National Nurses United ("NNU") submits this testimony in support of legislation mandating that the Occupational Safety and Health Administration’s ("OSHA") of U.S. Department of Labor issue a comprehensive occupational safety and health standard on workplace violence prevention in health care and social service settings. NNU, representing over 155,000 members across the country, is the largest union and professional association representing registered nurses ("RNs") in the United States. With members who work as bedside professionals in every state in the nation, NNU understands that workplace violence has become endemic for RNs and other workers in healthcare and social service settings.

The risk of workplace violence is a serious occupational hazard for RNs and other healthcare workers. Countless acts of assault, battery, and aggression that routinely take place in healthcare settings demonstrate a frightening trend of increasing violence faced by healthcare workers throughout the country. In addition to innumerable anecdotal and media accounts, several national surveys document the prevalence of violence committed against healthcare workers. We have included data on the incidence of violence, rates of injuries, and data and descriptions of the impact on nurses and other healthcare workers in Attachments 1 and 2.

As a persistent and endemic workplace hazard for our members, NNU has advocated for occupational health and safety standards to prevent violence in healthcare settings. Our efforts have resulted in the establishment of some of the best state-level standards on preventing and reducing violence in the workplace for our members. Where state-level standards have not been established, we have won strong protections for our members through collective bargaining. But despite these strides, protections for RNs and other healthcare workers across the country will remain piecemeal in light of federal OSHA's exclusive jurisdiction in 24 states. A federal OSHA standard on preventing workplace violence in healthcare is necessary to protect healthcare workers. We describe these reasons in more detail in Attachment 3.

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. (29 U.S.C. § 651) From the available data and from our members’ experiences, it is clear that OSHA is not upholding its duty, assigned by Congress, to protect healthcare workers from workplace violence. OSHA needs to pass a formal workplace violence prevention standard and implement a strong enforcement campaign to effectively protect healthcare workers from workplace violence. Despite
granting NNU’s petition for a workplace violence prevention standard in January of 2017, OSHA’s work on such a standard has stalled.¹

A bill introduced last week and referred to this Committee, The Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309), would mandate that OSHA promulgate an interim final standard on workplace violence prevention for healthcare employers within one year and a final standard within 42 months. Importantly, this bill would also set the minimum requirements for the OSHA standard, based on proven standards that have been implemented in California and on the published literature. We have described the contents of the bill and why they are important, including a description of the supporting published literature, in Attachment 4.

HEALTHCARE WORKERS REPORT A WIDE RANGE OF EXPERIENCES AND IMPACTS OF WORKPLACE VIOLENCE.

PHYSICAL FORCE AND INJURIES: The effects of workplace violence span a wide range of types and severity for RNs and other healthcare workers. 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. These injuries may result in days away from work. A 2004 study found that, about 20% of respondents who experienced physical violence responded that they self-treated injuries.²

THREATS OF VIOLENCE: Threats of physical force and threats of 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 RNs and other healthcare workers report serious and lasting effects, including stress, anxiety, difficulty working, post-traumatic stress symptoms and disorders. These non-physical injuries harm RNs’ health and may lead RNs to leave their jobs, implicating workplace violence in the high rates of turnover.³

¹ OSHA moved the workplace violence standard to the long-term action list in the Spring 2017 Unified Agenda of Regulatory and Deregulatory Actions. Although it has since been moved to the action list, OSHA takes an average of seven years to complete new standards according to the Government Accountability Office’s 2012 report.


³ Nurses who experience workplace violence are more likely to leave their jobs. Mazurenko et al. Analyzing U.S. nurse turnover: Are nurses leaving their jobs or the profession itself? J. Hospital Admin, Vol. 4 (4), 2015.
TRAUMA AND STRESS: One study of trauma and stress symptoms in emergency nurses was published in 2011. Using the Impact of Event Scale-Revised, researchers found that 94% indicated the presence of at least one stress symptom after a violent event, 25% indicated symptoms that posed clinical concern, and 15% indicated symptoms high enough to suppress the immune system. The researchers also found that 37% 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.

NNU SURVEY OF REGISTERED NURSES: In surveys on nurses’ experiences of workplace violence conducted by NNU during health and safety classes, the sample of 286 RNs provided responses to questions on the impact of workplace violence they experienced within the past year. These NNU survey results on the impact of workplace violence on RNs are included below in Table 1. Fifty-four percent of respondents reported that they experienced anxiety, fear, or increased vigilance due to a workplace violence incident in the previous year. Nearly 20% of the respondents reported taking time off from work to recover from workplace violence, and nearly 10% reported changing jobs or leaving their job due to workplace violence.

TABLE 1: NNU Survey on Workplace Violence – Impact of Workplace Violence on Nurses.

