Wisconsin Nurses Association

The Landscape of Wisconsin's Workplace Violence Towards Nurses: Education, Practice, and Policy

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ABBREVIATIONS

American Nurses Association	ANA
The Centers for Medicare and Medicaid Services	CMS
National Lieutenant Governors Association	NLGA
Occupational Safety and Health Administration	OSHA
The Joint Commission	TJC
Wisconsin Nurses Association	WNA
The World Health Organization	WHO
Workplace violence	WPV

EXECUTIVE SUMMARY

Nurses throughout Wisconsin have been feeling the stress in the post-COVID-19 pandemic era. Stressors include increasing aggression from patients and their family members, bullying and harassment from colleagues and other health care professionals. These factors are contributing to staffing shortages. Communications related to workplace violence (WPV) prevention have been released by The Joint Commission (TJC), The Centers for Medicare and Medicaid Services (CMS), and The Occupational Safety and Health Administration (OSHA). Federal legislation to improve healthcare working conditions has been drafted but not passed year after year. The guidelines from OSHA are not required by law and are leaving nurses exposed to WPV.

The Wisconsin Nurses Association (WNA) has recognized that WPV remains a critical issue and finds that it will require a multifaceted strategy to improve the working environments for Wisconsin's nurses. WNA formed a workgroup in November of 2023, with the advice from WNA's Workforce Advocacy Council, to develop and launch a survey about workplace violence towards nurses. The *WPV Prevention Survey Report* consists of complied information on the following categories: WPV prevention training, types of incidents seen in the workplace, the facility incident reporting process, impacts on the care of patients, and the impacts on nurses' wellbeing. From personal stories and data, WNA has created recommendations to support the nursing workforce, improve colleagues-to-colleague relationships, promote safe practice environments, involve key stakeholders, and advocate for federal and state policy change.

WNA urges nurses, nurse leaders, healthcare organizations, and policymakers to review the recommendations and implications to advance WPV prevention in Wisconsin.

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INTRODUCTION

WPV toward nurses continues to be a growing concern across health systems. According to a 2022 report, from Press Ganey's national database of nursing quality indicators, more than two nursing personnel were assaulted every hour (Press Ganey, 2022). That equates to roughly 57 assaults per day, 1,739 assaults per month, and 5,217 assaults per quarter. The most recent data on workplace violence from The U.S. Bureau of Labor Statistics indicates, "There were 41,960 total nonfatal cases of workplace violence requiring days away from work, job restriction, or transfer in the health care and social assistance industry over this time, accounting for 72.8 percent of all cases in private industry" (U.S. Bureau of Labor Statistics, 2024).

WNA has conducted a series of surveys of nurses related to workplace violence. In March of 2018, the WNA Workforce Advocacy Council worked with the University of Wisconsin Eau Claire DNP students to conduct a workplace violence survey of Wisconsin nurses (WNA, 2019). The results of the survey supported the adoption of legislation that made battery to a nurse a Class H felony. In February of 2020, this law was passed including a financial penalty and/or incarceration for physical harm to a nurse.

> According to a 2022 report from Press Ganey, more than two nursing personnel were assaulted every hour (Press Ganey, 2022).

In December of 2021, the WNA Workforce Advocacy Council conducted the *Verbal Abuse Towards Nurses by Patients/Clients, Families and Visitors* survey (Loughlin, et al., 2021). The 2021 survey report included recommendations from nurses on how to approach workplace violence as an employer and as a nurse. During this time COVID-19 was a high priority and efforts to further workplace violence prevention were delayed. WNA encountered challenges creating legislative policy around criminalizing verbal abuse towards nurses due to the ambiguity surrounding verbal abuse.

In 2023, WNA created the *WPV Prevention Survey* to better understand WPV in the post-COVID-19 era and its impact on the nursing workforce. 1,380 nurses throughout Wisconsin shared their experiences on WPV education, incidents, the incident reporting process, impacts on the care of patients, and the impacts on nurses' wellbeing. Given this information, WNA created recommendations for nurses, other healthcare professionals, healthcare organizations, and policymakers to address improving WPV prevention in Wisconsin.

RELEVANT BACKGROUND

I. The Occupational Safety and Health Administration's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

In 2016, OSHA published *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* which is a detailed set of guidelines for organizations to create WPV prevention programs. The categories are as follows:

- Management commitment and employee participation.
- Worksite analysis.
- Hazard prevention and control.
- Safety and health training.
- Recordkeeping and program evaluation (OSHA, 2016).

According to the American Nurses Association (ANA), OSHA has not implemented enforcement of their standards for employers to implement a WPV prevention program (ANA, 2024a). In early 2023, OSHA provided a meeting with the Small Business Advocacy Review panel (SBAR) which is a panel of employers to provide feedback on the 2026 standards. OSHA released the SBAR report on May 1, 2023. The response from ANA indicated disappointment that the report gives no timeline on next steps for the rulemaking. Nothing regarding enforcement has emerged from OSHA at this time. The full report is available here (OSHA, 2023). While OSHA continues to review the standards, workplace violence toward nurses continues to rise.

II. The Joint Commission's Workplace Violence Prevention Standards

In 2021, The Joint Commission (TJC) revised their Workplace Violence Prevention Standards. These prevention standards are based on the framework for hospitals to:

- Manage safety and security risks by conducting an annual worksite analysis and take actions to mitigate or resolve the safety and security risks based upon findings from the analysis.
- Establish process(es) for continually monitoring, internally reporting, and investigating workplace violence.
- Provide training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners.
- Maintains a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team (TJC, 2021).

These standards are part of TJC accreditation requirements for hospitals and critical access hospitals across the United States. There are 171 hospitals in Wisconsin that are TJC accredited (TJC, 2024).

III. The Centers for Medicare and Medicaid Services on Workplace Violence in Hospitals

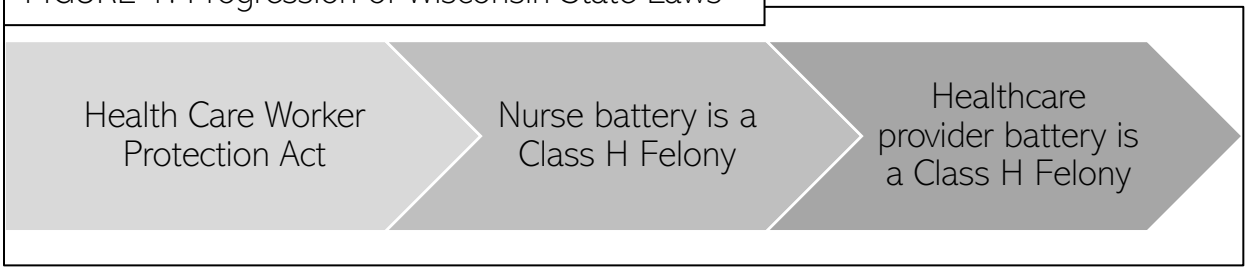
In 2022, The Centers for Medicare and Medicaid Services (CMS) addressed hospitals and healthcare facilities to enforce further regulatory efforts that combat WPV to ensure worker safety (Tritz & Wright, 2022). Measures that CMS requires of certified healthcare facilities include:

- Ensuring that leadership provides adequate training, sufficient staffing levels, and ongoing assessment of patients and residents for aggressive behavior and indicators to adapt their care interventions and environment appropriately.
- Identifying patients at risk for intentional harm to self or others.
- Identifying environmental safety risks for such patients.
- Providing education and training to staff regarding the identification of patients at risk of harm to self or others, environmental patient safety risk factors, and mitigation strategies. CMS recommends ongoing training at least every two years after initial training.
- Conducting a patient risk assessment and implement the appropriate strategies (CMS, 2024).

CMS is a federal regulating agency that provides health insurances such as Medicare, Medicaid, Children's Health Insurance Program, and the Health Insurance Marketplace. Healthcare facilities are encouraged to be certified by CMS for insurance reimbursement purposes and must follow specific safety regulations deemed appropriate by CMS (CMS, 2024).

IV. Existing State Laws in Wisconsin

FIGURE 1: Progression of Wisconsin State Laws



In 1999 the Health Care Worker Protection Act 176 was signed into Law which can be found in Wisconsin State Statute Chapter 146.997. The statute has been referred to as the Whistleblower Protection Act. The statute protects employees of health care facilities or providers from discipline at work for good faith reporting of any potential violations of state or federal law by the health care facility or provider, or any situation where care is provided in a manner that violates states or federal standards, laws, or recognized clinical or ethical standards. Protected reporting includes internal reports to any director, officer or supervisor of the health care facility or provider, or reports to an agency or body that accredits, certifies, or approves the facility or provider, unless disclosure is prohibited by law (Department of

Workforce Development, n.d.). Go to: Wisconsin Department of Workforce Development for further information about this law (Department of Workforce Development, n.d.).

On February 5, 2020, the Wisconsin Nurses Association led a successful advocacy campaign resulting in Governor Evers signing into law Wisconsin Act 97, which made it a Class H Felony to batter a nurse. The penalty for a Class H Felony can be $10,000 and/or six years of incarceration (Battery to a Nurse, 2020).

On March 23, 2022, Wisconsin Act 209, was strongly advocated by the Wisconsin Hospital Association and signed into law by Governor Evers. The law repealed Wisconsin Act 97 but addressed battery or threat to any health care provider or staff member of a healthcare facility. Wisconsin State Statute Section 940.204 (2) cites, "Whoever intentionally causes bodily harm or threatens to cause bodily harm to a health care provider or to a family member of a health care provider under all of the following circumstances is guilty of a Class H felony" (Battery or Threat, 2022).

