injured her right shoulder. The unit was short-staffed.
- » A nurse was hit by a patient going through withdrawal. The nurse's finger was broken and she was out of work on workers' compensation for several months.
- » I was kicked by a patient who was coming out of anesthesia.
- » Family member of a patient threatened to attack a nurse after work.
- » Family member of a patient threatened to physically attack a nurse and lunged at the nurse.
- » Confused patient punched me.
- » Patient was going through alcohol withdrawal, punched nurse when she was placing restraints.
- » Nurse was bit by a patient.
- » Patient tried to kick me when I attempted to stop him from falling.
- » Nurse was trying to insert an IV into a confused patient. The patient grabbed the nurse's hair. It took several nurses to pry the patient's hand off her hair.
- » Alcoholic patient actively withdrawing and having DTs was very combative despite being in four-point restraints. He broke out of his restraints and kicked an RN in the head.
- » Patient punched me in the face.
- » Patient's husband threatened to burn down the hospital if the patient died.

REMEMBERING CYNTHIA PALOMATA, RN

Cynthia Palomata, RN in Northern California » Palomata was an RN in a jail facility where she was killed in a workplace violence incident in 2010. She and her colleagues had alerted management that the dim lighting in their work area was a risk factor for workplace violence. Her employer delayed and refused to respond, eventually providing a heavy-bottomed table lamp to improve lighting. When Palomata was providing care to a patient, he picked up the lamp and hit her on the head with it. She was in the hospital for three days and never regained consciousness before she died. Palomata's murder was preventable, if only her employer had responded to nurses' reports of risk factors for workplace violence and had taken the necessary prevention measures.



Cynthia Palomata
October 28, 1955–October 28, 2010

Dedicated Public Servant and Nurse
Beloved by Many

s. A Visio Healthca

PSYCHIATRIC UNITS (INPATIENT)

- » Patient throwing objects at nurses.
- » Staff was bitten on the arm by a patient, requiring ER treatment.
- » Staff was punched in the head.
- » A psych nurse had her nose broken.
- » A patient punched a tech in the nose until he broke it.
- » A patient threatened to hit me.
- » A patient hit staff in the jaw while the nurse encouraged the patient to take medication.
- » Detainee sprayed a nurse with a concoction of feces and other bodily waste.
- » Patient punched nurse very hard in the chest. The nurse had a history of cardiac problems. The nurse was bruised.
- » Patient used a chair to break the window.
- » A detainee pushed a nurse down from behind. The nurse sustained a fracture of wrist and injury to the knee.
- » Nurse was administering medication in the hallway. The nurse was struck twice by a patient. Nurse was bleeding profusely from wounds to her face.
- » Acute breakdown schizophrenic patient hit one nurse in the face and kicked her, kicked another nurse and spit in her face, and spit in the face and kicked a nurses' aide. Delay in code because no one was available to help respond.
- » Patient scratched staff.
- » Patient punched a nurse in the face, fracturing the facial bone.

TELEMETRY UNITS

- » Patient hit nurse.
- » Dementia patient scratched the nurse providing care.
- » Combative patient hit nurse when providing care to him.
- » Older patient got confused, combative. He got out of bed and was going to leave the room. I put myself between the patient and the door. The patient put both hands on my shoulders and pushed me backwards.
- » Patient threw dirty, wet towel in nurse's face.
- » Nurse was punched in the throat by a patient with dementia. The patient went into other patients' rooms. Security was called to the floor and was kicked twice in the groin prior to restraining the patient.
- » Patient withdrawing from alcohol kicked nurse in the chest and grabbed the nurse's arm while she was trying to keep the patient from falling out of bed.
- » End-of-life patient had an upset son who said he was going to come back with either a lawsuit or a gun.
- » Nurse's arm was pulled by a patient. The patient punched the nurse in the face. Before the nurse could move away, the patient threw the call light at her face.
- » Patient waited for a nurse to turn around and then hit her really hard on her head with a steel handlebar from portable lift equipment.
- » Nurse was taking vitals and doing assessment when patient hit the nurse's hand.
- » Patient was not responsive. Apparently, he was ignoring us when trying to wake him to give him his medication. Nurse was concerned that the patient was non-responsive and didn't know the patient

was just ignoring us. After one person did a sterna rub, the patient swung at me, narrowly missing my face, and then jumped out of bed and chased us out of the room.

- » Transplant patient confused, kicking, scratching, spitting. Threw TV remote control.
- » Patient's wife came to visit unexpectedly. She started fighting with the patient's girlfriend.
- » Patient was withdrawing from drugs and became very combative. Security was called and a knife was found.
- » Psych patient was throwing feces at nurses.

OPERATING ROOMS (OR) AND POST-ANESTHESIA CARE UNITS (PACU)

- » While talking to patient, patient tried to hit a nurse and refused vital signs check. Patient stated that he was not here for that, just for a medication refill.
- » Patient was mad and tried to hit an employee. He was tired of waiting in the ER to be seen.
- » Doctor was handed the wrong instrument during surgery. The doctor threw the scalpel at a nurse who was impaled in the shoulder.
- » Gang members entered the OR, attempting to "finish off" the patient.
- » Patient woke up after anesthesia combative.
- » Patient in soft wrist restraints with sitter. Patient broke out of restraints and strangled the doctor.
- » Patient screamed at and threatened a nurse because he asked for his medication [before it was safe and medically appropriate].

- » Patient threw things at the nurse.
- » Patient was in pain and threatened to punch us in the face. The patient was given medication and appeared to be in less pain. The patient requested to get up to urinate.
- » During a leg assessment, the patient slammed the nurse's hand with his foot.
- » Patient combative and aggressive after surgery. The patient had a history of being combative after surgery if the wife was not present. The nurse's wrist was grabbed and bruised.
- » Pediatric patient was agitated after emerging from anesthesia. The patient calmed down to her baseline per her mom and wanted her IV out. The mother helped hold her arm down while I removed her IV. The patient tried to bite me as I was removing the tape.

LABOR AND DELIVERY UNITS

- » Infant admitted with heart condition. Father was aggressive and pushed staff.
- » Parents were yelling in the room with the door closed. The mother, patient, handed me the newborn and told me to take the baby since she was worried about what the father would do. Security and the police department came and removed him, but we don't have a locked unit.
- » Father of a baby threatened to "shoot up the place" if anyone took their baby. Child Protective Services was involved with the family due to a history of abuse and drugs. Security escorted him out.
- » I have been kicked multiple times.
- » Boyfriend and father-in-law were fighting. Boyfriend pulled out a knife and had a gun in his pocket.
- » Nurse transporting patient from Labor and Delivery Unit to the Post-Partum Unit was assaulted by patient en route.

- » Angry dad came on the unit, drunk and angry because the baby was listed under the mother's maiden name.
- » I had a patient who was physically combative, fighting against my care of her. I was hurt while doing a vaginal exam. My arm was outstretched and she clamped her legs against my right arm, tearing tendons. My workers' compensation claim was denied.
- » Family members threatened to harm nurses involved in a Child Protective Services case that resulted in their baby being taken away.
- » Patient bit a nurse and broke skin, causing the nurse to go to the ER.
- » The husband of a woman in labor had a gun. He gave three versions of why and said he had a permit.
- » A family threatened a nurse after a medical error. They threatened to catch her in the parking lot.
- » A patient's boyfriend and the father of her baby was intoxicated and on meth and threatened the nurse when asked to leave the post-partum unit. The nurse was fearful for weeks and had security escort her to her car after each shift.
- » Patient's husband yelled at a nurse when talking about pain management because he didn't want his wife to get any medications.

PEDIATRIC UNITS

- » A father was angry that his baby wasn't going home. He took a threatening posture, yelling, saying that he was going to take the baby against medical advice.
- » A parent said they would call the police on us.
- » A child slapped me.
- » A nurse was kicked by a psychotic pediatric patient.
- » Parent threatened a nurse because their baby wasn't doing well.

OUTPATIENT CLINICS

- » In group therapy, two patients pulled knives out.
- » Patient punched a dentist because he pulled the wrong tooth. Dentist was knocked out and had to go to the ER.
- » Patient threw a chair at a nurse.
- » Disgruntled patient shot a physician and technician. The physician required emergency surgery. Technician required treatment in the ER.
- » Patient hit a nurse with his cane.
- » A homeless patient was denied a bus pass after wound care. A bus pass was usually given at another clinic. The patient became aggressive and verbally abusive.
- » Patient threatening to leave against medical advice after a procedure. The patient had initially reported that they had a means of transportation before the procedure that necessitated sedation. The patient threatened the RN, "You had better not stand in my way." The patient left against medical advice after eventually signing the release form.

OTHER UNITS, SETTINGS, OR LOCATIONS IN THE HOSPITAL

- » Parents of patient slapped nurses' hands.
- » Parents of patient punched the wall.
- » Baby's father slapped a nurse in the face.
- » Patients spit on, throw urine and feces, curse out the nurses.
- » I was hit by a tele box, thrown by a confused patient.
- » A patient was verbally abusive because the patient was seen 15 minutes after their scheduled appointment time.
- » Family member broke glass in multiple windows along the hallway with their fist after viewing an expired family member.
- » Patient was combative, swiping at aides and nurses who were around him. He swung his catheter bag around to hit people.
- » Patient attempted to go to the bathroom, pooping himself, and was upset when I tried to help him to the bathroom. He started swinging his catheter bag, full of urine, at me, and tried to hurt me. Urine got in my hair.
- » Nurse was almost run down by a person stealing her car.
- » Patient blocked a nurse in a small room, got on top of her, and held a knife to her throat.

PARKING AREAS

- » A person [died by] suicide by shooting themselves in their car directly outside the hospital's Emergency Department entrance.
- » A patient died a year ago but the mother had still not accepted it. The mother waited in the parking lot, asking if each worker was a nurse. If the worker said yes, the mother said, "You killed my family, I will kill you."



Table 1. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »
Types of Workplace Violence²**

Types of workplace violence experienced in past year	Nurses reporting
Verbally threatened	62.4%
Pinched or scratched	35.8%
Verbally harassed based on your sex or appearance	27.6%
Slapped, punched, or kicked	26.6%
Objects thrown at you	24.9%
Spat on or exposed to other bodily fluids	20.6%
Physically threatened	20.6%
Groped or touched inappropriately	12.7%
I have not experienced workplace violence	16.7%

HIGH RATES OF VIOLENCE FOR NURSES AND OTHER HEALTH CARE WORKERS

As published in recent literature and reported by nurses to NNU, the incidence and threats of workplace violence for health care workers is alarmingly high.

NNU SURVEY OF NURSES ON WORKPLACE VIOLENCE

In surveys on workplace violence conducted by NNU between 2017 and 2019, the sample of 402 nurses provided responses to questions about their experiences within the past year (Table 1).