<table>
<thead>
<tr>
<th>How has workplace violence impacted you and your work?</th>
<th>Percent of respondents who experienced these effects from workplace violence in the past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical injury or other physical symptoms (e.g., headache, stomach aches, etc.)</td>
<td>16.8%</td>
</tr>
<tr>
<td>Took time off work</td>
<td>18.2%</td>
</tr>
<tr>
<td>Anxiety, fear, or increased vigilance</td>
<td>54.2%</td>
</tr>
<tr>
<td>Difficulty working in environment that reminds me of past incident</td>
<td>18.2%</td>
</tr>
<tr>
<td>Applied for workers’ compensation</td>
<td>4.9%</td>
</tr>
<tr>
<td>Changed or left job</td>
<td>9.1%</td>
</tr>
<tr>
<td>Physical injury prevents me from working</td>
<td>3.5%</td>
</tr>
<tr>
<td>Psychological effects prevent me from working</td>
<td>9.8%</td>
</tr>
<tr>
<td>No injury/no effect or did not experience violence</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

STORIES OF WORKPLACE VIOLENCE FROM DIRECT CARE REGISTERED NURSES.

Congress should consider descriptive information about worker’s experiences with workplace violence in evaluation of how to effectively protect health care and social service workers from workplace violence. Descriptive information played an important role in the development of the landmark California Division of Occupational Safety and Health Standard on Workplace Violence Prevention in Health Care that went into full effect just

---

In particular, descriptive information can inform the Committee on the 
quotidian experiences of nurses’ and other healthcare workers’ with workplace violence.

During NNU health and safety classes held between February and March 2017, we captured 
this type of 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. The full list of descriptive examples of workplace violence that NNU collected during 
hazard mapping activities is included in Attachment 1.

Included here are brief descriptions of workplace violence incidents experienced by NNU members.

- 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, especially given the risk factors associated with the specific 
population that they work with. 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 woke up before she died. Palomata’s 
murder was preventable, if her employer had responded to nurses’ reports of risk 
factors for workplace violence and the necessary prevention measures.

- Allysha Shin, RN in Southern California: Shin is a nurse on a neuroscience unit in a large 
acute care hospital. She was carefully monitoring a patient who had had a hemorrhagic 
stroke. This patient had a history of violence and had been verbally abusive to Shin the 
previous night. She started her shift with a sitter, who was assigned to help closely 
monitor this patient. After two hours, the sitter was called away to attend to another 
patient. Later, the patient grew agitated, kicked Shin in the face, and broke free of her 
restraints. Shin yelled for help. It required six other staff members to assist Shin in 
getting the patient back to bed and in her restraints, during which the patient kicked 
Shin several more times. Shin had to take the next two shifts off work to recover. She 
reports that she still suffers from anxiety.¹⁶

- Elizabeth Dehaemers, Kansas City, Missouri- Dehaemers is an RN in a progressive unit 
at an acute care hospital. She has experienced several workplace violence incidents 
over the course of her career as a nurse. She has been hit by patients who are

---

February 23, 2019).

¹⁶ Allysha Shin’s experience was reported on by Modern Healthcare on March 13, 2017. That article is 
disoriented. When she reports such incidents to management, she is often told that it is “just part of the job.” In one particular experience, Dehaemers was punched in the face by a patient in front of four other nurses. Nothing was done; there was no follow up. A few weeks after the incident, she was reassigned to care for the same patient with no additional safety measures or supports, despite having been previously assaulted by the patient. Dehaemers reports fear and anxiety upon returning to work.

Thank you to members of the Subcommittee for holding a hearing on this serious occupational hazard. We will remain diligent in our efforts to obtain the most protective health and safety standard for our members, and we look forward to our continued work with Congress to pass H.R. 1309 and to win the most protective occupational safety and health standard for NNU’s members as well as all direct care registered nurses, health care workers, and social service workers in the country.

**ATTACHMENTS**

1. NNU Fact Sheet: NNU “Hazard Mapping” Descriptive Data (By Hospital Unit)
2. NNU Fact Sheet: Alarmingly High Rates of Violence Among Healthcare Workers.
ATTACHMENT 1: NNU “Hazard Mapping” Descriptive Data (By Hospital Unit).

NNU surveyed 286 members in Sacramento, San Francisco, and Chicago during health and safety trainings that focused on workplace violence and safe patient handling and were led by an NNU staff industrial hygienist. Focus group-style discussions and “hazard mapping” on workplace violence were also conducted at these trainings. Trainings were held between February and March 2017. Findings and results from the NNU survey and discussions have been compiled by the NNU staff industrial hygienist.