V. Workplace Violence Prevention for Health Care and Social Service Workers Act

Wisconsin federal legislator, Senator Tammy Baldwin, sponsor of Senate Bill S.1176 (U.S. Senate, 2023), and Representative Joe Courtney, sponsor of HR.2663 (U.S. House, 2023), introduced the *Workplace Violence Prevention for Health Care and Social Service Workers Act* in April 2023. In summary, this bill addresses the fact that workforce shortages are directly linked to workplace conditions. The passage of this bill would ensure that healthcare workers are knowledgeable and have the resources to protect themselves, co-workers, and patients on the job. More importantly, this bill would require the Occupational Safety and Health Administration (OSHA) to develop and enforce specific standards for healthcare employers, holding them accountable for protecting their employees against WPV. The legislative proposal calls for employers to:

- Report workplace violence, the employer's response to the incident, and post-incident investigation.
- Respond to employee reports of workplace violence risks, hazards, and incidents.
- Perform a post-incident investigation and debriefing of all reports of workplace violence with the participation of employees and their representatives.
- Provide medical care or first aid to affected employees.
- Provide employees with information about available trauma and related counseling.

Variations of this bill have been introduced in previous congressional sessions but have not become law. This version of the bill was introduced in April 2023 and has been referred to the Committee on Health, Education, Labor, and Pensions. This legislation will have until the end of 2024 to be passed by both houses. At this point in the year, it is doubtful that this will occur.

VI. National Lieutenant Governors Association Resolution

In April 2024, the National Lieutenant Governors Association (NLGA) issued a Consensus Resolution on Workplace Violence Prevention in Health Care. The "Resolved" section of the resolution focused on the recognition of the seriousness of workplace violence and encourages NLGA members to be aware of the strategies that mitigate workplace violence. From a systematic review on workplace violence prevention strategies, they indicate that comprehensive evidence-based prevention programs reduce the risk of workplace violence against health care workers (Somani, et al., 2021). The NGLA notes that eight states require workplace violence prevention programs, two are surrounding states of Wisconsin (Illinois and Minnesota). Wisconsin Lieutenant Governor, Sara Rodriguez, is one of the two resolution cosponsors in the drafting of this resolution (NLGA, 2024).

VII. The Economic Impact of Workplace Violence Incidents

The financial impact of workplace violence in the health care setting is evident with nurses being a frequent victim of WPV threats and harm. According to the ANA, "13% of days away from work were the result of violence in 2013, and this rate has increased in recent years" (ANA, 2014). The absenteeism contributes to the on-going issue of nurse staffing shortages. From 2021 to 2022, the U.S. Bureau of Labor Statistics reports 41,960 total WPV cases for health care and social assistance professionals. 69% of these professionals (28,970 cases) required days away from work and 31% (12,980 cases) required days of job transfer or restriction (U.S. Bureau of Labor Statistics, 2024). Healthcare workers who experience workplace violence require an average of 60 more hours of sick, disability, and leave time annually compared to workers who are not exposed to violence (Nursing Solutions, Inc, 2024).

The financial impact of WPV for health care systems includes nurse turnover, either from disability or worker dissatisfaction. The 2024 NSI National Health Care Retention and RN Staffing Report noted the average cost of turnover for one RN during 2023 was $56,300 which was a 7.5% increase from 2022. The financial impact for one year of all healthcare facilities noted a loss of $3.9 million to 5.8 million. The costs incurred reflected hiring to replace nurses, the cost of on-boarding, and orientation of the nurse (Nursing Solutions, Inc, 2024).

A 2016 AHA report on *Cost of Community Violence to Hospital and Health Systems* estimates annual violence in U.S. hospitals cost approximately $2.7 billion or $481,596 per hospital (Van Den Bos, et al., 2017). Table 1 has a breakdown of specific cost for prevention and preparedness and post-incident violence in hospitals and health systems.

TABLE 1: Estimated Total Cost of Violence to U.S. Hospitals and Health Systems, 2016

COST CATEGORY	TOTAL, IN MILLIONS	PER HOSPITAL	% OF TOTAL
GRAND TOTAL	$2,679.6	$481,596	100.0%
PUBLIC VIOLENCE: PREVENTION AND PREPAREDNESS	$279.5	$50,234	10.4%
EMERGENCY PREPAREDNESS TRAINING	$174.6	$31,380	6.5%
COMMUNITY BUILDING RELATED TO VIOLENCE PREVENTION	$67.6	$12,150	2.5%
TRAINING TO IDENTIFY VIOLENCE-RELATED TRAUMA	$37.3	$6,704	1.4%
PUBLIC VIOLENCE: POST-INCIDENT	$852.2	$153,163	31.8%
COST OF UNCOMPENSATED OR UNDERCOMPENSATED CARE	$752.4	$135,226	28.1%
MEDICAL CARE	$651.0	$117,002	24.3%
BEHAVIORAL CARE	$101.4	$18,224	3.8%
CASE MANAGEMENT	$99.8	$17,937	3.7%
IN-FACILITY VIOLENCE: PREVENTION AND PREPAREDNESS	$1,119.4	$201,186	41.8%
SECURITY STAFF AND INFRASTRUCURE	$846.7	$152,175	31.6%
STAFF TRAINING	$175.1	$31,470	6.5%
PROCEDURE DEVELOPMENT	$97.6	$17,541	3.6%
IN-FACILITY VIOLENCE: POST-INCIDENT	$428.5	$77,013	16.0%
STAFF TURNOVER	$234.2	$42,092	8.7%
MEDICAL CARE	$42.3	$7,602	1.6%
INDEMNITY	$7.6	$1,366	0.3%
DISABILITY	$90.7	$16,301	3.4%
ABSENTEEISM	$53.7	$9,651	2.0%

Other reports on the financial burden of WPV indicated decreased productivity for the injured nurses and their colleagues following WPV incidents (Laschinger, 2014). Workplace violence inflicted upon nurses can cause both physical and emotional trauma, and consequently, substantial monetary loss for employers.

WORKPLACE VIOLENCE PREVENTION SURVEY RESULTS REPORT

I. Survey Design & Methodology

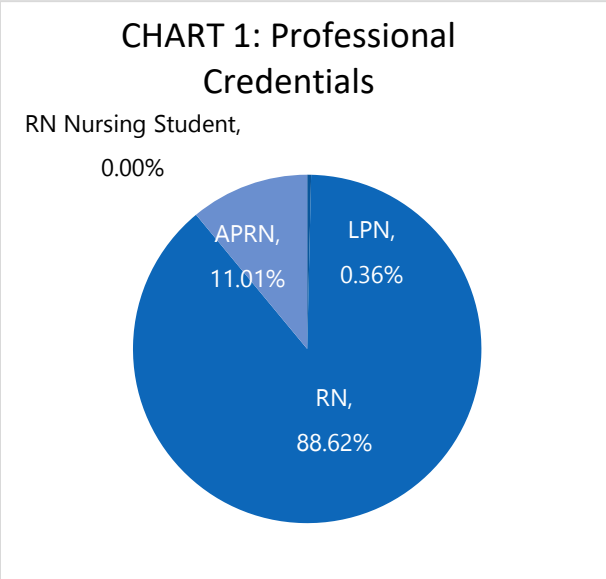
A workgroup consisting of Dr. Rene Buenzow, DNP, PMHNP-BC, APRN-BC, Faleasha Gallagher, MPH, RN, PCCN, ATCN, and Gina Dennik-Champion, MSN, MSHA, RN with advice from WNA's Workforce Advocacy Council began their work by reviewing past surveys on workplace violence toward nurses. In November 2023, the workgroup developed the *WPV Prevention Survey.* The survey content was developed using standards from TJC, CMS and guidelines from OSHA. The survey questions were formulated to determine if there were gaps throughout WPV prevention programs in Wisconsin's healthcare settings. This 27-question survey was created via Survey Monkey and shared with Wisconsin nurses from December 2023 to January 2024.