AVAILABLE DATA ON WORKPLACE VIOLENCE RATES IN HEALTH CARE

According to the U.S. Bureau of Labor Statistics (BLS), in 2019, registered nurses in private industry in the United States experienced a rate of 14.0 nonfatal violence-related injuries per 10,000 full-time employees. The injury rate for registered nurses is more than three times higher than the violence-related injuries for workers overall in the same year.³

The rate of violence-related injuries for private hospitals in the United States was 18.3 per 10,000 full-time employees in 2019. This is more than four times higher than the violence-related injury rate for private sector workers overall in the same year. State-run, public hospitals and nursing and residential care facilities have astonishingly higher rates of 175.4 and 243.8 per 10,000 full-time employees, respectively.

Table 2. **U.S. Bureau of Labor Statistics — Nonfatal cases resulting from violence involving days away from work, 2019**

Industry/occupation	Rate per 10,000 full-time employees
All private industry	4.4
Health care and social assistance (private industry)	14.7
Registered Nurses (private industry)	14.0
Hospitals (private industry)	18.3
Hospitals (public sector, state-run)	175.4
Nursing and residential care facilities (public sector, state-run)	243.8

The most recent data available from the U.S. Department of Health and Human Services National Electronic Injury Surveillance System-Work Supplement (NEISS-Work) estimates that the rate in 2011 of nonfatal injuries from workplace violence for health care workers was statistically greater than all workers combined.⁴

Between Jan. 1, 2012 and Sept. 30, 2014, a total of 112 health care facilities in the United States reported 10,680 OSHA-recordable injuries from workplace violence.⁵ Registered nurses and nurse assistants had the highest injury rates of all occupations examined.⁶ In the time period of the study, between 2012 and 2014, injury rates due to workplace violence increased for all job classifications and nearly doubled for both nurses and nurse assistants. Only 49 percent of all reports examined in this study specified the type of assault that led to the injury. Of these, 99 percent were physical assaults. The workplace violence injuries recorded were clustered in locations where direct patient care is provided in health care facilities.⁷

Data from recently published literature consistently demonstrates that the incidence and prevalence of workplace violence in health care settings is alarmingly high.

- » NNU's November 2020 survey of more than 15,000 registered nurses across the United States examined nurses' experiences of workplace violence during the Covid-19 pandemic. About 20 percent of nurses reported facing increasing workplace violence on the job, which they attributed to decreasing staffing levels, changes in patient population, and visitor restrictions.⁸
- » A study published in 2021 reported on a survey of nurses in British Columbia regarding their experiences of workplace violence and impacts on their mental health. Nearly 85 percent of the respondents reported having experienced more than one type of workplace violence over the previous year.⁹
- » A 2020 study examined workplace violence rates experienced by health care workers before and during the Covid-19 pandemic. The author reported an increase in frequency of health care workers dealing with aggressive or violent patients or patients' families during the Covid-19 pandemic compared to before.¹⁰

- » A 2019 article reported that 62 percent of hospital employees experienced violence on the job in past year.¹¹
- » A 2018 article studied occupational injuries and related factors among newly licensed registered nurses (nurses who were licensed between one year and two-and-a-half years prior to the survey date) working in hospitals in Florida.¹² The authors report that 25 percent of newly licensed registered nurses reported having experienced physical violence at least once.
- » A 2016 article reported on a survey of health care workers about their experiences of workplace violence and reporting practices.¹³ The authors reported that 39 percent of respondents reported having experienced an incident of workplace violence from a patient or a person accompanying a patient.
- » A 2015 article on a survey of hospital workers on workplace violence reporting found that 62 percent of respondents had been the target of violence in the past year, but that 88 percent of respondents had experienced a violent incident that they had not reported to their employer in the previous year.¹⁴
- » A 2011 article reporting on a survey of over 900 nurses working in nursing homes found that 48 percent of respondents reported being physically assaulted at least once in the prior three months by a resident or resident's visitor.¹⁵ Twenty-six percent of respondents reported being assaulted one or two times while 22 percent reported having experienced three or more assaults.
- » Another 2011 article reported on a study that recorded workplace violence incidents at six different hospitals that were implementing or continuing surveillance systems on workplace violence incidents.¹⁶ The authors reported a rate of 18.87 workplace violence incidents per 100 full-time employees for nursing staff.
- » A 2004 article reporting on a survey of almost 5,000 nurses licensed in Minnesota found that 12 percent of registered nurses reported experiencing physical assault at work annually and that 38.5 percent of registered nurses experienced nonphysical assault — including threats, sexual harassment, and verbal abuse — at work annually.¹⁷ The vast majority of physical violence was from patients or clients — 96.8 percent of physical violence related to a specific event and 90.7 percent of physical violence related to an ongoing event.

While the most recently available data indicates that rates of workplace violence are high for health care workers, it is also important to recognize that the problem is increasing. The health care industry has grown rapidly over the past ten years and, according to BLS projections, will continue to grow over the next ten years.¹⁸ Not only are there more affected workers, rates of workplace violence injuries have also increased in recent years. Between 2011 and 2013, rates increased by about 12 percent.¹⁹ With these rapidly increasing rates and employment, more and more workers will be injured, harmed, and killed unless protections are created and implemented.

While the most recently available data indicates that rates of workplace violence are high for health care workers, it is also important to recognize that the problem is increasing.

RIISING WORKPLACE VIOLENCE DURING THE COVID-19 PANDEMIC

The Covid-19 pandemic has disrupted many facets of our lives and the impact on health care settings has been substantial. Since the start of the pandemic, NNU has conducted surveys of nurses across the country, including union members and nurses who do not belong to a union.²⁰ NNU's November 2020 survey gathered information from more than 15,000 nurses about their experiences of workplace violence during the pandemic.²¹ About 20 percent of nurse respondents reported an increase in workplace violence since the pandemic began.

Nurses attributed increasing workplace violence during the Covid-19 pandemic to multiple factors including decreased staffing levels, changes in patient population, and visitor restrictions. Nurses also noted the following additional factors leading to increased workplace violence (edited for anonymity) »

- » Visitors refusing to adhere to universal masking policies.
- » Increased wait times or untreated conditions after loss of insurance leading to agitation, disorientation, or combativeness.
- » Increased risks of violence related to understaffing.

Additionally, during the pandemic, NNU nurses have reported violence from supervisors and managers. For example, one manager physically removed an N95 respirator from a nurse's face saying the nurse did not need it.

UNDERREPORTING OF WORKPLACE VIOLENCE

Many sources of data on workplace violence and related injuries underreport its prevalence. This is, in part, due to the mistaken understanding in health care that workplace violence is part of the job. Oftentimes, hospital supervisors and managers perpetuate this dangerous view of workplace violence, reinforcing the idea that reporting incidents is futile.

In focus group-style discussions in health and safety classes, NNU members have reported that supervisors and managers respond to reports of workplace violence with comments or actions that communicate to workers that violence is just “part of the job.” Also reflected in NNU members' experience with workplace violence, it is common for supervisors and managers to discourage employees from making reports of violence from patients. Nurses also describe in discussions on workplace violence that they are often hesitant to report violence from patients with dementia or other conditions that cause disorientation and combativeness, because they fear their patients, for whom they serve as advocates, will be criminally punished, otherwise blamed, or denied care as a result. These reasons for underreporting underline the importance of establishing clear communication procedures when developing workplace violence prevention plans. To encourage reporting on workplace violence, employers must clearly communicate prevention plan procedures to workers and should have nonretaliation policies for workers who report incidents of, risks for, and concerns about workplace violence.



Some researchers have attempted to measure the level and scope of underreporting. A 2015 study of one hospital system in the United States led by Judith Arnetz examined the difference between self-reported workplace violence incidents and those reported in the hospital system's electronic reporting database.²² Researchers sent surveys to employees working in 42 units of the hospital system on their experience with violence at work and whether they reported it. They found that 88 percent of respondents had not documented in their employer's electronic system an incident of violence they had experienced in the previous year.

Further, OSHA's current requirements for many employers to track work-related injuries and illnesses on OSHA 300 Logs are inadequate to address workplace violence. Only work-related injuries and illnesses that result in the following impacts must be recorded on the employer's OSHA 300 Log: death, days away from work, restricted work or transfer to

another job, medical treatment beyond first aid, loss of consciousness, or any injury or illness that requires diagnosis by a physician or other licensed health care professional (e.g., a fracture or traumatic brain injury).²³ The effects of workplace violence span a wide range of types and severity for nurses and other health care workers — from death to serious injuries to minor bruising and abrasions to nonphysical injuries (i.e., stress, anxiety, difficulty working, and, in some cases, job turnover). While some of these injuries meet the criteria to be recorded on employers' OSHA 300 Logs, many of them do not. Nurses have reported in NNU's focus group-style discussions that the kinds of nonphysical injuries that frequently result from workplace violence may require days away from work. Notably, nurses and other health care workers may take sick time to recover from these incidents, and, as a result, these days away from work are unlikely to be recorded in OSHA 300 Logs and other existing records.



THE PHYSICAL AND PSYCHOLOGICAL IMPACT OF WORKPLACE VIOLENCE ON NURSES AND OTHER HEALTH CARE WORKERS

The effects of workplace violence span a wide range of types and severity for RNs and other health care workers.

PHYSICAL FORCE AND INJURIES

Many incidents involving the use of physical force against an employee result in physical injuries, ranging from minor bruising and abrasions to death. Many of these injuries meet the criteria for recording in OSHA 300 Logs.²⁴ These injuries may result in days away from work. A 2004 study found that, about 20 percent of respondents who experienced physical violence responded that they self-treated injuries.²⁵

THREATS OF VIOLENCE

Threats of physical force and the use of a dangerous weapon — although they may be solely verbal — can result in severe psychological trauma and stress for workers, especially those who are repeatedly exposed to these threats. In these situations, a physical injury is not sustained, but nurses and other health care workers report serious and lasting effects, including stress, anxiety, difficulty working, post-traumatic stress symptoms and disorders. These nonphysical injuries harm nurses' health and may lead nurses to leave their jobs, implicating workplace violence in the high rates of turnover.²⁶

TRAUMA AND STRESS

Experiences of workplace violence — physical and nonphysical — can cause trauma and stress for nurses and other health care workers. NNU's survey of nurses indicates significant nonphysical health impacts resulting from experiences of workplace violence (see Table 3).