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 closed head trauma.
- Patient admitted via EMS in the ER for over 12 hours with a firearm.
- Patient angry about the wait times and threatened me that she was going to come back and hurt me in triage.
- 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.
- Family threatened the nurse after the patient had to be intubated and sent to the Operating Room.
- Suicidal psychiatric patient found a pair of large scissors for splint cutting. She held staff at bay until the deputies arrived, threatening to harm the staff and other patients.
- 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 (In-Patient):**
• 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.
• Nurse was hit by a patient in her ear that caused her ear to bleed. The nurse quit her job and did not return to work. Psychiatric patient on the med/surg floor without specialty training for staff.
• 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.
• I was taking care of a combative patient who had wrist restraints on. I turned my back and was kicked hard in the back. I made sure from then on I was far away before I turned around.
• A patient pushed me and said I stole his money.
• 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 food at nurse’s feet.
• Patient threw a can of soup at me, resulting in a black eye.
• Patient threw phone, IV pole, and chairs at staff from inside the room.
• Confused patient spitting at and punching nurses.
• Patient’s wife grabbed a nurse by her face.
• A patient threw hot coffee at a nurse’s chest. The nurse suffered first and second degree burns and left work.
• 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 had filled a few urinals and wanted to throw at staff if he didn’t receive the care that he wanted.
• 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 (In-Patient):**

• Patient was going through alcohol withdrawal, punched nurse when she was placing restraints.
• 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.

A patient’s family member physically bumped into me on purpose.

I was kicked by a patient who was coming out of anesthesia.

A patient was dying from a gunshot wound. The patient’s family member would not leave the room and kept insisting that the staff save the patient or he wouldn’t leave.

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.

Nurse struck on the nose by a patient. She required surgery to recover.

Confused patient punched me.

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.

Patient on a ventilator attempted to kick me in the head.

Patient admitted for alcohol withdrawal and drug use. Unprovoked, got out of bed after pulling out IV and catheter, left the unit, entered the elevator, and threatened to hit staff when approached.

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 became agitated while sitting on a chair. He grabbed a plastic knife from his dinner tray and was going to attack a nurse with the plastic knife.

Patient’s husband threatened to burn down the hospital if the patient died.

Confused patient tried to kick me in the head when I was emptying the catheter. Patient had wrist restraints on but legs had not been an issue prior to this.

Psychiatric Units (In-Patient):

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.

Nurse was hit and assaulted.
• Patient requested a banana and then threw it at the nurse.
• 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 handle bar from a 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 too soon.
• 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.

Parking Areas:

• A person committed 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.”

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 fifteen 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.
ATTACHMENT 2: Alarmingly High Rates of Violence Among Healthcare Workers.

AVAILABLE DATA ON WORKPLACE VIOLENCE RATES IN HEALTHCARE

As published in recent literature, the incidence of workplace violence and threats of workplace violence for healthcare workers is alarmingly high.

- A 2004 article reporting on a survey of almost 5,000 nurses licensed in Minnesota found that 12% of RNs reported experiencing physical assault at work annually and that 38.5% of RNs experienced non-physical assault—including threats, sexual harassment, and verbal abuse—at work annually. The vast majority of physical violence was from patients or clients—96.8% of physical violence related to a specific event and 90.7% of physical violence related to an ongoing event.

- A 2011 article reporting on a survey of over 900 nurses working in nursing homes found that 48% of respondents reported being physically assaulted at least once in the prior three months by a resident or resident’s visitor. Twenty-six percent of respondents reported being assaulted one or two times while 22% 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. The authors reported a rate of 18.87 workplace violence incidents per 100 full-time employees for nursing staff.

- A 2015 article on survey hospital workers on workplace violence reporting found that 62% of respondents had been the target of violence in the past year but that 88% of respondents had experienced a violent incident that they had not reported to their employer in the previous year.

- A 2016 article reported on a survey of healthcare workers about their experiences of workplace violence and reporting practices. The authors reported that 39% of respondents reported having experienced an incident of workplace violence from a patient or a person accompanying a patient (“Type II” workplace violence).

---

7 Gerberich (2004) at pp. 495-503. The annual incidence rate of physical assaults was 12.0 per 100 persons, 95% confidence interval (CI) 12.2 to 14.3. The annual incidence of non-physical assaults was 38.5 per 100 persons, 95% CI 36.7 to 40.3.
• A 2018 article studied occupational injuries and related factors among newly licensed registered nurses (nurses who were licensed between 1 year and 2.5 years prior to the survey date) working in hospitals in Florida. The authors report that 25% of newly licensed registered nurses reported having experienced physical violence at least once.

**NNU SURVEY OF REGISTERED NURSES ON WORKPLACE VIOLENCE**

NNU conducted a survey on nurses’ experiences of workplace violence during health and safety classes held between February and March 2017. The sample of 286 RNs from three cities—Chicago, IL, Sacramento, CA, and San Francisco, CA—reported the types of violence that they experienced within the past year at work. Results from the questions on RN experience with workplace violence are included below in Table 2.