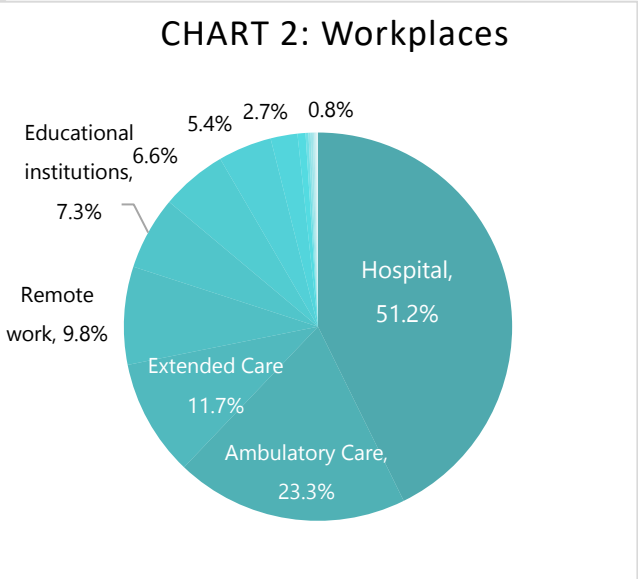
> "I do not think it is "just part of the job," but that is the overwhelming attitude most people seem to have adopted."
> – A Wisconsin Nurse

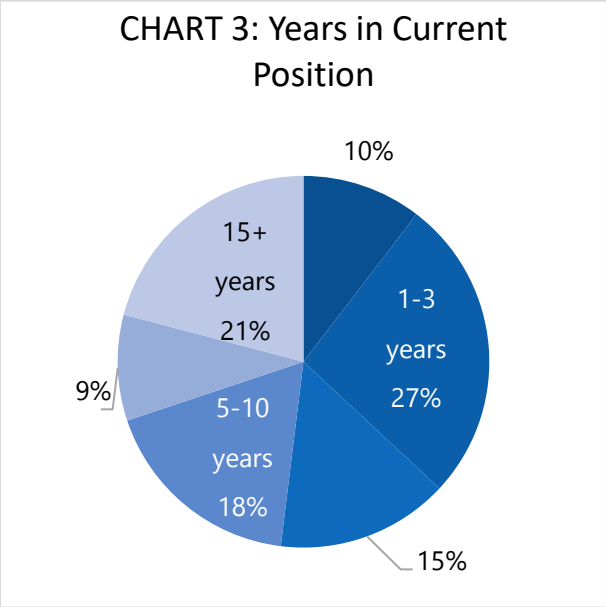
The survey was distributed via WNA's email, social media, and by partner organizations. There were 1,380 nurses comprised of Registered Nurses (RN), Licensed Practical Nurses (LPN), and Advanced Practice Registered Nurses (APRN) who responded to the survey regarding post COVID-19 WPV. The *WPV Prevention Survey Report* detailed a picture of WPV incidents for nurses in Wisconsin with data and personal stories. Questions were stratified by type of workplace and years in current position to further paint the picture on which departments and nurses are experiencing WPV. Personal quotes that are included throughout this report may be slightly modified to protect identification of nurses or workplaces. Data displayed in this section is from The *WPV Prevention Survey Report* and the full report is available on WNA's website.

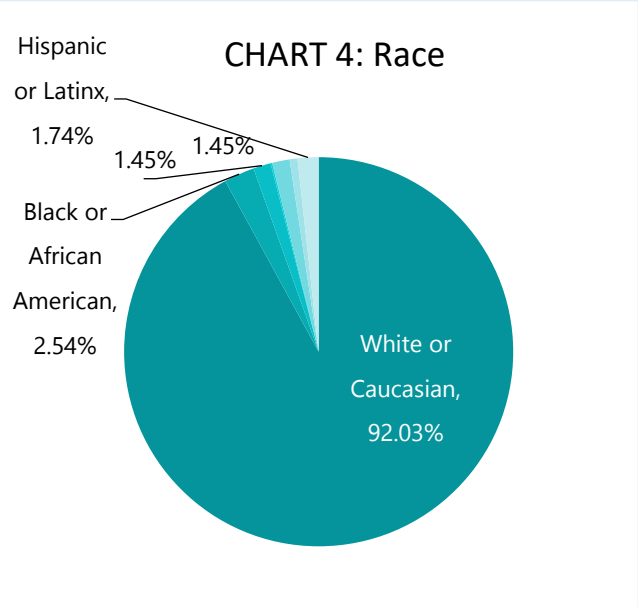
> "I chose to call in as long as that patient remained on our unit, and I got pulled into a disciplinary meeting with my manager and her supervisor where I felt greatly bullied. I was told during the meeting by my managers supervisor that, *If I became a nurse thinking I would never get hit, that was naïve*."
> – A Wisconsin Nurse

II. Survey Demographics









In Chart 1, approximately 90% of respondents are RNs and nearly 10% of respondents are APRNs. Chart 2 indicates the top three workplaces are hospitals (51.2%), ambulatory care (23.3%), and extended care (11.7%). Within years in current position, in Chart 3, the two highest reported categories are one to three years (26.5%) followed by fifteen-plus years (20.9%). In Chart 4, nurses identify as Caucasian (92%), African American (2.5%), and Hispanic (1.7%). Respondents identify as female (92%), male (7%), or non-binary/prefer not to answer (1%). Most of the nurses work in Milwaukee and Dane County in Southern Wisconsin.

III. Workplace Violence Training & Education

1,066 (78%) nurses reported receiving WPV prevention training in the last twelve months. Over 50% reported training on WPV worked in hospital settings. Among the 1,064 nurses who reported receiving training, they reported the frequency of training to be annually (87%), upon hire (28%), bi-annually (6%), and post-incident (10%). Those who worked in their current position for less than five years report receiving training upon hire more often than those who have been in their position for more than five years. Throughout all workplaces, nurses receive training annually most often. From 1,045 nurses, the format of WPV prevention training is seen most often online (80%), in the classroom (10%), and hybrid format (10%). Throughout all workplaces, WPV prevention training is mostly completed online.

In these training classes, 1,045 nurses report receiving information on policies and procedures (89%), how to report incidents (74%), and how to call for help (71%), which is shown in Figure 2. Nurses least often received training on trauma-informed care (26%). Trauma-informed care was most often taught to nurses who worked in public health and community health settings (53%). De-escalation techniques were most often taught in hospitals (71%), ambulatory care (67%), home health (62%), public/community health (64%), and educational institutions (60%).

FIGURE 2: Categories Taught in the WPVP Training Courses

> "Most of the abuse I get is verbal abuse from patients and this has increased by 100% since Covid-19. Patients seek free medicine and have become very verbally abusive. My place of employment does not have any education regarding this." -A Wisconsin Triage Nurse

IV. Reporting Workplace Violence Incidents

Reporting WPV incidents includes nurses' knowledge on how to complete their organization's incident report form, who to contact about an incident, and barriers to reporting an incident. A little over half (56%) reported knowing how to fill out an incident report and the other half (44%) were unsure or did not know how to fill it out. Those in public health and educational institutions more often did not know how to fill out incident forms. 80% of nurses reported knowing who to contact to report a WPV incident. Those who had been in their current position for more than a year understood who to contact more often than those who worked in their position for less than a year. Knowing who to contact was similar across all workplaces.

Once an incident was reported to an organization, response time from the organizations' leadership team varied, nurses said they were unsure how long it took to respond to an incident (49%), it took less than one week (40%), the response was within the month (6%), within three months (1%), or there was no response from their organization (4%). This trend was similar across all workplaces. 1,278 nurses shared whether they report incidents, and 575 (45%) nurses indicated that they do report incidents to their workplace. The other 703 (55%) nurses had reasons for not reporting incidents that included they thought nothing would be done from the incident (33%), that WPV is just part of the job (22%), they were afraid of retribution by the organization (17%), or they didn't understand how to report (10%). See Figure 3 for themes of nurses' comments on reasons for not reporting WPV incidents.

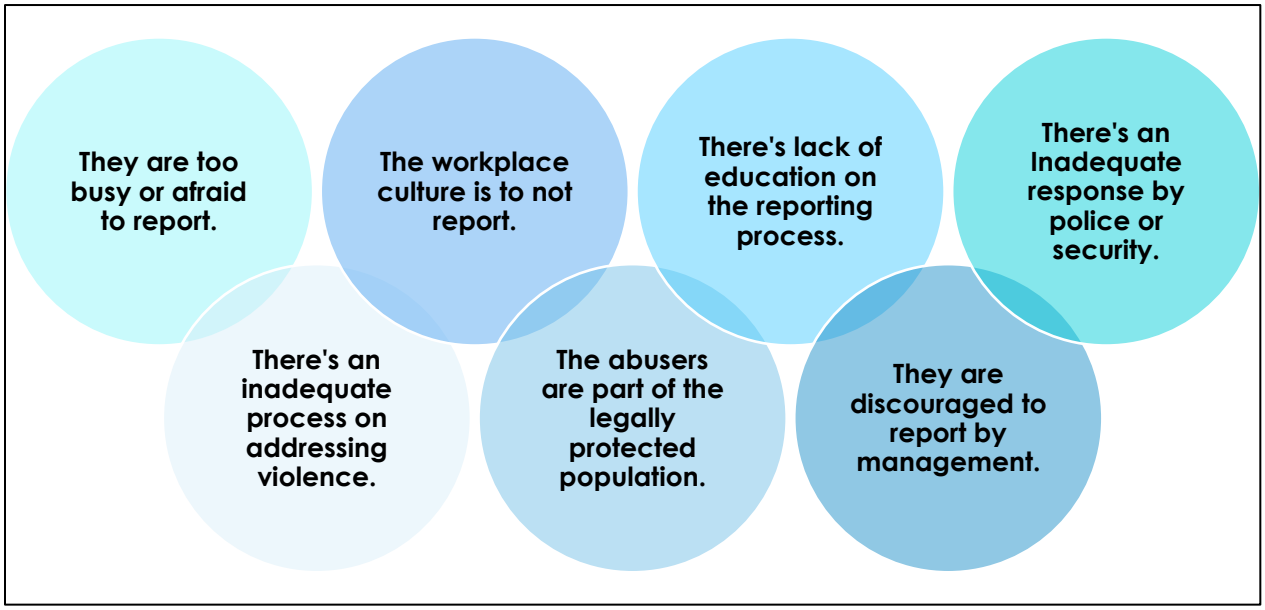
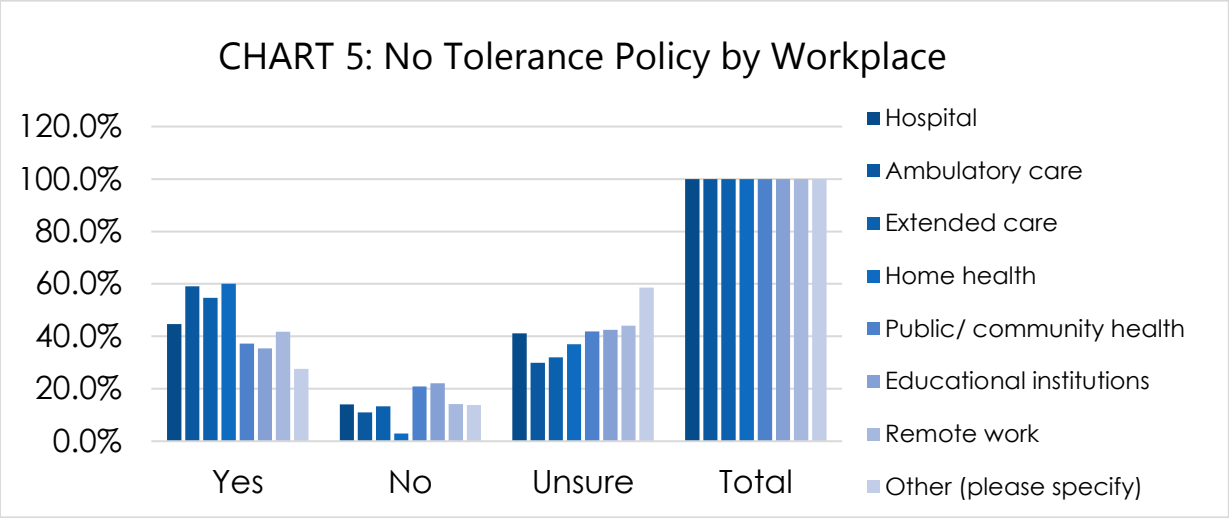