Data from recently published literature shows the substantial mental health impacts of workplace violence on nurses and other health care workers »

- » A study published in 2021 reported on a survey of nurses in British Columbia regarding their experiences of workplace violence and impacts on their mental health. Nearly 85 percent of the respondents reported having experienced more than one type of workplace violence over the past year.²⁷ Nearly 50 percent of nurses met the criteria for post-traumatic stress disorder and about 30 percent nurses met the criteria for anxiety, depression, and/or burnout. This study also documented that the more exposure nurses had to workplace violence — both directly through their own experience and indirectly — the more likely the nurses were to experience mental health impacts.
- » A 2020 study reported the results from an anonymous online survey of more than 1,000 health care workers regarding their experiences of workplace violence during the Covid-19 pandemic.²⁸ Not only have all nurses and other health care workers experienced extreme moral impacts during the Covid-19 pandemic,²⁹ but this study documented that health care workers who reported experiencing workplace violence during the pandemic were more likely to suffer from mental health problems than health care

Table 3. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 » Impacts of Workplace Violence³⁰**

Impacts of workplace violence	Nurses reporting
Anxiety, fear, or increased vigilance	54.5%
Difficulty working in environment that reminds of me past incident	19.9%
Physical injury or other physical symptoms (e.g., headaches, stomachaches, etc.)	18.9%
Took time off work	17.4%
Changed or left job	11.7%
Psychological effects prevent me from working	7.7%
Applied for workers' compensation	4.0%
Physical injury prevents me from working	3.0%
No injury/no effect	31.3%

workers who had not experienced workplace violence during the pandemic.

- » A study of trauma and stress symptoms in emergency nurses was published in 2011.³¹ Using the Impact of Event Scale-Revised, researchers found that 94 percent indicated the presence of at least one stress symptom after a violent

event, 25 percent indicated symptoms that posed clinical concern, and 15 percent indicated symptoms high enough to suppress the immune system. The researchers also found that 37 percent of respondent nurses had negative total productivity scores, which demonstrated decreased work performance after experiencing a violent event and found that there were significant indirect relationships between stress symptoms and work productivity.



A FOCUS ON WORKPLACE VIOLENCE PREVENTION

Health care employers have a moral and legal obligation to provide a safe and healthful workplace to their employees. This necessarily involves recognizing the hazard of violence on the job and implementing effective workplace violence prevention plans.

NNU's experience advocating for workplace violence prevention standards and the scientific literature indicate that effective workplace violence prevention in health care settings requires employers to create comprehensive, unit-specific plans to identify and mitigate risk factors for workplace violence. Engaging employee expertise is a fundamental and necessary part of this process — direct-care nurses and other health care workers have detailed and nuanced knowledge about their work processes and areas that is vital to effective workplace violence prevention. Continually reviewing and updating the workplace violence prevention plan is necessary to ensure that new risk factors are promptly identified and addressed. Employers must also create plans and assign staff to respond promptly to workplace violence situations when they arise.

Taken together, the elements listed below will ensure that workplace violence prevention plans are effective at abating and preventing this serious occupational hazard because they focus on creating a safe, therapeutic environment by addressing risk factors for violence and because employees serve critical roles in hazard identification, assessment, and correction.

PREVENTION VERSUS PATIENT PUNISHMENT » AVOIDING CRIMINALIZATION OF PATIENTS

Fundamental to NNU's approach to advocacy on workplace violence prevention is the understanding that health care employers are responsible for the care environment — including the staffing, infrastructure, and policies and procedures that can increase or decrease the risk of workplace violence occurring. When health care employers provide a safe workplace and effectively prevent workplace violence, they not only improve the health and safety of nurses and health care workers but also enable those workers to provide optimal, safer patient care. The goal of workplace violence prevention in health care should be to create and maintain a therapeutic environment that enables health care workers to care for patients safely. NNU advocates for enforceable standards that require employers to implement plans that prevent workplace violence *before it happens*.

In juxtaposition to this approach of workplace violence *prevention*, there are approaches that react to violence after it has occurred and treat patients as the problem. This type of approach focuses on punishment and retribution through enhanced criminal penalties for patients who assault health care workers. This is an ineffective strategy to prevent violence and it actively harms the very patients our members are caring for.³² At least 37 states already have enhanced criminal penalties on their books for violence against health care workers and many have had these penalties in place for decades. Yet, violence on the job for health care workers continues to skyrocket.

*NNU advocates for enforceable standards that require employers to implement plans that prevent workplace violence **before it happens**.*

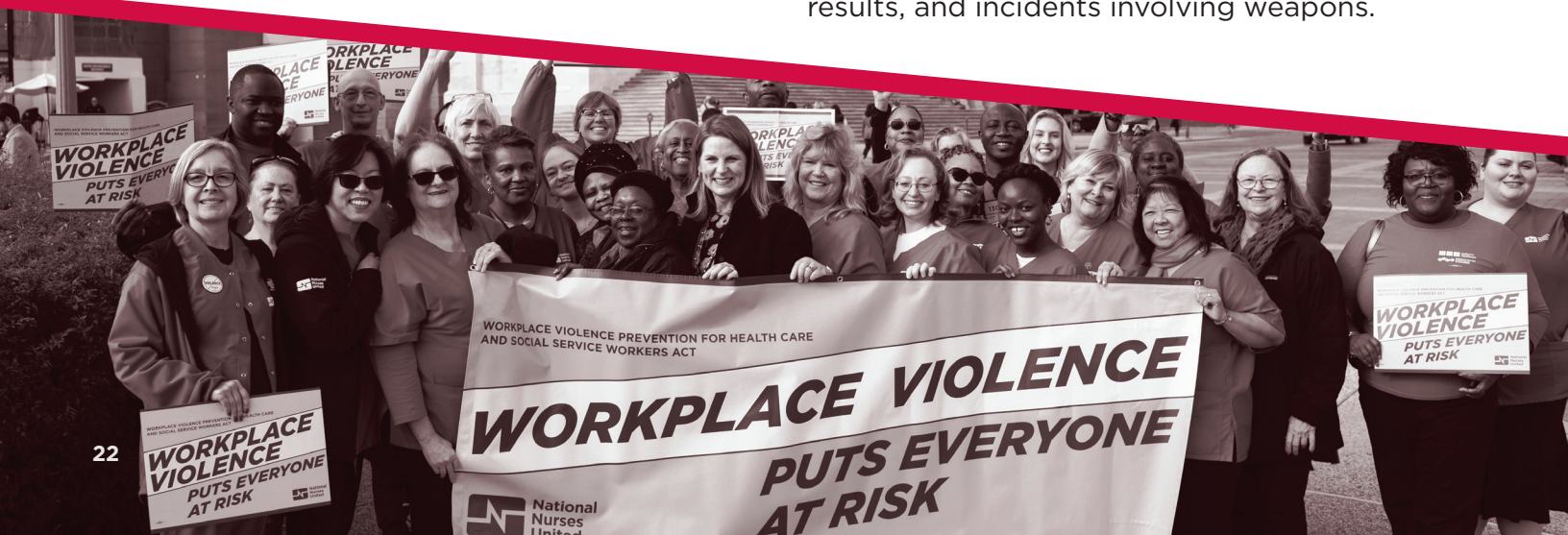
Indeed, policy approaches that further criminalize workplace violence in health care misunderstand and disavow the causes of violence. Because violence may be related to a patient's condition, the criminal intent necessary to legally apply enhanced criminal penalties is often absent. While the majority of workplace violence incidents experienced by health care workers come from patients, an overwhelming proportion is related to the patient's disease process or a treatment or medication they are receiving.³³ For example, a patient may be combative or disoriented as a result of dementia or because the patient is coming out of anesthesia. In these situations, the criminalization approach would be inapplicable because there is no legally cognizable intent. Structural inadequacies in our health care system may also contribute to the risk for violence. For example, patient aggression may be related to unmet health care needs or untreated chronic conditions, resulting from the patient's lack of health care access, which may be causing pain or agitation.

Importantly, policy approaches to workplace violence should avoid interventions that put nurses and other health care workers in opposition to their patients' interests or that interfere with the provision of care. Because nurses and other direct patient care staff have a duty of patient advocacy, their active involvement in the response to violence means that there is both an emphasis on patient care and an emphasis on prevention. By not placing the blame on patients and looking at ways that health care employers can protect both workers and patients, patient care can improve while, at the same time, workers are protected.

UNIT-SPECIFIC PREVENTION PLANS

There is no one-size-fits-all workplace violence prevention plan. To effectively prevent workplace violence, health care employers must create workplace violence prevention plans that include procedures for unit-specific and facility-specific assessments and prevention methods. Units of similar types — such as intensive care units — are not the same between different hospitals; they do not have the same risk factors for violence because of differences in physical layouts, patient populations, staffing levels, policies and procedures, and other facility-specific considerations. Additionally, each unit or work area within the same facility must also have its own unique workplace violence prevention plan because they have different risk factors for workplace violence; for example, an emergency department has different risk factors from a neonatal intensive care unit or an operating room. Other health care settings — such as outpatient clinics, nursing facilities, and home health care — have different risk factors from inpatient hospital units and will require their own plans.

Workplace violence prevention plans must cover not just every unit and work area within the health care facility but also other areas within (e.g., elevators and stairwells, waiting rooms, and the lobby) and surrounding (e.g., employee parking areas, walkways, and other outdoor areas) the facility. Plans must also cover employees who perform work in settings outside the hospital, including outpatient clinics, home health care, and others. Unit-specific workplace violence prevention plans must be in effect at all times and must cover the expansive definition of workplace violence described above, including both threats and acts of physical violence, regardless of whether an injury results, and incidents involving weapons.



To create an effective workplace violence prevention plan, health care employers must conduct comprehensive, unit-specific assessments of environmental risk factors for violence in all units, other work areas, and other areas in and around the health care facility. Employee involvement — both from direct-care nurses and other health care workers — in these risk assessments is vital. Environmental risk factors include »

- » Working in an isolated or remote area.
- » Working in an area with dim lighting or blocked areas of visibility where possible assailants may be present.
- » Working late at night or early in the morning.
- » Working in an area where an assailant could prevent entry by responders or other employees.
- » Lack of physical barriers between employees and persons at risk of committing workplace violence.
- » Lack of effective escape routes.
- » Obstacles to alarm systems or impediments to using alarm systems, including nonfunctional alarm systems.
- » Entryways where unauthorized entrance may occur, e.g., doors designated for staff-only entrance or emergency exits.
- » Presence of weapons, including improvised weapons.
- » Storage of high-value items, currency, or pharmaceuticals.

Health care employers must also create procedures to assess patient-specific risk factors for workplace violence. These risk assessments should occur initially and continue in an ongoing basis at frequent intervals.. Patient-specific risk factors that may increase the likelihood of violent behavior include »

- » A patient's mental status, conditions that may cause the patient to be nonresponsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively.

- » A patient's treatment and medication status, type, dosage.
- » A patient's history of violence.
- » Disruptive or threatening behavior displayed by a patient.