**TABLE 2: NNU Survey on Workplace Violence – Experience Rates by RNs in the Past Year.**

<table>
<thead>
<tr>
<th>What types of workplace violence have you experienced in the past year?</th>
<th>Percent of respondents who experienced this type of violence in the past year at work.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objects thrown at you</td>
<td>24.5%</td>
</tr>
<tr>
<td>Pinched or scratched</td>
<td>34.6%</td>
</tr>
<tr>
<td>Slapped, punched, or kicked</td>
<td>26.2%</td>
</tr>
<tr>
<td>Spat on or exposed to other bodily fluids</td>
<td>18.9%</td>
</tr>
<tr>
<td>Verbally threatened</td>
<td>62.9%</td>
</tr>
<tr>
<td>Physically threatened</td>
<td>21.0%</td>
</tr>
<tr>
<td>Groped or touched inappropriately</td>
<td>11.9%</td>
</tr>
<tr>
<td>Verbally harassed based on your sex or appearance</td>
<td>30.1%</td>
</tr>
<tr>
<td>I have not experienced workplace violence</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

**AVAILABLE DATA ON WORKPLACE VIOLENCE-RELATED INJURY RATES IN HEALTHCARE**

The U.S. Bureau of Labor Statistics (“BLS”) conducts annually the Survey of Occupational Injuries and Illnesses and reports data on non-fatal work-related injuries on their website. According to the BLS, in 2017, RNs in private industry in the U.S. experienced a rate of 13.6 violence-related injuries per 10,000 full-time employees. The injury rate for RNs is more than three times higher than the violence-related injuries for workers overall in the same year.

The rate of violence-related injuries for private hospitals in the U.S. was 17.2 per 10,000 full-time employees. This is more than four times higher than the violence-related injury rate for workers overall in the U.S. in 2017 was 4.0 per 10,000 full-time employees.

---


14 The violence-related injury rate for workers overall in the U.S. in 2017 was 4.0 per 10,000 full-time employees.
rate for workers overall in the same year. State-run, public hospitals and nursing and residential care facilities have astonishingly higher rates of 145.9 and 222.4 per 10,000 full-time employees, respectively.

Data 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 healthcare workers was statistically greater than all workers combined.\(^\text{15}\)

Between January 1, 2012 and September 30, 2014, a total of 112 U.S. healthcare facilities reported 10,680 OSHA-recordable injuries from workplace violence.\(^\text{16}\) Registered nurses and nurse assistants had the highest injury rates of all occupations examined.\(^\text{17}\) 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\% of all reports examined in this study specified the type of assault that led to the injury. Of these, 99\% were physical assaults. The workplace violence injuries recorded were clustered in locations where direct patient care is provided in healthcare facilities.\(^\text{18}\)

While the most recently available data indicates that rates of workplace violence are high for healthcare workers, it is also important to recognize that the problem is increasing. The healthcare industry has grown rapidly over the past ten years and, according to the BLS projections, will continue to grow over the next ten years.\(^\text{19}\) Not only are there more affected workers, rates of workplace violence injuries have also increased in recent years. Between 2011 and 2013, rates increased about 12\%.\(^\text{20}\) With these rapidly increasing rates and employment, more and more workers will be harmed and killed unless protections are created.

**UNDERREPORTING OF WORKPLACE VIOLENCE**


\(^\text{16}\) OSHA-recordable injuries are defined as work-related injuries and illnesses that result in at least one of the following: death, loss of consciousness, days away from work, restricted work activity or job transfer, medical treatment beyond first aid, or a diagnosis by a physician or other licensed health care professional. See 29 C.F.R. §1904, et seq.; see also Occupational Safety & Health Administration. U.S. Department of Labor. “OSHA Recordkeeping and Reporting Requirements,” available at [https://www.osha.gov/recordkeeping/](https://www.osha.gov/recordkeeping/) (Accessed February 21, 2019).


\(^\text{18}\) Id.


All incidents of violence must be reported for the prevention plan to be fully effective, but employees need training on why reporting is important and how to report without fear of reprisal for themselves or their patients. Many sources of data on workplace violence and related injuries underreport its prevalence. This is, in part, due to the mistaken understanding in healthcare that workplace violence is part of the job. Oftentimes, hospital supervisors and managers perpetuate this dangerous view of workplace violence, reifying the idea that reporting incidents is futile.

In focus group-style discussions, NNU members have reported that supervisors and managers respond to reports of workplace violence with comments or actions that communicate to workers that it 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. RNs also describe in discussions on workplace violence that they are 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 clear communication procedures to effective workplace violence prevention plans and of protections, like non-retaliation policies, for reporting incidents and concerns about risks of violence.

Some researchers have attempted to measure the level and scope of underreporting. A study of one hospital system in the United States led by Judith Arnetz, the results of which were published in 2015 in Workplace Health and Safety, examined the difference between self-reported workplace violence incidents and those reported in the hospital system’s electronic reporting database. 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% of respondents had not documented in their employer’s electronic system an incident of violence they had experienced in the previous year.

---

21 See Attachment 1 (summarizing observations from NNU focus-group style discussions on workplace violence).
22 Arnetz et al. (2015).