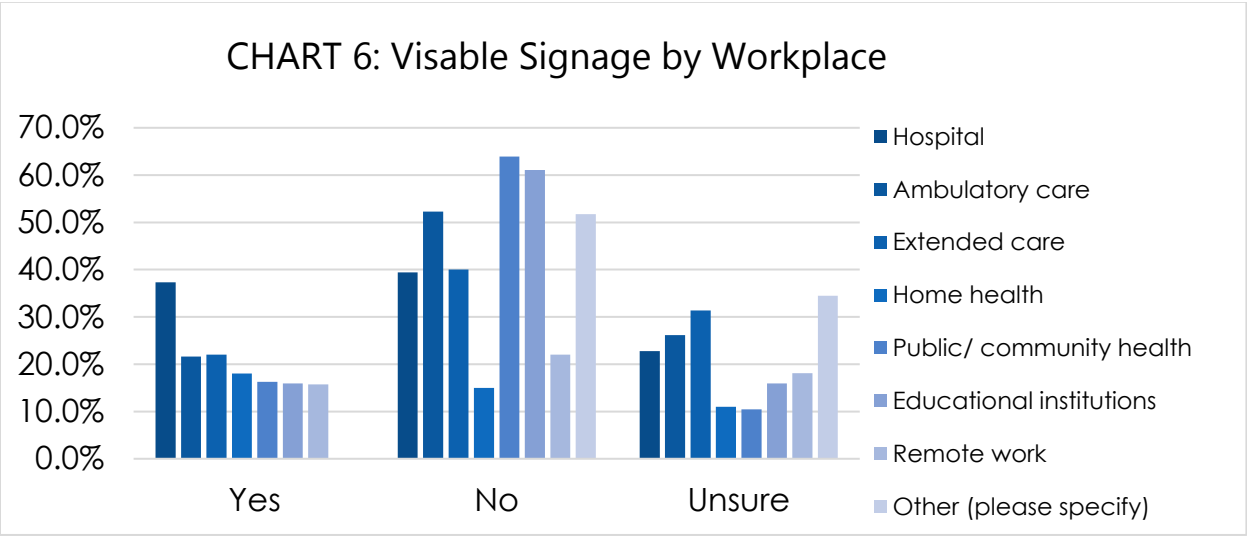
FIGURE 3: Reasons Nurses Are Not Reporting Workplace Violence Incidents

V. Environmental Aspects of Workplace Violence Prevention

The survey included questions related to the environmental aspects of WPV prevention that included a no-tolerance policy in the patient bill of rights document, signage regarding felony charges for physical abuse to healthcare workers, and structural equipment within the organization. Regarding the no-tolerance policy in the patient bill of rights document, 44% of nurses indicated that they did have this, while 12% said they did not, and 44% were unsure. Chart 5 depicts those who have a no tolerance policy in their patients' bill of rights document divided by workplaces.



Twenty-three percent of nurses said that they have visible signage regarding felony charges for physical abuse to healthcare workers, 45% said they did not, 25% were unsure, and 7% worked in home settings. Chart 6 shows that hospitals have visible signage more often than other workplaces.

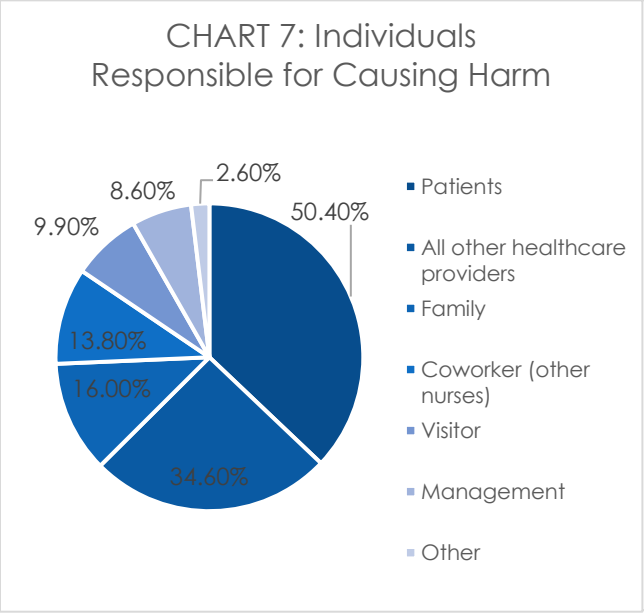


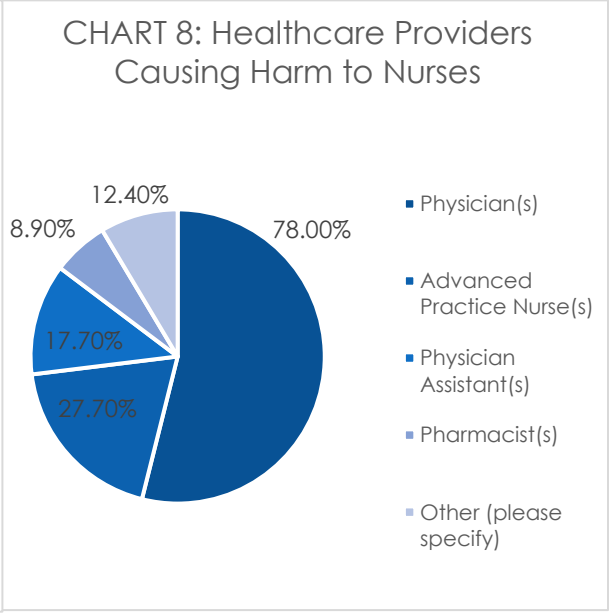
Structural equipment within the workplace that aids in preventing workplace violence are door locks (41%), panic buttons (40%), paging systems (35%), closed circuit videos (indoor) (33%), closed circuit videos (outside) (29%), cell phones (29%), using physical barriers (22%), and many other devices. Over 70% of nurses working in ambulatory care indicated they had door locks. Over 50% of nurses working in hospitals had panic buttons. Over 65% of nurses working in home health had cell phones. About 50% of nurses working in educational institutions indicated they have closed-circuit videos indoors and outside as well as door locks. Over 50% of nurses in public/ community health had door locks and cell phones.