Where an environmental or patient-specific risk factor is identified, employers must take action to remove or mitigate that risk factor. As discussed in more detail above, the orientation of a workplace violence prevention program should be towards maintaining a safe and therapeutic environment for both patients and staff. The following list provides a brief summary of effective workplace violence prevention measures »

- » Staffing is the most effective workplace violence prevention measure. Increased nurse and health care worker staffing levels ensure patients get the care they need in a timely fashion, provide staff more time to recognize and de-escalate indicators of potential violent behavior, and provide for a faster and more effective response to workplace violence incidents when they begin.
- » Ensuring line of sight or other immediate communication in all areas where patients or members of the public may be present. This can include reorganizing the layout of physical spaces, using a buddy system, improving illumination, installing sight aides such as mirrors, and installing and maintaining alarm systems.
- » Configuring facility spaces so that employees' access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
- » Removing or fastening furnishings and other objects that could be used as improvised weapons.
- » Preventing the transport of unauthorized firearms and other weapons into the facility.

- » Installing and maintaining effective alarm systems to enable employees to summon other staff to help defuse or respond to a workplace violence incident.
- » Instituting communication procedures to alert employees to the presence, location, and nature of a security threat.
- » Having an effective response plan for actual and potential violent incidents that includes procedures to obtain help from other staff, facility security, and, where appropriate, local law enforcement.

Health care employers must also develop systems for effective communication about workplace violence hazards between coworkers, across shifts and units, between paramedics and receiving facilities, and between employees, emergency services, and law enforcement. Effective communication systems are important to ensure that staff have the information they need regarding workplace violence risk factors. Many nurses have told NNU that they learn information about a patient's risk factors for violence only after experiencing a violent incident. Communication systems should include procedures for employees to report workplace violence concerns, procedures for obtaining employee input during incident investigations, and procedures for taking corrective action once concerns are communicated.

Multiple studies have documented the effectiveness of unit-specific workplace violence prevention plans created with employee input »

- » A 2017 randomized control trial examined the effectiveness of unit-specific workplace violence prevention plans created with the input of direct care staff.³⁴ The study randomized 42 inpatient hospital units into intervention and control groups. A worksite walkthrough, including assessing environmental risk assessments, was conducted on each intervention unit. Unit supervisors were given incident and injury data for their unit from the past three years and worked with direct care staff to develop an action plan to reduce workplace

violence using administrative, behavioral, and environmental strategies that best addressed each unit's violence risks. The authors found that »

- » Intervention units reported *less than half* the violent incident rate of control units at six months post-implementation.
- » Intervention units reported *nearly a third* the violence-related injuries of control units at 24 months post-implementation.
- » A similar 2014 repeated-measures study examined the impact of unit-specific workplace violence prevention plans created with employee input. This study randomized six emergency departments into intervention and control groups.³⁵ Researchers partnered with direct care employees, managers, and hospital administrations to develop workplace violence prevention plans including environmental changes, policies and procedures, and education and training. While not all intervention units fully implemented the plans, the authors observed »
 - » A 50 percent decrease in assaults in the unit that most thoroughly implemented a unit-specific workplace violence prevention plan.
 - » Increased awareness and reporting of violent incidents on intervention units.
 - » The authors of this study concluded: "This result emphasizes that the effectiveness of WPV prevention programs is predicated not only on strategies examining risk factors related to patients, employees, and the employer but on programs with employee involvement and management commitment and endorsement."

- » A 2010 paper reported on the development of a workplace violence incident response plan at an emergency department in the United States.³⁶ After an increase in workplace violence incidents, emergency department management met with nursing staff, social workers, security personnel, supervisors, and local law enforcement representatives to develop a security plan for the department. The plan included procedures to assess risks for workplace violence, communication procedures to alert staff to an increased risk, plans to engage local law enforcement in certain situations, and staff training on all parts of the program. While the authors did not quantify violence incidents, they report the following findings »
 - › A significant decrease in the workplace violence-related injuries among staff in the emergency department after implementation of the program, with only one incident reported post-implementation.
 - › “Staff do not believe that the security status color change has helped to decrease the day-to-day risk from patients who become violent or abusive unexpectedly, but it has helped staff to identify the stages of escalation and take appropriate prompt measures to intervene early and remain safe.”³⁷
 - › While a prompt response plan is not sufficient to prevent workplace violence, it is a vital part of an effective workplace violence prevention program. Employee involvement is key to making such a program effective.
- » A 2011 study examined the impact of a workplace violence prevention plan implemented in a psychiatric rehabilitation unit in Italy over a period of 10 years.³⁸ The workplace violence prevention plan involved continual assessments of environmental and patient-specific risk factors, implementing environmental and architectural changes, policies and procedures, and staff education with the dual goal of decreasing violent incidents towards staff and decreasing patient restraint and seclusion measures. The author reported »
 - › A statistically significant reduction in workplace violence incidents post-implementation.
 - › A significant decrease in use of restraints and seclusion measures for patients who became aggressive or violent.
 - › Engaging the expertise of direct care health care workers was vital to identifying and understanding the sources, patterns, and opportunities for prevention of workplace violence.
 - › Developing a workplace violence prevention plan specific to the workplace resulted in a long-term significant reduction in workplace violence to staff and increased patient safety.
- » A 2011 study examined bed occupancy and staff reports of workplace violence.³⁹ The researchers found that workplace violence incidents were statistically significantly more likely to happen on overcrowded units. This relationship was found to be dose-dependent, which is an important element for establishing causality in research studies.
- » A 2005 study surveyed more than 6,000 nurses in Minnesota about their experiences of workplace violence and employers’ prevention measures.⁴⁰ The researchers found that certain environmental interventions were significantly associated with lower rates of workplace violence. The odds for workplace violence were about twice as high when the workplace was less bright than daylight as compared to when the units were lit “as bright as daylight.” Having physical barriers blocking vision was associated

with increased workplace violence. Having security personnel was associated with decreased workplace violence rates.

PLAN TO RESPOND TO WORKPLACE VIOLENCE INCIDENTS

Health care employers must also establish, as a part of their workplace violence prevention plans, effective unit-specific plans to respond to workplace violence incidents when and after they occur. Effective violent incident response measures include »

- » Implementing a system for staff to effectively seek immediate assistance when a workplace violence incident begins or when they identify indicators of potential violent behavior.
 - » Assigning and placing sufficient staff who are trained and available to respond effectively to workplace violence incidents to assist with de-escalation and to maintain both patient and staff safety. Staff must be truly available to respond, meaning they must not have other job duties that could conflict with being immediately available to respond to a violent incident.
 - » Providing immediate medical care or first aid to employees affected by a workplace violence incident.
 - » Identifying all employees involved in the incident and following up with all involved employees. This should include conducting a post-incident debriefing as soon as possible after the incident with all employees, supervisors, security, and other staff involved in the violent incident.
 - » Making confidential, individual trauma counseling available to all employees affected by the violent incident.
- Health care employers must also establish a system for employees to report all workplace violence incidents without fear of reprisal for themselves or their patients. Employees should receive training on why reporting is important and how to report without fear of reprisal. Employers must investigate each report of a workplace violence incident, with employee involvement, and identify contributing factors and prevention measures that would be effective at preventing a similar incident from occurring in the future. Employers' review and tracking of workplace violence incidents must include the following »
- » Reviewing any risk factors and risk reduction measures that were or should have been in place when the violent incident began.
 - » Reviewing whether appropriate prevention measures were effectively implemented and if additional measures would prevent similar incidents from occurring in the future. If additional measures are identified, the employer should implement them in a timely fashion.
 - » Involving employees and other personnel who were involved in the incident in the incident reviews and identification of additional prevention measures.
 - » Maintaining thorough records and adhering to rigorous reporting requirements, both of which are critical to the effectiveness of annual evaluations of workplace violence prevention plans and hazard correction.

TRAINING FOR ALL WORKERS

Employees should be trained on their employer's workplace violence prevention plan, how to report violent incidents, how to seek assistance during a violent incident, and more. Worker training is an important facet of an effective workplace violence prevention plan, but by itself, training is insufficient to prevent workplace violence. Several studies have documented the importance — but insufficiency — of training to workplace violence prevention »

- » A 2017 study examined the impact of a unit-specific educational program in two hospital units in Australia.⁴¹ The educational program was conducted in person and addressed four key areas: assessment, planning, implementation/crisis, and post-incident. The authors reported »
 - › A decrease in reported violent incidents by 45 percent following the educational program.
 - › A significant decrease in the proportion of recurring incidents following the educational program. Before, 10 patients were responsible for 30 incidents (at most seven from one patient), while after the educational program, 17 incidents were reported from 11 patients with two at most from each patient.
 - › Unit-specific, in-person educational programs that clearly address the employer's workplace violence prevention plan were important in reducing workplace violence incidents.
- » A 2009 study reported on the effectiveness of a workplace violence intervention implemented in a psychiatric inpatient unit at a Veterans Health Administration hospital that included real-time incident recording tools and regular meetings on workplace violence with all staff and patients.⁴² To implement the intervention, the hospital gave unit staff members hand-held event recorders to easily record violent incidents in real-time during their shifts and began holding
- » “The Violence Prevention Community Meeting” twice weekly on day shift but not the night shift. The meetings were attended by all patients and all day-shift staff on the psychiatric inpatient unit. Rates of violence were significantly reduced on the day shift — by 89 percent during treatment and 57 percent from pre-treatment to post-treatment — but the night shift did not show significant changes in violent incident rates.
- » A 2005 paper reported on a nested case-control study of workplace violence rates experienced by Minnesota nurses.⁴³ Nurses who reported being physically assaulted while working in the past 12 months were selected as cases and compared to controls, who were selected from nurses who reported experiencing no workplace violence. The authors reported that, when controlling for potentially confounding factors (e.g., type of unit, environmental protection implemented by employer, types of patients), training by itself was not protective for workplace violence.
- » A 2002 paper reported on the implementation of an in-depth workplace violence training program in a hospital emergency department in Canada.⁴⁴ The training was interactive and included role play, videos, and group discussion on de-escalation and other topics. The authors found »
 - › Workplace violence rates decreased immediately following the training but at six months had returned to pre-training levels.
 - › In-person training is important for workplace violence prevention plans but, by itself, is insufficient and must be consistently updated.

WORKER INVOLVEMENT IN ALL ASPECTS OF THE WORKPLACE VIOLENCE PREVENTION PLAN

Active worker involvement — throughout all stages of the workplace violence prevention plan, including plan development, implementation, and review — is key in ensuring that workplace violence prevention plans are effective. Worker involvement goes hand-in-hand with the comprehensive training requirements discussed above. Workers who are directly involved in incidents of workplace violence, including both nurses or other direct patient care staff as well as other non-direct patient care staff, can provide valuable insight on how to prevent or mitigate similar incidents of violence in the future. Because direct-care nurses and other health care workers have an intimate understanding of situations and locations that have increased risks for violence reflective of their daily experiences at the worksite, their expertise and input in the development, implementation, and review of a workplace violence prevention plan is essential and invaluable.