THE IMPORTANCE OF AN OSHA STANDARD

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

Through the Occupational Safety and Health Act (“OSH Act”), Congress mandated prioritization of the safety of workers and the prevention of occupational injury and created an obligation by employers to provide a workplace free from recognized hazards, including workplace violence in healthcare 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.\(^\text{23}\) 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.”\(^\text{24}\) 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 OSHA standard on workplace violence in healthcare would fulfill the Agency’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 healthcare 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.\(^\text{25}\) Through the creation of specific requirements for employers’ workplace violence prevention plans, a formal standard would fortify OSHA’s ability to

\(^{23}\) Control of Hazardous Energy Sources (Lockout/Tagout), 58 Fed. Reg. 16612-02, 16614-15, at fn. 109 (Final Rule, supplementation statement of reasons, Mar. 30, 1993) (codified at 29 C.F.R. §1910) (“In setting safety standards, OSHA must act consistently with the Act’s overriding purposes, which is to provide a high degree of employee protection.”).


enforce this obligation to protect healthcare employees from workplace violence through improved measures in evaluating and citing violations.

**OSHA’s Current Efforts Are Inadequate**

Forty-five years of ineffective voluntary measures requires the immediate attention of Congress to 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 the General Duty Clause and has taken some action to see that it is enforced. Accordingly, the agency has performed inspections and issued citations under the 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 healthcare settings.

However, the 2016 GAO report on workplace violence in healthcare examined OSHA’s enforcement record on workplace violence under the General Duty Clause and found it wanting. The GAO analysis found that approximately 65% of the inspections of healthcare 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 ten OSHA regions conducted 60% of all the inspections performed. Moreover, only 5% of the inspections conducted in healthcare facilities between 1991 and early 2015 resulted in a General Duty Clause citation.

It is clear that enforcement efforts have not been coordinated or 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.

On June 25, 2015, following the release of the GAO report, OSHA issued a memorandum to establish guidance for inspections conducted in inpatient healthcare settings, North
American Industry Classification System ("NAICS") Major Groups 622 (hospitals) and 623 (nursing and residential care facilities). 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 healthcare workers from violence in the workplace.

**OSHA’S CURRENT VOLUNTARY GUIDELINES ARE INSUFFICIENT**

In the area of workplace violence in healthcare settings, OSHA first issued voluntary guidelines in 1996, which were updated in 2004 and again last year. These guidelines provide recommendations for employers on how to assess and evaluate workplace violence hazards and on control measures that may be implemented to reduce or eliminate these hazards, but 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 healthcare employers comply even with mandated standards and laws.

Employers have not followed OSHA’s non-mandatory suggestions or guidelines where there are no associated penalties or consequences. One study found that more than 80% of U.S. employers report no change in their workplace violence prevention programming after a significant violent event, even though 35% cite negative effects such as increased absenteeism and reduced productivity. OSHA should recognize that voluntary guidelines have not and will not ensure that healthcare workers are protected from workplace violence.

The failure of voluntary guidelines and the recognition of the necessity for developing standards are 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, 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.” Glaringly missing from ANSI’s process of creating national standards are any workers directly affected by workplace violence in the healthcare industry and their

---


32 See 29 C.F.R. § 1910.2(g).

unions. The lack of worker representation and participation in ANSI is juxtaposed to the unabashed presence of representatives of healthcare employers, universities, 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 healthcare 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 healthcare 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 37% of the RN respondents to NNU’s survey on workplace violence, which is described in more detail above, reported that their employer has a clear way to report workplace violence incidents. And while the majority of RN respondents reported that their employers provide some level of training on workplace violence, many respondents also noted on the paper 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. NNU survey results are included below in Table 3.

**TABLE 3: NNU Survey on Workplace Violence Results – Employers’ Prevention Measures.**

<table>
<thead>
<tr>
<th>What does your employer currently do to prevent workplace violence? (Select all that apply.)</th>
<th>Percent of respondents reporting that their employer has implemented this prevention measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides training on workplace violence</td>
<td>57.7%</td>
</tr>
<tr>
<td>Uses a chart or room flagging system to indicate patients with increased risk for violence</td>
<td>22.4%</td>
</tr>
<tr>
<td>Provides a clear way to report incidents</td>
<td>36.7%</td>
</tr>
<tr>
<td>Has security guards available at all times to respond to violent incidents</td>
<td>43.4%</td>
</tr>
<tr>
<td>Uses metal detectors</td>
<td>2.1%</td>
</tr>
<tr>
<td>Uses security cameras</td>
<td>24.1%</td>
</tr>
<tr>
<td>Limits visiting hours</td>
<td>13.6%</td>
</tr>
<tr>
<td>Includes nurses and other employees in violence risk assessments</td>
<td>19.9%</td>
</tr>
<tr>
<td>I’m not sure</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

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. RN involvement in the development of hazard prevention measures is essential to an effective prevention program. But only 20% of respondents to NNU’s survey on workplace violence reported that their employer includes RNs and other healthcare employees in violence risk assessments.

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 install prevention measures as needed to prevent future similar incidents from occurring. In the NNU survey, data results 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 almost 60% reported receiving training on workplace violence. These RNs 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 4.