> "My clinic has no security. I have been asking for over 5 years. No cameras at all. No panic buttons. Unlocked doors from the lobby to our urgent care, unlocked doors from the breakroom that leads into lab and radiology."
>
> – A Wisconsin Clinic Nurse

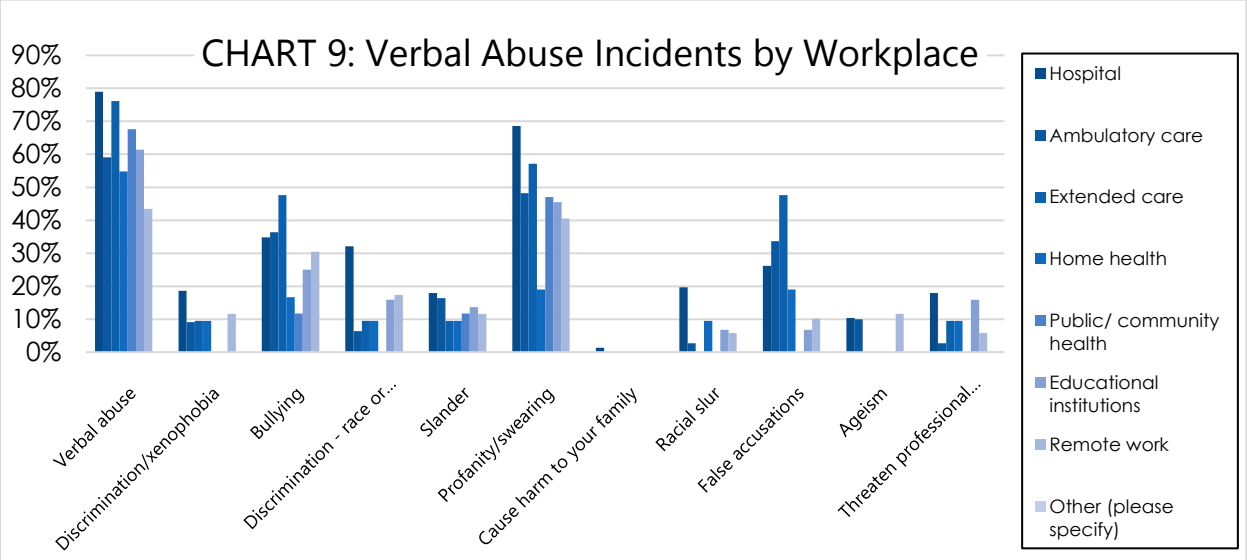
VI. Workplace Violence Incidents

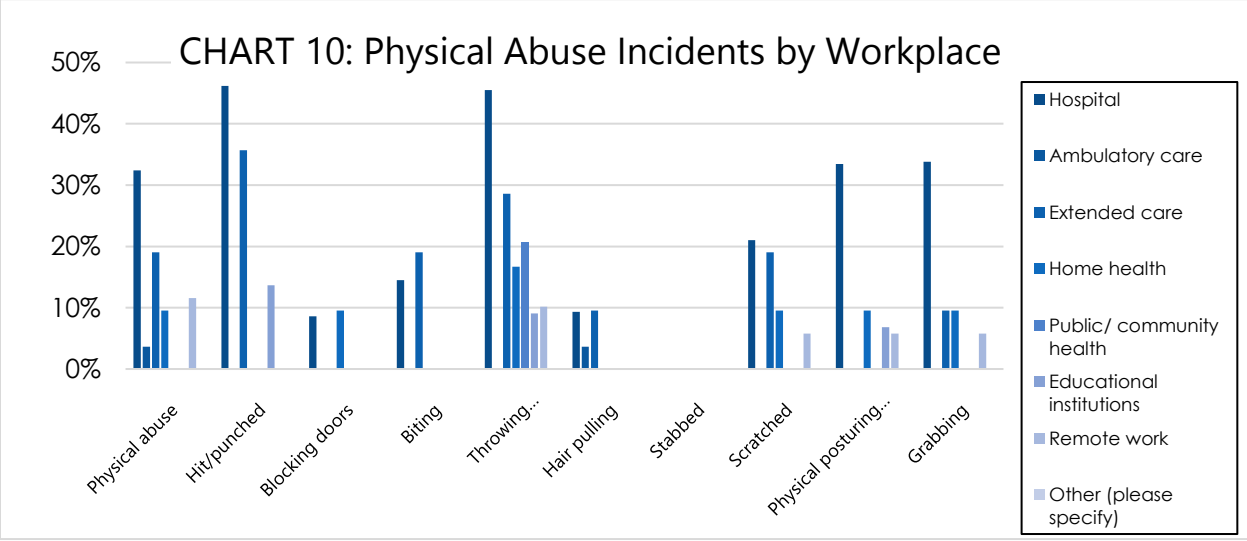
821 nurses indicated, as seen in Chart 7, that those who are responsible for causing WPV are patients (50%), family (16%), other nurses (14%), visitors (10%), management (9%), and others. 284 nurses (35%) selected "All other healthcare staff." 282 nurses depicted additional healthcare staff that caused harm to nurses, as seen in Chart 8, including physicians (78%), APRNs (28%), physician assistants (18%), pharmacists (9%), nursing assistants (8%), and other healthcare staff. Nurses in hospital settings had the overall highest percentage of harm caused by other healthcare staff. Over 50% of those who caused WPV knew that the victim was a nurse. Additionally, nurses said that 40% of the time it was intentional harm.





540 nurses indicated they either witnessed or experienced the following acts of violence in the last 12 months: verbal abuse (68%), profanity swearing (58%), bullying (34%), throwing objects/fluids or being hit/punched (30%), false accusations (28%), discrimination (22%), dirty talk (21%), threatened professional license (16%), and many other types of violence, as seen in Chart 9 and Chart 10. 19% of nurses indicated they had not witnessed or experienced violence in their workplace. Almost 50% of those who work in extended care indicated they had seen bullying, swearing, or false accusations. In hospitals, almost 80% of nurses experienced verbal abuse and 70% experienced swearing.





> "This behavior seems to be tolerated by others. As nurses we need to stand together to not allow the verbal and physical abuse." – A Wisconsin Nurse

For physical abuse, hospitals had the highest incidents of nurses being hit/punched (46%), having objects/fluids thrown at them (46%), scratched (21%), physical posturing (33%), and grabbing (34%). Graph 4 shows that extended care nurses had the second highest incidence of being hit/punched (36%), biting (19%), having objects/fluids thrown at them (29%), hair pulling (10%), and being scratched (19%). Sexual abuse was highest in hospital settings with groping (13%), dirty talk (25%), and kissing (1%). Extended care had the second highest amount of sexual abuse with groping (10%), and dirty talk (19%).

"I was physically assaulted (punched) by a patient who was a Tribal member. The incident went in front of the Tribal Council. The Tribal Council elected not to punish the Tribal member."
-A Wisconsin Clinic Nurse

422 nurses who indicated they had experienced or witnessed violence answered the following questions. 25% of nurses were emotionally/psychologically injured during the incident, 4% reported physical injury, and 7% noted to have both types of injury. Nurses who had been in their current position for one to three years had the highest percentage of physical injury (50%) and both types of injury (45%). Nurses in their position between 10-15 years had the lowest overall percentage of injury. Hospital settings had the highest percentage of all injuries with 80% of physical and both types of injuries. Nurses in public/community health, educational institutions, remote work, and others reported no physical injuries. Of the 422 nurses, 45% did report their WPV incidents. Nurses who had one to three years in their position reported WPV incidents the most (35%). Hospitals (60%), ambulatory care (22%), and extended care (10%) nurses reported incidents just as much as they did not report incidents.

"I have filed multiple police reports after being struck or attacked by patients that were of sound mind. Nothing happened. The District Attorney always dropped my cases. I was spoken to by my manager stating, *what could you have done different in that situation to prevent the patient from becoming violent towards you?* Nothing was asked towards me in the nature of *how are you doing? Do you need time off to recover from the incident mentally or emotionally?* Nothing."
– A Wisconsin Nurse

VII. Workplace Violence Impact & Outcomes

The impact of WPV has an unintended consequence on patients and the care provided by nurses. 610 nurses reported impacts on patient care after a WPV incident, shown in Figure 4, including medicating patients for behaviors (36%), reassigning patients (30%), checking on patients less frequently (28%), putting restraints on behavioral patients (24%), and patients leaving against medical advice (AMA) (19%). Positive impacts that were mentioned include communicating the situation with other staff, de-escalating the situation, having two or more staff to assist with the patient, and verbally redirecting the individual.

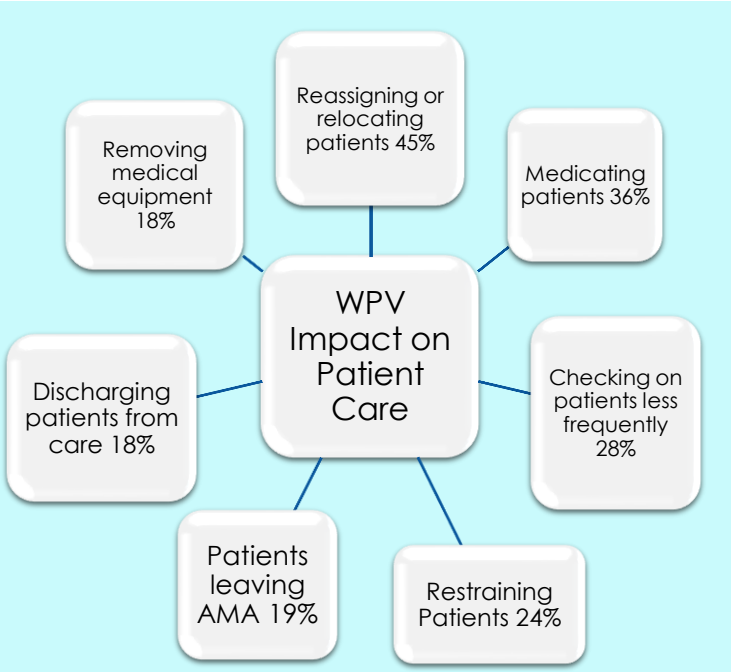


FIGURE 4: WPV Impact on Patient Care

Outcomes for 515 nurses from WPV incidents include that the incident was addressed (54%), they received education on WPV prevention (22%), they left their place of employment (13%), filed a police report (12.6%), and nothing came from the incident (11%). Additional comments discussed being harassed, afraid of losing their job, and taking time off work. The top eight impacts of experiencing or witnessing WPV reported by 655 nurses are noted in Figure 5. Most nurses responded that they had multiple mental health impacts from WPV incidents. Other impacts were that nurses felt inadequate, frustrated with the profession, annoyed, or desired to leave the workplace.