NNU members' experience with these programs and plans demonstrate that plans will not be effective without active employee involvement in plan development, including hazard assessment, prevention measure selection, and evaluation of the plan's effectiveness. Without their active involvement in all steps of program development, workers would not know how to identify risk factors for violence, how to communicate those risks to their employer, how to get assistance in evaluating, correcting, and mitigating those identified risk factors, how to get help if an incident does occur, or how to report incidents when they happen. To put it another way, effective communication with employees about the requirements of a workplace violence prevention plan is critical to the program's success.

Including direct patient care staff is also important in ensuring that workplace violence interventions do not negatively impact patient care. For example, unsafe staffing levels may ultimately jeopardize patient care and a direct-care nurse on that unit will be able to flag a workplace violence intervention or response plan that does not consider the specific unit's

Importantly, the research literature also indicates that all staff should be actively involved in workplace violence prevention activities.

safe patient staffing needs. Moreover, direct patient care staff on a unit are familiar with the patient population and can readily assess the risks for violence for patients.

The need for direct patient care staff involvement in workplace violence prevention plan development is also supported in the research literature. A 2017 randomized control trial, mentioned above, examined the effectiveness of unit-specific workplace violence prevention action plans created with the input of direct care staff.⁴⁵ In developing the action plans, the intervention units conducted walkthroughs and risk assessments using unit-specific data — and both walkthroughs and assessments were conducted with the unit's direct patient care staff. The study reported that the rates of violence in the intervention units dropped at first but increased again 24 months post-intervention. The authors observed, "The study design did not include any form of booster intervention, such as an additional site visit. The fact that significant group by time differences were evident 6 months post-intervention, but not at later time points, suggests that some sort of booster measure might enhance this intervention methodology." In our view, this study indicates that, in practice, not only should direct patient care staff be actively involved in the development of workplace violence prevention plans and in the assessing the risks on their unit but that direct patient care staff involvement should occur frequently and in an ongoing manner.

Importantly, the research literature also indicates that *all staff* should be actively involved in workplace violence prevention activities. A 2009 study, also mentioned earlier, reported on the effectiveness of a workplace violence

intervention implemented in a psychiatric inpatient unit at a Veterans Health Administration hospital that included real-time incident recording tools and regular meetings on workplace violence with all staff and patients.⁴⁶ To implement the intervention, the hospital gave unit staff members hand-held event recorders to easily record violent incidents in real-time during their shifts and began holding "The Violence Prevention Community Meeting" twice weekly on day shift but not the night shift. The meetings were attended by all patients and all day-shift staff on the psychiatric inpatient unit. Rates of violence were significantly reduced on the day shift — by 89 percent during treatment and 57 percent from pre-treatment to post-treatment — but the night shift did not show significant changes in violent incident rates. The disparate study results between day-shift and night-shift rates of violence demonstrate that continuous involvement of all staff in risk assessment and prevention is critical in ensuring the effectiveness of workplace violence interventions implemented by employers.

Other health care facility staff — including patient care staff, administrators, security guards, temporary employees, and janitorial staff — should also receive training on the workplace violence prevention plan and should be given the opportunity to provide input on the development and review of the workplace violence prevention plan. By including all staff, the range of risk levels and types for different individuals within a single facility can be incorporated into the prevention plan. For example, a janitor who works in isolated areas at night is exposed to different hazards and levels of risk than a nurse who works during the day shift in an outpatient unit.



WHY DO WE NEED A FEDERAL OSHA STANDARD?

EMPLOYERS' DUTY TO PROVIDE SAFE AND HEALTHY WORKPLACES

Employers must fulfill their obligations under the Occupational Safety and Health Act (OSH Act) to protect employees from hazardous exposures on the job — including workplace violence — because nurses and other health care workers deserve safe and healthful workplaces. Under Section 5(a)(1) of the OSH Act, an employer has a general duty to its employees in that it must “furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”⁴⁷ Section (a)(2) requires that employers “comply with occupational safety and health standards promulgated under this chapter.”⁴⁸

OSHA'S DUTY TO PASS AND ENFORCE WORKER SAFETY STANDARDS

Under the OSH Act, Congress tasked OSHA with assuring “so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources...” including by passing mandatory standards.⁴⁹ From the available data and from NNU members' experiences, it is clear that OSHA is not upholding its duty, assigned by Congress, to protect health care workers from workplace violence. OSHA needs to pass a formal workplace violence prevention standard and implement a strong enforcement campaign to effectively protect health care workers from workplace violence. Despite granting NNU's petition for a workplace violence prevention standard in January 2017, OSHA's work on such a standard has stalled.⁵⁰

THE IMPORTANCE OF AN OSHA STANDARD

Despite recognition of workplace violence as a hazard in health care and significant attention to the issue, OSHA continues to delay development of a workplace violence prevention standard.

Through the OSH Act, Congress mandated prioritization of the safety of workers and the prevention of occupational injury and created an obligation for employers to provide a workplace free from recognized hazards, including workplace violence in health care settings. To fulfill this legislative mandate, OSHA was tasked and is required by the OSH Act to promulgate mandatory health and safety standards to protect workers across the country from workplace hazards.

Congress envisioned in the passage of the OSH Act that all workplace safety standards promulgated by OSHA be highly protective.⁵¹ It recognized that OSHA's leadership would be necessary in creating uniform standards across the nation, requiring, where conflicts existed among occupational standards, that “the Secretary [of Labor] promulgate the standard which assures the greatest protection of the safety or health of the affected employees.”⁵² Thus, where serious occupational hazards persist despite voluntary measures, OSHA is required by law to act and to establish a mandatory workplace health and safety standard.

A formal standard on workplace violence prevention in health care would fulfill OSHA's statutory obligations. As documented by a Government Accountability Office (GAO) report from March 2016 recommending that OSHA provide additional information to assist inspectors in developing citations and recommending that OSHA develop a policy for following up on hazard alert letters concerning workplace violence hazards in health care facilities, OSHA inspectors would be able to utilize the specific requirements of a formal standard to assess the effectiveness of employers' plans, ensuring that these plans are comprehensive, focused on prevention, and created with the

input and insight from affected employees.⁵³ Through the creation of specific requirements for employers' workplace violence prevention plans, a formal standard would fortify OSHA's ability to enforce this obligation to protect health care employees from workplace violence through improved measures in evaluating and citing violations.

OSHA'S CURRENT EFFORTS ARE INADEQUATE

For several decades, OSHA has attempted to use ineffective voluntary measures to respond to workplace violence in health care settings. In order to ensure that nurses are protected, Congress must pass legislation requiring OSHA to establish a federal workplace violence prevention standard. Strong enforcement programs are necessary to encourage employer compliance with OSHA standards.

OSHA already has established that workplace violence qualifies under its General Duty Clause⁵⁴ and has taken some action to see that it is enforced. Accordingly, the agency has performed inspections and issued citations under its General Duty Clause. In April 2015, OSHA also released an enforcement directive and a three-year National Emphasis Program - Nursing Home and Residential Care Facilities to increase enforcement efforts around workplace violence in health care settings.⁵⁵

However, the 2016 GAO report on workplace violence in health care examined OSHA's enforcement record on workplace violence under the General Duty Clause and found it wanting. The GAO analysis found that approximately 65 percent of the inspections of health care facilities for workplace violence that OSHA conducted between 1991 and April 2015 took place between 2012 and 2014. The analysis also found that OSHA citations are region dependent and inconsistent across the United States. Three of the 10 OSHA regions conducted 60 percent of all the inspections performed. Moreover, only 5 percent of the inspections conducted in health care facilities between 1991 and early 2015 resulted in a General Duty Clause citation.⁵⁶

It is clear that enforcement efforts have been neither coordinated nor effective. OSHA inspectors interviewed during the GAO analysis agree »

Some inspectors and other regional officials from 5 OSHA regional offices said it is difficult to collect sufficient evidence to meet all four criteria [for a General Duty Clause citation] during an inspection.... Another inspector noted that an employer may have a minimal workplace violence prevention program and that it is sometimes difficult to prove that the employer has not done enough to address the hazard.⁵⁷

On June 25, 2015, following the release of the GAO report, OSHA issued a memorandum to establish guidance for inspections conducted in inpatient health care settings, North American Industry Classification System (NAICS) Major Groups 622 (hospitals) and 623 (nursing and residential care facilities).⁵⁸ The memorandum requires that all inspections, both programmed and unprogrammed, cover the focus hazards from the expired National Emphasis Program - Nursing and Residential Care Facilities, which includes workplace violence among a list of four other focus hazards. While admirable, the memorandum does not establish a clear and enforceable standard to protect health care workers from violence in the workplace.

In addition to promulgating a federal standard on workplace violence prevention in health care, OSHA must also improve and strengthen its enforcement program. Throughout the Covid-19 pandemic, OSHA has neglected its duty to protect the lives and health of working people in this country. As of Dec. 30, 2020, federal OSHA reported it has received 12,083 complaints from workers since the beginning of the pandemic and reports having opened a mere 333 inspections in response to complaints (2.8 percent).⁵⁹ President Joe Biden's administration has committed to strengthening OSHA's enforcement program, including increasing the number of inspectors. We look forward to working with President Biden's administration to reinvigorate, revive, and strengthen OSHA's enforcement and inspection efforts, which will be crucial to the enforcement of a federal workplace violence prevention standard.

OSHA'S CURRENT VOLUNTARY GUIDELINES ARE INSUFFICIENT

In the area of workplace violence in health care settings, OSHA first issued voluntary guidelines in 1996, which were updated in 2004 and again in 2016. These guidelines provide recommendations for employers on how to assess and evaluate workplace violence hazards and recommendations on control measures that may be implemented to reduce or eliminate these hazards. But these guidelines fall short of creating any mandatory requirements or enforceable provisions to protect workers. NNU's experience tells us that coordinated worker enforcement campaigns are necessary to ensure that health care employers comply even with mandated standards and laws.

When there are no associated penalties or consequences, employers have failed to follow OSHA's nonmandatory suggestions or guidelines. One study found that more than 80 percent of employers report no change in their workplace violence prevention programming after a significant violent event, even though 35 percent cite negative effects such as increased absenteeism and reduced productivity.⁶⁰ OSHA should recognize that voluntary guidelines have not and will not ensure that health care workers are protected from workplace violence.