TABLE 4: NNU Survey on Workplace Violence – Incident Investigation Measures.

<table>
<thead>
<tr>
<th>After a workplace violence incident, my employer generally</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigates what happened</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>63.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>18.1%</td>
</tr>
<tr>
<td>No</td>
<td>18.9%</td>
</tr>
<tr>
<td>Provides access to counseling</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31.3%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>50.4%</td>
</tr>
<tr>
<td>No</td>
<td>18.3%</td>
</tr>
<tr>
<td>Trains or retrains employees</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>39.8%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>41.7%</td>
</tr>
<tr>
<td>No</td>
<td>18.5%</td>
</tr>
<tr>
<td>Changes practices to reduce risk of violence</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>51.6%</td>
</tr>
<tr>
<td>No</td>
<td>18.3%</td>
</tr>
<tr>
<td>Discourages employees from reporting incidents</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13.3%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>68.1%</td>
</tr>
<tr>
<td>No</td>
<td>18.6%</td>
</tr>
<tr>
<td>Reprimands or blames employees</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26.0%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>57.2%</td>
</tr>
<tr>
<td>No</td>
<td>16.7%</td>
</tr>
<tr>
<td>Ignores it</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28.3%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>48.1%</td>
</tr>
<tr>
<td>No</td>
<td>23.5%</td>
</tr>
</tbody>
</table>
INDIVIDUAL STATES HAVE MOVED AHEAD OF OSHA ON PREVENTING WORKPLACE VIOLENCE.

Through the stewardship of NNU and our affiliate, the California Nurses Association (“CNA”), healthcare workers in California are now covered under a comprehensive workplace violence prevention standard promulgated by the California Division of Occupational Safety and Health (“Cal/OSHA”) that we believe will be the best in the nation. California recently 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 healthcare settings is a serious occupational hazard for healthcare workers in California and throughout the nation. Rulemaking was completed in October of 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 February 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 healthcare workers from violence in their workplaces. The petition was granted by OSHSB, which noted that ‘violence directed against healthcare workers is a serious and on-going problem’ and that “no federal OSHA standard or national consensus standard directly addresses workplace violence protection.” The OSHSB authorized an advisory committee, the Workplace Violence Prevention in Healthcare Committee, composed of unions, healthcare employers, and other stakeholders, to begin developing the standards. The committee held its first meeting on September 10, 2014.

During that same year and in recognition of the serious threat of workplace violence against RNs and other healthcare workers, Senator Alex Padilla, now California’s Secretary of State, authored legislation, S.B. 1299, directing Cal/OSHA to issue a standard with specific, prescribed elements requiring healthcare 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 healthcare workers had a high risk of work-related assault with RNs in particular having the highest risk. Relying on the 2007 National Institute of Occupational and Environmental Health report, the Senate committee recognized that industry

36 Hearing on S.B. 1299 Before the California Senate Committee on Labor and Industrial Relations, 2013-2014 Regular Session, pp. 3-4 (April 24, 2014) (Committee analysis and report).
prevention efforts were inadequate, stating that the report “found some consistent areas which suggested potential for improved protection and/or improved efficiency.” In its analysis, the state Senate committee highlighted the following problem areas as in clear need of improvement:

1. Surveillance of workplace violence events is uncoordinated and inefficient;
2. Nursing staff within emergency departments were often unsatisfied with their interactions with security personnel;
3. Although all hospitals trained the majority of personnel in emergency and psychiatric units, no hospitals trained all employees regularly stationed in the unit;
4. Employee training programs rarely included review of violence trends within their specific hospital;
5. OSHA logs and employers’ reports did not provide detailed information about the circumstances of a violent event, which could limit prevention efforts; and
6. 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.

And California is in good company. Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington all recognize and regulate workplace violence in healthcare, social services, or both. All nine states’ requirements are similar to OSHA’s guidelines on effective comprehensive workplace violence prevention plans. 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 January 1, 2016. Several additional states seek to educate employers about the hazard of workplace violence through published guidance. North Carolina, for example, published guidelines explaining that healthcare, long-term care, and social service workers all face an increased risk of work-related assaults.

A state-by-state effort, however, is insufficient to protect all healthcare workers. Twenty-four states are under federal OSHA jurisdiction in addition to the private industry in five additional states. Federal OSHA should act now to promulgate a workplace violence prevention standard so that all US healthcare workers are protected from workplace violence.

---

37 Id. at p. 4.
38 Id.
ATTACHMENT 4:  **H.R. 1309 & Necessary Elements of an OSHA Workplace Violence Prevention Standard.**

H.R. 1309 (Courtney) would require OSHA to promulgate a standard on workplace violence prevention for healthcare and social service employers, setting timelines on promulgation and minimum content requirements for the standard. NNU strongly encourages the Subcommittee to take action on this bill, with one significant amendment.