FIGURE 5: Top 8 WPV Impacts on Nurses

1. Burnout (67%)
2. Feeling anxious (61%)
3. Lack of empathy (38%)
4. Avoiding/ withdrawing from work (35%)
5. Work/life imbalance (35%)
6. Depression (25%)
7. PTSD (17%)
8. Anger/ outbursts (15%)

> "I struggle with my passion for nursing and my anger that our nurses have to endure this." -A Wisconsin Nurse Manager

SURVEY RESULTS DISCUSSION

The main purpose of this survey was to gather information from nurses about their experiences with violence in healthcare organizations, personal stories, and training they received on incident reporting and WPV prevention techniques. Convenience sampling was used as those who are members of WNA and affiliated with WNA received the link to the survey. It was disheartening to receive the many stories submitted by nurses about physical and verbal violence, some of which are highlighted in this report. It is imperative that key stakeholders in Wisconsin learn about these stories to support the urgency to make the needed system changes.

Regarding demographics of nurses responding to the survey we find that there are limitations in comparing the representation of nurses who took this survey to all Wisconsin nurses. Although race, gender, hospital, and ambulatory care workplaces are comparable to the demographics from the Wisconsin 2022 RN Survey Report (Zahner, et al., 2022). Regarding nurses working in extended care, it was found that the proportion of nurses responding to this survey was higher than the percentage of nurses reported in the RN Survey Report. Most nurses that responded were from Milwaukee and Dane County, so it is not representative of all Wisconsin counties.

Of the 1,066 nurses that responded about their WPV training, the majority (78%) received training in the previous 12 months from their employer. In examining categories that were taught during these trainings, 67% were taught de-escalation techniques, 58% were taught verbal intervention skills and 26% were taught about trauma informed care. From reviewing these results, nurses would benefit from additional education on practical WPV prevention techniques from their employers. This fact underscores the necessity of workplace violence prevention standards, including education and training, for all healthcare organizations in Wisconsin.

721 (56%) nurses reported knowing how to fill out WPV incident reports. 575 (45%) nurses do report these incidents to their employer. Figure 3 summarizes the themes of why nurses are not reporting WPV incidents. Nurses need the knowledge, time, and support to feel empowered to report verbal and physical abuse for every incident. The organizational culture

> "The police did not want to file the report, but I was kicked in the stomach while 9 weeks pregnant. My health outcomes were good, but it is disheartening and made me upset at the time. It puts you on edge with other patients thinking something bad is going to happen again."
>
> – A Wisconsin Nurse

of reporting incidents in healthcare must shift to allow tracking these incidents for system improvement.

Workplace safety equipment is an important part of WPV prevention. The WPV Survey Report asked nurses about equipment in their workplaces that OSHA recommended. The survey data noted that the highest reported intervention was door locks with 41% of the 1,278 nurses indicating they were in their workplace. There are environmental risk assessment tools available to healthcare organizations that can contribute to their WPV improvement programs.

Over half of the nurses surveyed said that patients were the source of WPV, but the other half are a mixture of family, visitors, nurses, management, and other healthcare professionals. These findings indicate that all sources of WPV need to be addressed using a comprehensive approach.

Hospitals have the highest percentage of verbal and physical abuse towards nurses. Those who are causing WPV 50% of the time are aware that the victim is a nurse and 40% of the time it is intentional. From this data, half of these WPV incidents would be eligible to be reported to law enforcement under the battery against nurses' law, but many challenges impede reporting. 422 nurses who indicated they had experienced or witnessed violence answered the following questions. Twenty-five percent of nurses were emotionally/psychologically injured during the incident, 4% reported physical injury, and 7% noted to have both types of injury. Nurses who had been in their current position for one to three years had the highest percentage of physical injury (50%) and both types of injury (45%). This is consistent with other reports on WPV that newer nurses are involved in these WPV incidents more often than experienced nurses. There are a variety of strategies that healthcare organizations and nursing education programs can access to better prepare the new graduated nurse for response to WPV.

610 nurses reported impacts on patient care after a WPV incident, shown in Figure 4, including medicating patients for behaviors (36%), reassigning patients (30%), checking on patients less frequently (28%), putting restraints on behavioral patients (24%), and patients leaving against medical advice (AMA) (19%). All these actions have potential to negatively affect the patient's health.

For 655 nurses, the survey results showed that these nurses were personally impacted by either experiencing or witnessing WPV. Figure 5 shows the effect of WPV toward nurses that ranges from burnout to PTSD. Healthcare organizations also have staffing challenges due to WPV incidents with nurses taking time off, leaving the workplace, or profession. WPV perpetuates the ongoing cycle of maintaining a sufficient supply of nurses for healthcare organizations.

> "I'm leaving nursing. I'm tired of vicious nurses. Not all people are vicious, but all nurses have the ability to be vicious to each other. When do we begin to show this elusive 'nursing compassion' to each other? I used to believe in compassion and support. That got beat out of me pretty early on. I stuck with it for over 20 years." – A Wisconsin Nurse

MULTILEVEL RECOMMENDATIONS

I. Nursing Workforce Recommendations

The ANA *Code of Ethics for Nurses with Interpretive Statements* is a standard that guides the practice of nursing with nine provisions. Provision one states, "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (ANA, 2015). The role of the nurse is to coordinate care for patients in many different settings which allows for them to have a direct impact on WPV prevention. See Table 2 for WNA's recommendations for nurses.

Table 2: Workplace Violence Prevention Recommendations for Nurses

Nursing Practice	Education	Report Workplace Violence Incidents	Participant in Organizational Change
Assess patients' psychosocial behaviors to implement interventions.	Attend WPV prevention training and review annually.	Prior to any incident that needs to be reported, nurses should understand where their incident reporting system is located and how to complete the form.	Participate in committees to prevent WPV at the organizational level.
Use trauma informed nursing care practices (Fleishman, et al., 2019).	Use mental health resources and Employee Assistance Programs to address the psychological impact of WPV (Morris, 2024; Doran, 2022).	Report any injury, regardless of severity, both psychological and physical through appropriate workplace processes.	Review organizational policies on WPV.
Balance nurses' safety with the safety of nurses' patients.		If reasons for not reporting stem from organizational issues, nurses must express their concern to the appropriate authority or committee.	Assist in creating awareness of environmental safety precautions and support colleagues using de-escalation training.
WPV should not be tolerated and never viewed as "part of the job."		Report individuals who cause harm and are aware that they are injuring a healthcare professional, to security and law enforcement for further action.	

The subsection, "1.2 Relationships with Patients" notes that nurses are to foster trust with patients and provide nursing care according to need without bias or prejudice. Nurses are to respect patient decisions even if they do not support or agree with these decisions. The nurse has an obligation to act when patients' choices are self-destructive. They must address the behavior by offering alternative opportunities and resources to assist with behavior change or

stop the risk altogether (ANA, 2015). When patients are becoming violent, nurses must attempt to de-escalate the situation, offer other routes of care and treatment, but ultimately not allow the patient to become a danger to themselves or others. As this can look very different depending on practice setting, nurses need WPV education training to know how to react in these situations (OSHA, 2016).

Trauma-informed nursing care practices are an essential tool in de-escalation strategies. One intervention from the *Online Journal of Issues in Nursing*, is asking yourself three questions,

- "Safety: Does this cultivate a sense of safety?
- Respect: Am I, and others, showing respect?
- Trust: Does this build trust?" (Fleishman, et al., 2019).

Nurses should also be aware of their WPV facility policies. Since these scenarios can be unpredictable, nurses need to review WPV training and policies at time of hire, annually, and with changes to the WPV program to ensure they have up-to-date information on facility practices (TJC, 2021).

Provision five states, "The nurse owes the same duties to self as to others…" (ANA, 2015). This statement indicates that self-care is as important as care provided to patients. The subsection, "5.2 Promotion of Personal Health, Safety, and Well-being" discusses that nurses should model the health maintenance and promotion measures that they teach to patients and avoid taking unnecessary health or safety risks in their professional or personal activities (ANA, 2015). Regarding WPV, the nurse should balance their safety with the safety of their patients. Nurses deserve to provide care in a safe setting (Tritz & Wright, 2022). When a WPV incident does occur, impacts to nurses are commonly burnout, stress, and an array of mental health impacts (O'Brien, et al., 2024). Nurses should take advantage of trauma-crisis counseling, stress debriefing or employee assistance programs to address the mental health impacts of WPV (OSHA, 2016).

A nurse is expected to report WPV incidents when they happen to allow organizations to see the volume and frequency of violence towards nurses (TJC, 2021). Prior to any incident, nurses should understand where the incident form is located and how to complete it. When reasons for not reporting stem from organizational issues, nurses must express their concern to the appropriate authority or committee. The issue then falls onto the nurse administrators to respond to the concerns and seek to change the practices (ANA, 2015). The subsection, "5.4 Preservation of Integrity" states that verbal abuse or other forms of abuse are a threat to the nurses' integrity and should never be tolerated (ANA, 2015). This counters the mentality that WPV "is just part of the job." In practice, WPV is not to be tolerated. Individuals who cause harm and are aware that they are injuring a healthcare professional are to be referred to security and law enforcement for further action. Those who are unaware they are causing harm can potentially be mitigated by protective factors such as adequate environmental safety precautions and supportive colleagues with de-escalation training.