The failure of voluntary guidelines and the recognition of the necessity for developing standards are also evident in the American National Standard, which was approved by the American National Standards Institute, Inc. (ANSI). ANSI, a recognized source of national consensus standards in federal regulation,⁶¹

developed its workplace violence standard based on "a majority consensus among professionals from disparate disciplines (including security, human resources, mental health, law enforcement and legal arenas) regarding practices viewed as effective, recommended, and — in some cases — essential through work in this field."⁶² Glaringly missing from ANSI's process of creating national standards are any workers directly affected by workplace violence in the health care industry and their unions. The lack of worker representation and participation in ANSI is juxtaposed to the unabashed presence of representatives of health care employers, universities, and insurance providers as well as a variety of corporate interests.

ANSI's orientation towards industry representation highlights the scope of the problem in establishing occupational safety and health standards that can effectively address hazards that employees face in the workplace. Not surprisingly, the "voluntary standards" set by the guardians of health care management and corporate interests have failed to stem the tide of workplace violence. This is an overwhelming testament to the futility of "voluntary" guidelines in reducing death and disability in the workplace and especially in the health care setting.

NNU members report that current employer-initiated efforts to prevent workplace violence are lacking. Reporting of all violent incidents is a crucial element for an effective workplace violence prevention plan, but only 35.8 percent of the nurse respondents to NNU's survey on workplace violence reported that their employer has a clear way to report workplace violence incidents (see Table 4). And while a majority of nurse respondents reported that their employers provide some level of training on workplace violence, many respondents also noted on the surveys that their employer's training is brief, online, or not effective. Without a clear mechanism to report incidents of workplace violence and without training on how and why it is important to report, workers will not report all incidents of violence. With limited information on the circumstances that result in or have a high likelihood of escalating to violence, lack of reporting severely limits the effectiveness of any hazard assessment, prevention, or control procedures and measures.

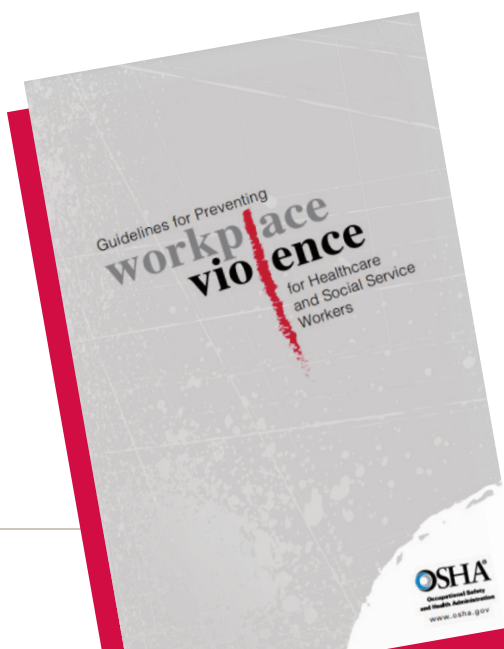


Table 4. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 » Employers' Prevention Measures**⁶³

Employer prevention measures	Nurses reporting
Provides training on workplace violence	55.0%
Has security guards available at all times to respond to violent incidents	44.5%
Provides a clear way to report incidents	35.8%
Uses security cameras	28.4%
Uses a charting or room flagging system to indicate patients with increased risk for violence	22.6%
Includes nurses and other employees in violence risk assessments	16.2%
Limits visiting hours	14.2%
Uses metal detectors	5.5%
I'm not sure	13.7%

NNU's survey results, which demonstrate the lack of workplace violence prevention by many employers, are included in Table 4.

Also lacking from many current employer-driven workplace violence prevention and control measures is the active involvement of direct patient care employees in the development of those measures. Nurse and other direct care health care worker involvement in the development of hazard prevention measures is essential to an effective prevention program. But only 16.2 percent of respondents to NNU's survey on workplace violence reported that their employer includes nurses and other health care employees in violence risk assessments (Table 4).

Moreover, NNU's survey data demonstrates that current training provided by employers has been ineffective. When workplace violence incidents do occur, employers should follow up promptly to provide medical care to injured employees, to investigate what happened,

and to implement prevention measures as needed to prevent future similar incidents from occurring. In the NNU survey, data on this account were striking — a large percentage of respondents replied “I don't know” when asked about what measures their employer's take to investigate or follow up on incidents of workplace violence even though 55.0 percent reported receiving training on workplace violence (Tables 4 and 5). These nurses did not know whether their employer provides access to counseling, trains or retrains employees, or changes practices to reduce risk of violence. If training does not effectively convey basic information about the employer's prevention plan, that training is ineffective. NNU's survey results on questions about incident investigation measures are included in Table 5.

Table 5. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »
Employers' Response to Workplace Violence Incidents⁶⁴**

Employer response to workplace violence	Nurses reporting	
Investigates what happened	Yes	60.0%
	I don't know	19.7%
	No	20.3%
Provides access to counseling	Yes	28.1%
	I don't know	42.0%
	No	29.9%
Trains or retrain employees	Yes	35.1%
	I don't know	36.7%
	No	28.2%
Changes practices to reduce the risk of violence	Yes	30.5%
	I don't know	41.2%
	No	28.3%
Discourages employees from reporting incidents	Yes	12.7%
	I don't know	53.7%
	No	33.6%
Reprimands or blames employees	Yes	29.7%
	I don't know	44.9%
	No	25.3%
Ignores it	Yes	33.8%
	I don't know	40.5%
	No	25.7%

INDIVIDUAL STATES HAVE MOVED AHEAD OF OSHA ON PREVENTING WORKPLACE VIOLENCE

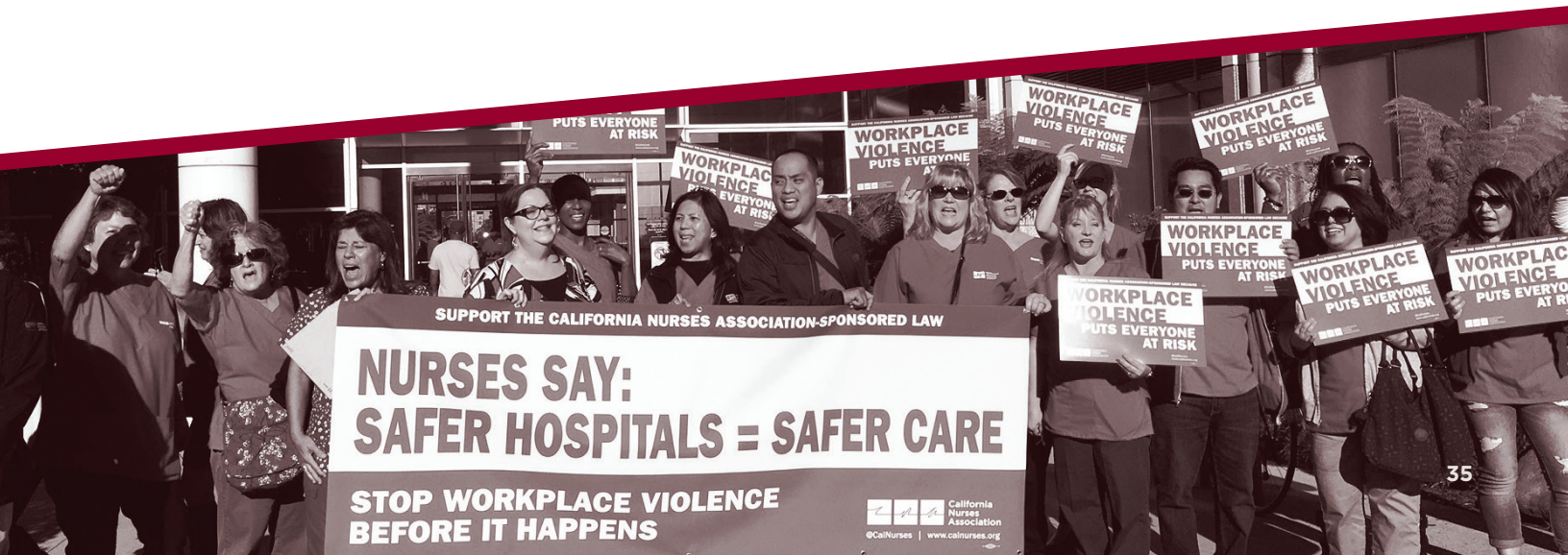
While several states have moved forward with recognizing and regulating workplace violence in health care, ultimately, a state-by-state effort is insufficient to protect all health care workers in the United States. Twenty-eight states and territories are under federal OSHA jurisdiction, which means that not only is a state OSHA standard impossible in those states but that public sector workers in those states do not have OSHA coverage. Six states have a state OSHA plan that only covers public sector workers in the state, leaving private sector workers under federal OSHA's jurisdiction in those states.⁶⁵ Federal OSHA should act now to promulgate a workplace violence prevention standard, and Congress should pass the Workplace Violence Prevention for Health Care and Social Service Workers Act, so that all nurses and other health care workers in the United States are protected from workplace violence.

State standards, some of which provide strong protections to nurses and health care workers in those states, provide models for a federal workplace violence prevention standard. Specifically, California's Violence Prevention in Health Care Standard, the most comprehensive standard in the country, provides an important model.⁶⁶ Through the stewardship of NNU and our affiliate, the California Nurses Association (CNA), health care workers in California are now covered under a comprehensive workplace violence prevention standard promulgated by the California Division of Occupational Safety and Health (better known as Cal/OSHA).

California enacted CNA-sponsored legislation requiring the creation of a statewide standard on workplace violence prevention plans based on the long-standing recognition that violence in health care settings is a serious occupational hazard for health care workers in California and throughout the nation.⁶⁷ Rulemaking was completed in October 2016. The Workplace Violence Prevention in Health Care Standard has been fully in effect since April 1, 2018. The final standard reflects Cal/OSHA's collaborative process with CNA members, employer representatives, content matter experts, and members of other unions.

CNA's experience in California serves as an apt model on the national scale. On Feb. 20, 2014, CNA submitted a petition to California's Occupational Safety and Health Standards Board (OSHSB) calling for a workplace violence prevention standard to protect California RNs and other health care workers from violence in their workplaces. The petition was granted by OSHSB, which noted that "violence directed against health care workers is a serious and on-going problem" and that "no federal OSHA standard or national consensus standard directly addresses workplace violence protection."⁶⁸ The OSHSB authorized an advisory committee, the Workplace Violence Prevention in Healthcare Committee, composed of unions, health care employers, and other stakeholders, to begin developing the standards. The committee held its first meeting on Sept. 10, 2014.

During that same year and in recognition of the serious threat of workplace violence against RNs and other health care workers, then state Senator Alex Padilla (now California's U.S. senator), authored legislation, S.B. 1299,



directing Cal/OSHA to issue a standard with specific, prescribed elements requiring health care employers to establish, implement, and maintain workplace violence prevention plans. We are proud to have sponsored this important legislation on behalf of our California members. This legislation is now law.