**Timeline for Promulgation**

This bill 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.\(^{42}\) Importantly, H.R. 1309 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.\(^{43}\) Quick action is needed to protect registered nurses and other healthcare workers from the growing epidemic of workplace violence.

**Scope**

The scope of H.R. 1309 is expansive, including many healthcare and social service employers where workplace violence is a significant hazard. Importantly, hospitals, clinics, nursing homes, home health care, and other healthcare 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 provisions in the H.R. 1309 are outlined here.

**H.R. 1309, Sec. 103 (1)(A)(i)**

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 healthcare 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

\(^{42}\) See H.R. 1309, Sec. 101.

\(^{43}\) See H.R. 1309, Sec. 103 (1).
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.

The published literature supports the importance of direct care employee involvement in crafting workplace violence prevention plans.

- A 2014 study found a 50% decrease in assaults after implementation of a plan created with employees, managers, and administration. The authors noted “This result emphasizes that the effectiveness of workplace violence 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 2017 study of compared hospital units where unit supervisors worked with direct patient care staff to develop workplace violence action plans based on unit-specific data and worksite walkthroughs to others that did not have any interventions. Intervention units reported less than half the violent incident rate of control units at six months.
- 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. The author highlighted that engaging the expertise of direct care healthcare workers was vital to identifying and understanding the sources, patterns, and opportunities for prevention of workplace violence. The plan involved continual assessments of environmental and patient-specific risk factors, implementing environmental and architectural changes, policies and procedures, and staff education. The author reported a statistically significant reduction in workplace violence incidents post-implementation (p<0.001) and a significant decrease in use of restraints and seclusion measures for patients who became aggressive or violent.

**H.R. 1309, Sec. 103 (1)(A)(ii)**

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 healthcare 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.

---


The published literature supports the importance of the unit- or work area-specific requirement for workplace violence prevention plans.

- A 2017 study randomized 42 inpatient hospital units into intervention and control groups. The authors found that intervention units—which including worksite walkthroughs, environmental risk assessment, unit-specific data analysis, and input of direct care staff to develop unit-specific action plans—reported less than half the violent incident rate of control units at 6 months post-implementation and that intervention units reported nearly a third the violence-related injuries of control units at 24- months post-implementation.

- A similar 2014 repeated-measures study randomized six emergency departments into intervention and control groups. Researchers partnered with direct care employees, managers, and hospital administrators 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% decrease in assaults in the unit that most thoroughly implemented a unit-specific workplace violence prevention plan.

**H.R. 1309, Sec. 103(1)(B)(ii)**

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.

Once again, the published literature affirms that many of these factors indicate an increased risk for workplace violence.

- One 2011 study examined bed occupancy and staff reports of workplace violence. 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.

---

47 Arnetz et al. (2017).
• One 2005 study surveyed over 6,000 nurses in Minnesota about their experiences of workplace violence and employers’ prevention measures. 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. Staffing can be important to reducing workplace violence.

**H.R. 1309, Sec. 103(1)(B)(iii)**

That employers must implement prevention measures, engineering controls, and work practice controls to correct workplace violence hazards; however, this language must be strengthened.

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 healthcare facilities. While H.R. 1309 sets forth a requirement that workplace violence prevention plans effectively prevent and control hazards in each work area and unit in healthcare and social service settings, the language included in Sec. 103(1)(B)(iii) potentially undermines this intent. Specifically, the requirement that employers implement “hazard prevention, engineering controls, or work practice controls to correct, in a timely manner, hazards that the employer creates or controls applying industrial hygiene principles of the hierarchy of controls...” (emphasis added). Hospitals and other healthcare facilities employ nurses and other healthcare workers to provide hands on care to patients. There are effective measures that healthcare employers can implement that reduce the risk of or mitigate the frequency and impact of workplace violence. This potentially limiting language should be deleted from the bill to provide the necessary protection to nurses and other healthcare workers at risk of injury from workplace violence.

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 the odds without administrative controls.

H.R. 1309, Sec. 103(1)(B)(iv)
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. H.R. 1309 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. However, there are a few missing elements. First, post-incident response should provide immediate medical care for employees who have been injured, including making trauma counseling accessible to all employees affected. OSHA recognizes that injury from workplace violence may manifest in nonphysical manners and including trauma counseling is an important tool in mitigating the psychological impact of violence. This requirement should be added to H.R. 1309.

Second, a post-incident debriefing should be conducted as soon as possible after an incident and must include the input from employees involved on their opinions on the cause of the incident and what measures could have been taken to prevent the injury. Finally, the post-incident response includes a review of the risk factors identified and corrective measures taken under the workplace violence prevention plan. Such requirements serve to 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. NNU urges Congress to include this language in H.R. 1309.

Inclusion of a requirement for employers to develop preparedness plans for workplace violence emergencies, including active shooter events, is increasing important. One study examined media reports of hospital-based shootings between 2000 and 2015. The authors found that the number of hospital-based shootings per year has been increasing for approximately the past decade. H.R. 1309 importantly includes such a requirement.