II. Interpersonal and Environmental Recommendations

Revisiting provision one from the *Code of Ethics for Nurses with Interpretive Statements*, subsection "1.5 Relationships with Colleagues and Others*"* indicates that nurses are expected to exude kindness, and respect toward their colleagues, coworkers, employees, students, and others. Unacceptable practices towards one another include bullying, harassment, intimidation, threats, violence, or manipulation (ANA. 2015). WNA's *WPV Prevention Survey,* results show that these unacceptable behaviors toward nurses are occurring throughout Wisconsin healthcare organizations. It would be beneficial for nursing leadership to review and discuss with all nursing personnel ANA's *Code of Ethics for Nurses with Interpretive Statements.* It is the responsibility of nursing leadership to address unacceptable behavior toward any employee.

Younger, inexperienced healthcare workers are more likely to have WPV incidents (O'Brien, et al., 2024). This was identified throughout WNA's *WPV Prevention Survey* where nurses that are newer to the profession experienced violence more often than seasoned nurses. There are strategies that can be applied that support newer nurses that include mentorship programs, improved communication and conflict resolution skills, evidence-based techniques for de-escalation, and injury severity reduction. Mentorship programs have been shown to improve the mentees' communication, raise self-confidence, and increase job satisfaction which retains new nurses to the profession (Gularte-Rinaldo, et al., 2023). Many healthcare organizations and nursing associations like ANA offer their own nurse mentorship programs. To achieve safe patient outcomes, nurses must collaborate effectively with one another (ANA, 2015). Another recommendation is that new graduates receive WPV prevention education prior to transitioning to practice. The content taught can include techniques on how to recognize and address WPV, bullying, and harassment.

The environment in which nurses provide quality patient care depends on the organization's commitment to safety. Maintaining a culture of safety includes assessing and reducing environmental risks. There are nationally developed recommended guidelines for all healthcare organizations to adopt environmental risk reduction. First, conduct an annual safety and security risk assessment, analysis, and implement strategies to mitigate any risks (TJC, 2021). Second, implement a patient risk assessment and enforce strategies that are tailored to the setting (Tritz & Wright, 2022). These guidelines have led to organizations implementing various safety elements. WNA recommends that facilities review and adopt the comprehensive list of factors in *OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (OSHA, 2016).

> "Now I am not sure compassionate nurses exist. They are unicorns." -A Wisconsin Nurse

III. Organizational Recommendations

Healthcare organizations that are invested in preventing WPV have created and maintained a formal workplace violence prevention program that has an effective WPV committee which includes clinical nurse representation. The committee's responsibilities should start with an evaluation of their current WPV program using evidenced-based evaluation tools. Refer to Table 3. The committee will review collected and analyzed data, identify if there are gaps, opportunities for improvements, and assess the impact of proposed program change. There will be different priorities for each organization depending on the types of WPV that are most prevalent based on information gleaned from a completed comprehensive risk assessment. The Hospital Association of Oregon has an all-encompassing workplace violence toolkit and section three outlines risk assessment tools (Hospital Association of Oregon, 2020). Oregon is one of eight states that require a statewide WPV program.

There is no current standardization on the WPV definition across healthcare facilities. Beliefs and barriers on the definition and meaning of WPV vary across organizations and nursing cultures. These inconsistencies within and between organizations in defining WPV result in incongruent action to address and revise WPV policies. It is essential to review policies and procedures for gaps and ease-of-use to ensure healthcare organizations are providing proper guidance on workplace violence. When the WPV Committee is reviewing policies, they should support and recommend a zero-tolerance policy of violence that exists in the Patient Bill of Right as well as the Employee Handbook (OSHA, 2016). A visible no tolerance for violence sign is also imperative to have in waiting areas to indicate to patients, families, and visitors that aggressive behaviors have potentially negative repercussions (OSHA, 2016).

WNA recommends that healthcare organizations expand the use of violence risk assessment tools outside of behavioral health settings to predict and prevent violent behaviors from escalating. Patients that struggle with mental health disorders are in all healthcare settings and adoption of evidence-based violence risk assessment tools can be beneficial in all healthcare settings. Such tools include:

- Staring, Tone and volume of voice, Anxiety, Mumbling, and Pacing (STAMP) is a validated tool for use in the ED (Luck, et al., 2007).
- Overt Aggression Scale (OAS) is a reliable tool for use in the inpatient setting for children and adults (Coccaro, 2020).
- Broset Violence Checklist (BVC) is a validated tool for use in the adult inpatient psychiatric unit (Frenzs, n.d.).

When nurses encounter patients that are scoring high on any of these scales, it is essential to have resources available to assist with the situation. Behavioral emergency response teams (BERT) are a commonly used resource for when patients are becoming aggressive (Pestka, et al., 2012). The organization can decide on the individuals involved on the team and provide

them with additional training on de-escalation and verbal intervention techniques. This team can be called on during an incident, round on patients that have known aggression, or be an additional resource for nurses that need help navigating a tough situation (Hendrickson, 2022). An article on a BERT program, referenced in Table 3, is about a hospital in Minnesota that goes through how they created their BERT program with successes and challenges (Pestka, et al., 2012).

The American Society for Healthcare Risk Management has an evaluation tool to review WPV incidents that includes resources for staff and next steps to take post incident (American Society for Healthcare Risk Management, n.d.). A WPV committee representative can follow-up with the nurse, follow-up with the unit, identify education and training gaps, implement activities for improvement, and evaluate effectiveness of the chosen intervention.

Training for nurses and providers is an essential part of de-escalating situations that have the potential to become WPV incidents. The National Institute for Occupational Safety and Health (NIOSH) created a workplace violence training program that has essential skills for nurses.

- Identify institutional, environmental, and policy risk factors for workplace violence.
- Recognize behavioral warning signs of violence in individuals.
- Define communication skills used to prevent and manage workplace violence.
- Examine appropriate resources/strategies to support injured healthcare professionals.
- Recognize at least three key elements of a comprehensive workplace violence prevention program.
- Identify effective team skills by sharing information effectively, listening and responding to feedback from others, and using simple communication (National Institute for Occupational Safety and Health, 2013).

Training for nurse managers should focus on effective and empathetic communication with nurses that are going through this challenging time in the workplace. Those in a leadership role should be using effective communication skills with active listening, making others comfortable by welcoming difficult conversations, reading the room to know when to hold back information, and being respectful to gain trust of nurses (Mahoney, 2023). Table 3 provides a listing of topics, tools, and resources that WPV committees can refer to when evaluating their WPV prevention program.

Table 3: Checklist to Evaluate Workplace Violence Prevention Programs	
Topics	**Tools & Resources**
1. Develop a well-defined definition of WPV.	• Workplace Violence Definition (TJC, 2021).
2. Update WPV policies that respond to actual or potential incidents and are patient and nurse centered.	• Workplace Violence Prevention Toolkit-Section 4 (Hospital Association of Oregon, 2020). • Policy Position Statement (American College of Healthcare Executives, 2023).
3. Visible signage for zero tolerance of violence against healthcare workers.	• OSHA & Worker Safety: Guidelines for Zero Tolerance (TJC, 2015).
4. Inclusion of zero tolerance of violence in Patient Bill of Rights and Employee Handbook.	• Zero Tolerance Policy (Suffolk Mental Health Partnership NHS Trust, 2011).
5. Improve environmental safety based on risk assessment results.	• Workplace Violence Toolkit – Section 3 (Hospital Association of Oregon, 2020).
6. Implement an evidenced-based violence risk assessment tool that can predict and prevent violent behaviors.	• STAMP (Luck, 2007). • OAS-M (Coccaro, 2020). • BVC (Frenzs, n.d.).
7. Development of a behavioral emergency response team (BERT).	• Enhancing Safety in Behavioral Emergency Situations (Pestka, et al., 2012).
8. Utilize an incident reporting system that provides data reports including incident trends, root cause analysis to identify gaps, and other steps needed. Have a WPV committee representative follow-up with the nurse, follow-up with the unit, identify education and training gaps, implement activities for improvement, and evaluate effectiveness of the chosen intervention.	• Workplace Violence Toolkit (American Society for Healthcare Risk Management, n.d.).
9. Provide evidence-based training and resources for nurses and providers.	• WPV Prevention Course for Nurses (National Institute for Occupational Safety and Health, 2013).
10. Provide leadership training and resources that focus on effective communication.	• Conflict Resolution Playbook (Pollack, 2020). • Communication Tips for Nurse Leaders (Mahoney, 2023). • Fast Facts on Combating Nurse Bullying, Incivility and WPV (Ciocco, 2017).

IV. Community and Key Stakeholder Engagement Recommendations

Preventing and addressing incidents of workplace violence against a nurse needs engagement and support from a variety of communities and key stakeholders. The extent of engagement, response and support involves not only the health care organization but external governmental agencies and other organizations. There are a variety of key stakeholders that are engaged in addressing workplace violence against nurses. Below is a listing of key stakeholders in workplace violence prevention and response.

I. Internal Stakeholders

- Healthcare organizations – System leadership, board of directors, managerial and security staff nurse councils, risk management, and quality improvement. Develop and enforce WPV prevention through education/training, risk assessment, analyzing and reporting incidents, strategies for improvement.
- Healthcare settings where incidents are most common – hospitals, clinics, long-term care, home health agencies and psychiatric-mental health.
- Patients and clients – behavioral expectation and awareness of consequences of WPV against a nurse.
- Family members and visitors – awareness of the behavioral expectations and consequences.