The state's Senate Committee on Labor and Industrial Relations noted in the legislative record that health care workers had a high risk of work-related assault with RNs in particular having the highest risk.⁶⁹ Relying on the 2007 National Institute of Occupational and Environmental Health report, the Senate committee recognized that industry prevention efforts were inadequate, stating that the report "found some consistent areas which suggested potential for improved protection and/or improved efficiency."⁷⁰ In its analysis, the state Senate committee highlighted the following problem areas as in clear need of improvement »

- » Surveillance of workplace violence events is uncoordinated and inefficient;
- » Nursing staff within emergency departments were often unsatisfied with their interactions with security personnel;
- » Although all hospitals trained the majority of personnel in emergency and psychiatric units, no hospitals trained all employees regularly stationed in the unit;
- » Employee training programs rarely included review of violence trends within their specific hospital;
- » OSHA logs and employers' reports did not provide detailed information about the circumstances of a violent event, which could limit prevention efforts; and
- » Few hospitals had effective systems to communicate about the presence of violent patients, hospital security equipment systems were uncoordinated and insufficient to protect the unit, and security programs and training were often less complete in psychiatric units than in emergency departments.⁷¹

Additionally, as recognized in the GAO report, Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington all recognize and regulate workplace violence in health care, social services, or both. All nine states' requirements are similar to OSHA's guidelines on effective comprehensive workplace violence prevention plans.⁷² In addition to these states recognized in the GAO report, NNU-affiliate Minnesota Nurses Association recently worked with state legislators to pass a law that requires hospitals to develop and implement comprehensive workplace violence prevention plans. This law took effect Jan. 1, 2016. Since the GAO report was published, additional states have taken action to recognize and regulate workplace violence, including Nevada⁷³ and Illinois.⁷⁴ Several additional states seek to educate employers about the hazard of workplace violence through published guidance. North Carolina, for example, published guidelines explaining that health care, long-term care, and social service workers all face an increased risk of work-related assaults.⁷⁵

THE WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT » ENSURING AN EFFECTIVE OSHA STANDARD TO PREVENT WORKPLACE VIOLENCE

For an OSHA standard to effectively prevent violence from ever happening in the first place in health care and social services settings, there are elements of a workplace violence prevention standard that are essential. The research literature discussed above supports the specific elements of an OSHA workplace violence prevention standard that is detailed in the Workplace Violence Prevention for Health Care and Social Service Workers Act. These key elements of an OSHA standard on violence prevention include unit-specific hazard analysis and correction, active worker involvement, unit-specific documentation, and regular review.

The Workplace Violence Prevention for Health Care and Social Service Workers Act would require OSHA to promulgate a standard on workplace violence prevention for health care and social service employers, setting timelines on promulgation, and establishing minimum content requirements for the standard that aligns with the research literature described above.

Importantly, the Workplace Violence Prevention for Health Care and Social Service Workers Act incorporates a conceptual policy framework that is essential to creating an effective and protective OSHA standard to address this serious occupational hazard. At its core, the bill would create an OSHA standard that is

centered around prevention, focusing on assessing risks for violence and then implementing controls or corrections based on those identified risks.

The OSHA standard would be a performance-based occupational safety and health standard, not a prescriptive one. The Workplace Violence Prevention for Health Care and Social Service Workers Act conceptually demonstrates how a performance-based OSHA standard can be dynamic and decidedly not one-size-fits-all. The interventions and measures adopted by employers under this standard would be tailored to the specific risks in each work site and work area. By including regular worksite and work area assessments, this standard fundamentally appreciates that the risks of violence may be different for different workers and work areas, based upon both the environmental design of a worksite as well as the risks presented from the specific kinds of patients (or visitors) to a unit and the risks presented by particular facets of that work area, such as those associated with a particular unit's level of under-staffing or the risks associated with the availability or training (or lack thereof) of security staff.

Importantly, as a result of the regular review and assessments required by the standard, the protections and hazard controls in a workplace can and should change as different risks are



Table 6. **Challenges in Workplace Violence Prevention and Responses Needed in a Federal OSHA Standard**

Challenge	Response
Fear of retaliation and lack of reporting	<ul style="list-style-type: none"> » Nonretaliation requirements » Require procedures for employees to seek assistance during incident and to report concerns
Duty of patient advocacy	<ul style="list-style-type: none"> » Unit- or work-area specific plans » No blame attached to patients » Identifying risks related to understaffing » Identifying patient-specific risk factors
Patchwork state laws and regulations	Federal OSHA standard as a floor

identified. For example, the standard would require patient-specific risk assessment, which allows for nurses and direct patient care staff to assess how interventions may impact patient care. Or how risk factors for workplace violence are created by broad or structural health care policies, such as long wait times or lack of insurance, which can lead to untreated illness.

Additionally, the Workplace Violence Prevention for Health Care and Social Service Workers Act would create an OSHA standard that effectively recognizes and responds to a series of important challenges to effective workplace violence prevention in health care settings. These challenges — and the corresponding response within the Workplace Violence Prevention for Health Care and Social Service Workers Act — are outlined in Table 6.

TIMELINE FOR PROMULGATION

The Workplace Violence Prevention for Health Care and Social Service Workers Act sets timelines for promulgation of an interim final standard and a final standard. Given OSHA's delay in work on a workplace violence prevention standard, it is necessary for Congress to set such timelines.⁷⁶ Importantly, the bill allows the text of the Act to be enforced as an OSHA standard should OSHA miss the one-year timeline to pass an interim final standard. The bill

also requires OSHA to issue a proposed final standard within two years of enactment and to promulgate a final standard within 42 months of enactment. Additionally, employers would be required to implement workplace violence prevention plans within six months of promulgation of an interim final standard. Quick action is needed to protect registered nurses and other health care workers from the growing epidemic of workplace violence.

SCOPE

The scope of the Workplace Violence Prevention for Health Care and Social Service Workers Act is expansive, including many health care and social service employers where workplace violence is a significant hazard. Importantly, hospitals, clinics, nursing homes, home health care, and other health care employers would be covered. The bill specifies requirements for an OSHA standard, including, importantly, the minimum necessary components for employers' workplace violence prevention plans. Some key provisions in the legislation are outlined here.

That employers obtain the active involvement of employees in creating, implementing, and maintaining the workplace violence prevention plans.

Active worker involvement in every step of creating, implementing, and reviewing a workplace violence prevention plan is a vital element ensuring their effectiveness. Direct care registered nurses and other health care workers have nuanced knowledge and expertise in how workplace violence happens and what prevention measures will be effective. Their involvement is necessary to effectively identifying workplace violence risk factors and hazards as well as to selecting the most effective prevention measures and crafting effective policies and procedures for reporting, communication, and other elements. However, the responsibility to create the workplace violence prevention plan must lie with the employer, which always has the responsibility to provide a workplace free from recognized hazards under the OSH Act.

That employer workplace violence prevention plans must be unit specific.

Workplace violence prevention plans must be tailored to each patient care unit or other work area to be effective. Each patient care unit or other work area within a hospital or other health care facility has different risk factors for workplace violence. Such risk factors depend on a multitude of factors that are often specific to the unit at that particular hospital. For example, an intensive care unit at hospital A may have different risk factors than an intensive care unit at hospital B based on physical infrastructure differences, patient population differences, policy and procedure differences, staffing differences, and other factors. Each covered employer's workplace violence prevention plan must be specific to each unit or work area.

That employers must conduct risk assessments, including assessments of environmental risk factors and patient-specific risk factors, for each unit or work area, with direct care employee involvement.

Risk assessments are important elements of workplace violence prevention plans. Employers must identify all risk factors for

workplace violence and workplace violence hazards to effectively implement control and prevention measures. Such risk assessments must evaluate both environmental risk factors and patient-specific risk factors. Environmental risk factors include when employees are working in isolated or remote locations, where assailants could prevent entry into the work area by responders or other employees, poor illumination or blocked visibility, lack of physical barriers, lack of effective escape routes, obstacles and impediments to accessing alarm systems, locations where alarm systems are not operational, entryways where unauthorized access may occur, presence of furnishings or any objects that can be used as weapons, and storage of high-value items, currency, or pharmaceuticals.

That employers must implement prevention measures, engineering controls, and work practice controls to correct workplace violence hazards.

Under the OSH Act, employers are responsible for providing a workplace free from recognized hazards. This includes the significant hazards posed by workplace violence in health care facilities. It is an important requirement in this section that employers implement prevention measures according to the hierarchy of controls. In our members' experience, employers often rely exclusively on training and worker behavior when responding to workplace violence. When these are the only measures an employer implements, it effectively shifts the burden of prevention onto employees. While training is an important element of workplace violence prevention, engineering and work practice or administrative controls should be prioritized according to the hierarchy of controls.

The published literature, as described above, has a wealth of evidence supporting the myriad measures that employers can implement to prevent or control workplace violence. Additionally, a 2002 study of workplace fatalities from workplace violence over a period of years in North Carolina found that certain environmental interventions were statistically significantly associated with a lower risk of worker homicide. Workplaces with bright exterior lighting had half the odds for worker

homicide than without bright exterior lighting; workplaces with staffing that prevented workers from being alone at night had less than half the odds for worker homicide than without these staffing levels; workplaces with alarms had half the odds for worker homicide than without alarms; and workplaces with combinations of five or more administrative controls very significantly reduced the odds for worker homicide to 0.1 compared to the odds without administrative controls.

That employers must implement incident response and post-incident investigation procedures.

Clear response and post-incident follow-up plans are also an important part of an effective workplace violence prevention plan. The Workplace Violence Prevention for Health Care and Social Service Workers Act includes many of the important elements of effective response and post-incident investigation, including the requirement to investigate workplace violent incidents and to seek involved employees' opinions on what could have prevented the incident from occurring. After a workplace violence incident occurs, employers should provide immediate medical care or first aid and information about available trauma and related counseling to employees affected by a workplace violence incident. These requirements are included in the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Additionally, the Workplace Violence Prevention for Health Care and Social Service Workers Act would require a post-incident investigation and debriefing to be conducted after a workplace violence incident. Such investigations and debriefings must include employees and their representatives. Such requirements, importantly, recognize that the employees directly involved in incidents of workplace violence can provide valuable insight on how to prevent or mitigate similar incidents of violence in the future. Post-incident investigations should also identify the cause(s) of the incident and what measures could have been taken to prevent the injury. Any additional measures that would prevent a similar incident from occurring in the future should be identified and implemented.

Inclusion of a requirement for employers to develop preparedness plans for workplace violence emergencies, including active shooter events, is increasingly important. One study examined media reports of hospital-based shootings between 2000 and 2015.⁷⁷ The authors found that the number of hospital-based shootings per year has been increasing for approximately the past decade. The Workplace Violence Prevention for Health Care and Social Service Workers Act importantly includes such a requirement.

That employers develop communication and reporting procedures.