---

53 See H.R. 1309, Sec. 103(1)(B)(v).
**H.R. 1309, Sec. 103(1)(B)(v)**

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 H.R. 1309 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 co-workers. Communication procedures enable nurses and other healthcare 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.

**H.R. 1309, Sec. 103(1)(B)(v)**

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, healthcare employers often assign online training modules to RNs to complete during a shift while they are 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. In order for training to be effective, an OSHA should opt for frequent, in-person training with hands-on practice where appropriate.

The published literature underlines the importance of hands on, interactive training.

- A 2002 described the effectiveness of staff training intervention in the emergency department at a large academic, urban hospital. Results showed that interactive, hands-on training can be effective in reducing violence rates but that refresher training is needed to maintain those

---

effects. Researchers measured violent incident rates using a survey filled out by staff at the end of each shift on alternate days for two weeks before implementation, at three months, and at six months post-implementation of the staff training intervention. Data results showed a statistically significant decrease in the rates of violence at three months post-implementation, which then increased slightly at six months post-implementation.

- A 2009 study reported on the effectiveness of a workplace violence intervention implemented in a psychiatric inpatient unit at a Veterans’ Affairs hospital that included real-time incident recording tools and regular meetings on workplace violence with all staff and patients. 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% during treatment and 57% from pre-treatment to post-treatment—but the night shift did not show significant changes in violent incident rates.

H.R. 1309, Sec. 103(4)
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.

H.R. 1309 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, the Violent Incident Log must capture information solicited from employees involved in the incident. Second, 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.

H.R. 1309 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.

**H.R. 1309, Sec. 103(6)**

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

H.R. 1309 includes a provision that would require employers to review the effectiveness of their workplace violence prevention plans with the active participation of employees and their representatives. 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.

**H.R. 1309, Sec. 103(7)**

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. H.R. 1309 current contains this important language.
ATTACHMENT 5: TIMELINE OF STATE & FEDERAL EFFORTS ON WORKPLACE VIOLENCE.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Federal OSHA updates their voluntary guidelines.</td>
</tr>
<tr>
<td>2013</td>
<td>California Nurses Association sponsors SB 718 (Senator Yee) to require Cal/OSHA to develop a workplace violence prevention standard for hospitals and other healthcare employers.(^{57})</td>
</tr>
<tr>
<td></td>
<td>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 healthcare and social service settings.(^{58})</td>
</tr>
</tbody>
</table>
| 2014 | 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 healthcare employers and set minimum requirements for such a standard. It passes and is signed by the Governor.
|  | California Nurses Association petitions the California Occupational Safety and Health Standards Board to promulgate a standard on workplace violence prevention in hospitals and other healthcare facilities. The petition is granted.\(^{59}\) |
| 2015 | Federal OSHA updates their “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers” for a second time.\(^{60}\) |
| 2016 | 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.”\(^{61}\) |
|  | National Nurses United submits a petition to federal OSHA to promulgate a workplace violence prevention standard for hospitals and other healthcare employers, based upon the comprehensive Cal/OSHA standard.\(^{62}\) |

---


\(^{57}\) For the original text of SB 718 (Yee), see [http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0701-0750/sb_718_bill_20130222_introduced.html](http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0701-0750/sb_718_bill_20130222_introduced.html) (Accessed February 23, 2019).


\(^{59}\) For the text of the petition and the Occupational Safety and Health Standards Board’s analysis and decisions see [https://www.dir.ca.gov/oshsb/petition_539.html](https://www.dir.ca.gov/oshsb/petition_539.html) (Accessed February 23, 2019).

\(^{60}\) OSHA’s “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers” was updated twice, in 2004 and 2015. The updated version is available at [https://www.osha.gov/Publications/osh3148.pdf](https://www.osha.gov/Publications/osh3148.pdf) (Accessed February 23, 2019).

The California Occupational Safety and Health Standards Board unanimously approves the proposed Cal/OSHA Workplace Violence Prevention in Health Care Standard.  

2017  Assistant Secretary of Labor David Michaels grants NNU’s petition for a federal OSHA standard on workplace violence prevention in healthcare.  

2018  Representative Ro Khanna introduced the Health Care Workplace Violence Prevention Act, H.R. 5223.  
Cal/OSHA’s Workplace Violence Prevention in Health Care Standard goes fully into effect.  
Representative Joe Courtney introduced the Workplace Violence Prevention for Health Care and Social Service Workers Act, H.R. 7141.  


---


63  For minutes of the meeting where the California Occupational Safety and Health Standards Board unanimously approved the Workplace Violence Prevention in Health Care Standard see https://www.dir.ca.gov/OSHSB/documents/minutesOct2016.pdf (Accessed February 23, 2019).


66  For the full text of this standard, 8 CCR §3342, see https://www.dir.ca.gov/title8/3342.html (Accessed February 23, 2019).