Communicating information regarding increased risks for workplace violence between employees and between shifts and units is critical in hazard identification and assessment. It is important that the Workplace Violence Prevention for Health Care and Social Service Workers Act includes a requirement that employers establish effective communication procedures in their workplace violence prevention plans. These communications procedures are vital to the effectiveness of a workplace violence prevention plan. NNU members have raised concerns in the health and safety classes that they find out about an ongoing incident with the potential to affect the entire facility only long after the fact informally from their coworkers. Communication procedures enable nurses and other health care workers to be aware of increased risk for violence, contribute to the ongoing assessment of workplace violence risks, and to implement the employer's preventive measures and other parts of the workplace violence prevention plan.

That employers must provide training.

Training is a necessary element of an effective workplace violence prevention plan but training by itself is not enough to provide the highest level of protection for employees against workplace violence. Under a federal standard on workplace violence prevention, OSHA should require that employees receive in-person and hands-on training so that they are educated regarding the workplace violence hazards that they face in the course of doing their jobs, the prevention measures implemented by their employer, and the policies, procedures, and

communication methods established by their employer on workplace violence.

Because training is an important aspect of safety and health programs, it should always be provided to employees on paid time. Additionally, health care employers often assign online training modules to RNs to complete during a shift while they also have full patient assignments. During NNU's focus group-style discussions, RNs reported that online formats are not effective at conveying information about workplace violence plans and risks of workplace violence. The Workplace Violence Prevention for Health Care and Social Service Workers Act includes these important requirements, including that training is required to be provided in-person and that live video training may be used only for annual refresher training where "in-person training is impracticable."

That employers must create and maintain violent incident logs, making these logs available to employees and their representatives on request, and report related information electronically to OSHA.

The Workplace Violence Prevention for Health Care and Social Service Workers Act importantly includes provisions that would require covered employers to create violent incident logs and to record information about every workplace violence incident that occurs in the facility. Such a requirement is important to capture information necessary for effective hazard assessment and plan evaluation. Existing forms and recordkeeping — like workers' compensation forms, OSHA 301 forms, and 300 Logs — are insufficient to capture the information necessary. An effective workplace violence prevention program or plan is dependent upon accurate reporting of incidents.

Accurate recordkeeping of all incidents in the Violent Incident Log is critical to the development of a comprehensive workplace violence prevention plan. There are several components to these recordkeeping requirements. First, because blame is not attached to a patient, recordkeeping provides the data and opportunity to evaluate unintentional acts in the aggregate and can help in identifying ways to reduce the frequency of these incidents. Additionally, information about patient specific

risk factors is collected in Violent Incident Logs, which is to adopt safety measures and to address any medical conditions or disease process that may increase patient confusion, disorientation, aggression, or other patient behavior that may lead to acts of violence.

The Workplace Violence Prevention for Health Care and Social Service Workers Act would also require that OSHA create an online reporting system for employers to report certain information about workplace violence rates and severity in their facilities. This would be useful information for OSHA to have that could drive more effective enforcement activities.

That employers must at least annually review and update the workplace violence prevention plan.

The Workplace Violence Prevention for Health Care and Social Service Workers Act includes provisions that would require employers to review the effectiveness of their workplace violence prevention plans with the active participation of employees and their representatives and make updates to the plan based on these reviews. Such a review is important to maintaining an effective workplace violence prevention plan and provides a consistent and regular point of input for employees and their representatives to provide feedback on the workplace violence prevention plan. However, the annual evaluation should be unit specific.

That employers are prohibited from retaliating against an employee for making a report, concern, or seeking assistance for a workplace violence incident.

Anti-retaliation provisions are important to ensuring that employees can report workplace violence incidents and concerns about workplace violence effectively to their employers. It is also important that employees' right to report workplace violence incidents to local law enforcement or to seek assistance from local law enforcement during a workplace violence incident is protected.

TIMELINE OF NNU'S WORK TO WIN A FEDERAL OSHA STANDARD

1995	Cal/OSHA, releases "Cal/OSHA Guidelines for Workplace Security." ⁷⁸
1996	Federal OSHA issues voluntary guidelines, "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers."
2004	Federal OSHA updates their voluntary guidelines.
2013	<p>California Nurses Association sponsors SB 718 (Senator Yee) to require Cal/OSHA to develop a workplace violence prevention standard for hospitals and other health care employers.⁷⁹</p> <p>U.S. Representatives George Miller and Robert Scott submit a letter to the Government Accountability Office to request an investigation into federal OSHA's activities on workplace violence in health care and social service settings.⁸⁰</p>
2014	<p>California Nurses Association sponsors SB 1299 (Padilla) in the California legislature, which required Cal/OSHA to develop a workplace violence prevention standard for hospitals and other health care employers and set minimum requirements for such a standard. It passes and is signed by Governor Jerry Brown.</p> <p>California Nurses Association petitions the California Occupational Safety and Health Standards Board to promulgate a standard on workplace violence prevention in hospitals and other health care facilities. The petition is granted.⁸¹</p>
2015	Federal OSHA updates their "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" for a second time. ⁸²
2016	<p>The U.S. Government Accountability Office releases their report on federal OSHA's enforcement activities on workplace violence, "Workplace Health and Safety: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence."⁸³</p> <p>National Nurses United submits a petition to federal OSHA to promulgate a workplace violence prevention standard for hospitals and other health care employers, based upon the comprehensive Cal/OSHA standard.⁸⁴</p> <p>The California Occupational Safety and Health Standards Board unanimously approves the proposed Cal/OSHA Workplace Violence Prevention in Health Care Standard.⁸⁵</p>
2017	Assistant Secretary of Labor David Michaels grants NNU's petition for a federal OSHA standard on workplace violence prevention in health care. ⁸⁶
2018	<p>U.S. Representative Ro Khanna introduced the Health Care Workplace Violence Prevention Act, H.R. 5223.⁸⁷</p> <p>Cal/OSHA's Workplace Violence Prevention in Health Care Standard goes fully into effect.⁸⁸</p> <p>U.S. Representative Joe Courtney introduced the Workplace Violence Prevention for Health Care and Social Service Workers Act, H.R. 7141.⁸⁹</p>
2019	<p>U.S. Representative Joe Courtney introduced H.R. 1309 on Feb. 19, 2019.⁹⁰</p> <p>H.R. 1309 passed the House of Representatives with 251 votes in favor, including 32 Republican votes in favor of passing the bill.</p>

HOW CAN YOU GET INVOLVED IN THE CAMPAIGN TO PASS AND WIN A FEDERAL WORKPLACE VIOLENCE PREVENTION STANDARD?

SHARE YOUR STORY

Nurses and health care workers, one of the most impactful ways you can get involved in the campaign to pass the Workplace Violence Prevention for Health Care and Social Service Workers Act and win a federal workplace violence prevention standard is to share your experiences of workplace violence. Legislators and policy makers need to understand the issue and how it impacts you and your patients. When nurses and other health care workers speak, they listen.

Share your story »

<http://bit.ly/NNU-WPV-Survey>

NURSES, HEALTH CARE WORKERS AND COMMUNITY ALLIES » JOIN THE NURSE ADVOCACY NETWORK!

The Nurse Advocacy Network is National Nurses United's network of health care workers and community allies who are ready to spring into action and fight to ensure that our elected officials and health care employers adequately protect nurses and other frontline health care workers — during the Covid-19 pandemic and beyond. As we work to hold our elected officials and decision-makers accountable, it is our ability to come together and act that gives us the power to win the protections that nurses other health care workers, and their patients need!

Sign up for the Nurse Advocacy Network »

<https://bit.ly/joinNAN>



APPENDICES »

NNU'S WORKPLACE VIOLENCE SURVEY DATA

In surveys on nurses' experiences of workplace violence conducted by NNU between 2017 and 2019, the sample of 402 nurses provided responses to questions on the impact of workplace violence they experienced within the past year.

Appendix A. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »** **Types of Workplace Violence**

Violence experienced in past year	Nurses reporting
Objects thrown at you	24.9%
Pinched or scratched	35.8%
Slapped, punched, or kicked	26.6%
Spat on or exposed to other bodily fluids	20.6%
Verbally threatened	62.4%
Physically threatened	20.6%
Groped or touched inappropriate	12.7%
Verbally harassed based on your sex or appearance	27.6%
I have not experienced workplace violence	16.7%

Appendix B. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »
Employers' Response to Workplace Violence Incidents**

Employer response to workplace violence	Nurses reporting	
Investigates what happened	Yes	60.0%
	I don't know	19.7%
	No	20.3%
Provides access to counseling	Yes	28.1%
	I don't know	42.0%
	No	29.9%
Trains or retrains employees	Yes	35.1%
	I don't know	36.7%
	No	28.2%
Changes practices to reduce the risk of violence	Yes	30.5%
	I don't know	41.2%
	No	28.3%
Discourages employees from reporting incidents	Yes	12.7%
	I don't know	53.7%
	No	33.6%
Reprimands or blames employees	Yes	29.7%
	I don't know	44.9%
	No	25.3%
Ignores it	Yes	33.8%
	I don't know	40.5%
	No	25.7%

Appendix C. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »**
Impacts of Workplace Violence

Impacts of workplace violence	Nurses reporting
Physical injury or other physical symptoms (e.g., headaches, stomach aches, etc.)	18.9%
Took time off work	17.4%
Anxiety, fear, or increased vigilance	54.5%
Difficulty working in environment that reminds me of past incident	19.9%
Applied for workers' compensation	4.0%
Changed or left job	11.7%
Physical injury prevents me from working	3.0%
Psychological effects prevent me from working	7.7%
No injury/no effect	31.3%

Appendix D. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »
Employers' Prevention Measures**

Employer prevention measures	Nurses reporting
Provides training on workplace violence	55.0%
Uses a charting or room-flagging system to indicate patients with increased risk for violence	22.6%
Provides a clear way to report incidents	35.8%
Has security guards available at all times to respond to violent incidents	44.5%
Uses metal detectors	5.5%
Uses security cameras	28.4%
Limits visiting hours	14.2%
Includes nurses and other employees in violence risk assessments	16.2%
I'm not sure	13.7%

Appendix E. **NNU Survey of Nurses' Experience of Workplace Violence, 2017 – 2019 »
Type of Health Care Facility Respondent Works In**

Type of health care facility respondent works in	Nurses reporting
Hospital	81.8%
Home care/hospice	0.5%
Skilled nursing facility/long-term care	2.5%
Outpatient clinic	8.0%
Medical offices	1.2%
Retired	0.7%
Currently not employed as a nurse	1.5%

ENDNOTES

- 1 One study of nurses in Minnesota reported that 97 percent of the physical violence experienced by nurses was perpetrated by patients and for about 90 percent of those patients the violent behavior was related to the patient's disease or illness. In 18 to 22 percent of patients, impairment was related to prescribed medication.
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