II. External Stakeholders

- Law enforcement – training, responding, and investigating WPV incidents.
- Legal advisors and prosecutors – pursue criminal charges or other remedies.
- Professional associations – provide education on WPV prevention and safety.
- Nursing associations – ANA and the WNA advocate for safer working conditions and provide resources for violence prevention.
- Regulatory and accrediting bodies – develop, investigate, and enforce standards.
- Government and legislators – develop and enact laws that protect nurses from violence.
- Community and patient advocacy groups – support nurses' safety through patient awareness education.
- Mental health professionals – support nurses exposed to workplace violence and provide timely assistance.
- Nursing education and training programs – curricula on workplace violence prevention and continuing education providers.
- Patients' rights and ethics committees – evaluate incidents of nurses experiencing workplace violence and provide ethical advice to healthcare leadership.

- Insurance companies – involvement in investigating incidents of workplace violence, offer guidance in reduction, and offer premium discount for those facilities who have implemented an evidence-based WPV Prevention Program.
- General public – awareness of the impact of workplace violence against nurses and how to prevent it.

WNA recommends healthcare organizations engage these stakeholders in their community to address WPV prevention.

V. Federal and State Policy Recommendations

Incidents of WPV continue to occur throughout Wisconsin and the nation. Legislative proposals have been introduced at the federal level, however, there does not seem to be an appetite for passage or implementation. WNA supports the passing of the federal legislation "Workplace Violence Prevention for Health Care and Social Service Workers Act" (U.S. Senate, 2023). The passage of this bill would ensure that healthcare workers are knowledgeable and have the resources to protect themselves, co-workers, and patients on the job. More importantly, this bill would require OSHA to develop and enforce specific standards for healthcare employers, holding them accountable for protecting their employees against WPV.

WNA supports OSHA in developing and enforcing the standards on *Prevention of Workplace Violence in Healthcare and Social Assistance* (OSHA, 2016). The current guidelines are not legally binding, but OSHA has the capacity to change how these guidelines are enforced. In May 2023, OSHA begun its rulemaking process on the proposed standards beginning with a Small Business Advocacy Review Panel which created recommendations for further action (OSHA, 2023). OSHA needs to implement their new standards without delay as they are the federal agency charged with protecting health care professionals from WPV. For more information go to: ANA Letter to OSHA on Workplace Violence Prevention (ANA, 2024b).

WNA supports Wisconsin policymakers in creating state legislation or regulation for all licensed health care facilities to adopt WPV prevention programs with standards from OSHA, TJC, and CMS as applicable. Neighboring states Minnesota and Illinois have adopted their own WPV prevention strategies with state legislation (Healthcare Violence Prevention Act, 2018; Violence Against Health Care Workers, 2024).

Minimally, Wisconsin health care facilities shall adopt a formal WPV prevention program that will:

- **Define:** Adopt the following definition of workplace violence: *An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors* (TJC, 2022).
- **Zero tolerance:** Revise the Patient Bill of Rights and Employee Handbook to include a statement on zero tolerance for threatening or harming a nurse.
- **Visible signage:** Provide visible signage for zero tolerance of violence against healthcare workers that is located throughout the facility.
- **Educate:** Provide education and training on how to recognize, prevent and respond to workplace violence, and how to report and seek assistance for any incidents.
- **Report:** Expect reporting of all incidents that will be reviewed and analyzed for trends, and effective response.
- **Assess:** Conduct periodic assessments of the workplace violence program, including assessment of the physical environment, to determine its effectiveness and make any necessary changes or improvements.
- **Inclusion:** Consult with employees and their representatives on the development and implementation of the workplace violence prevention plan and ensure their participation and feedback through the development of an effective WPV prevention Committee.
- **Resources:** Provide medical and mental health resources to all parties in the WPV incident, provide debriefing resources, and access to filing a report with law enforcement.

National health care organizations and groups are in opposition to supporting effective WPV legislation and regulation, citing the financial burden of implementation. These organizations believe that they have provided best-practice assessment and response resources for WPV prevention. Although, nurses at these organizations are still experiencing WPV incidents at an alarming rate that require additional costs of taking leave of absence, workers compensation, and replacing nurses that leave the organization. The lack of enforcement through Congressional action remains a safety issue for those nurses providing care 24 hours a day, 365 days a year.

CONCLUSION

The 2023 WNA Workplace Violence Survey provided data on reasons nurses are not reporting WPV, the common types of violence taking place in health care settings, the impact on patient care, and the wellbeing of nurses. It is essential that nurse leaders, organizations, and policy makers support change in the WPV culture by implementing organizational change and policy revisions.

It is important that nurses report incidents to support a more comprehensive organizational approach to preventing WPV. Nurses can positively impact WPV by participating in WPV committees, changing nursing practice, and attending trainings. It is best practice for nurses to assist each other in handing violent patient behaviors and participate in mentor programs to improve communication skills. Organizations shall commit to supporting safe working conditions by evaluating the environment for risks and applying appropriate interventions.

The cost and benefits associated with implementation of a WPV prevention program will outweigh the current costs paid for workers compensation, missed days of work due to injuries, and staff turnover due to continued incidents of WPV. Internal and external stakeholder support for the development and implementation of WPV prevention programs will have a positive impact on reducing the incidents of WPV.

The federal bill, *Prevention of Workplace Violence in Healthcare and Social Assistance Act* (U.S. Senate, 2023) needs to be enacted to enforce WPV prevention program standards across the United States. Wisconsin cannot wait for the federal legislation to have an effective response on WPV throughout healthcare facilities. WNA supports Wisconsin policy makers in addressing state legislation or regulation for all licensed health care facilities to adopt WPV prevention programs. Surrounding state legislatures in Illinois and Minnesota have already adopted statewide WPV prevention programs.

WNA'S CALL TO ACTION

I. Education

- Inform all nurses about WNA's Workforce Advocacy Council recorded webinar from November 14, 2024. *The Landscape of Wisconsin's Workplace Violence Towards Nurses: Education, Practice, and Policy*. The webinar provides a summary of the key elements of this report.
- Share the report with legislative bodies, governmental agencies, schools of nursing, WNA members, associations, and nurse leaders.
- Promote use of evidence based WPV prevention education tools including de-escalation and verbal intervention skills.
- Encourage health care organizations with WPV committees to annually review policies and procedures for best practice on WPV prevention.
- Work with WNA's Nursing Practice, Education and Research Council to develop a WPV toolkit for nursing school faculty.

II. Practice

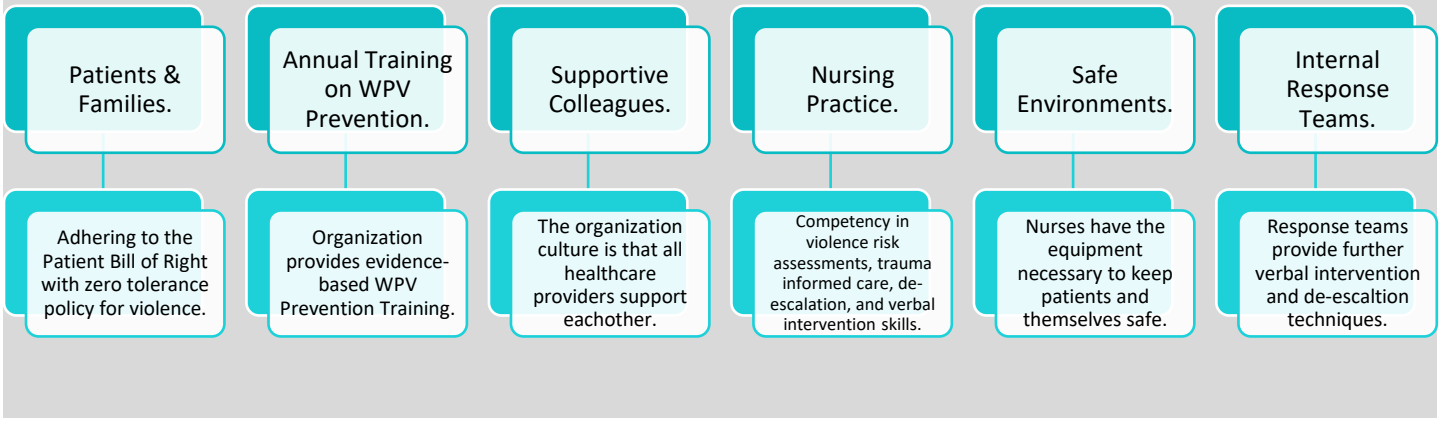
- Empower nurses to report WPV incidents, review post incident events, and support colleagues to give them time to debrief.
- Advocate for research on innovative technology, Ambient AI, to detect and inform the nurse of escalating behaviors to implement strategies for effective response.
- Bullying, harassment, intimidation, and other inappropriate behaviors by nurses and other healthcare staff are apparent across all workplace settings. WNA's Workforce Advocacy Council will review the literature and evidence-based practices to develop a strategy and guidelines on how to address these behaviors.
- Request that the Wisconsin Center for Nursing and the Department of Workforce Development develop questions for the RN & LPN Nursing Workforce Surveys on workplace violence.
- WNA's Nurses Caring for Nurses Task Force will review and identify support resources related to the physical and emotional impact of WPV.

III. Policy

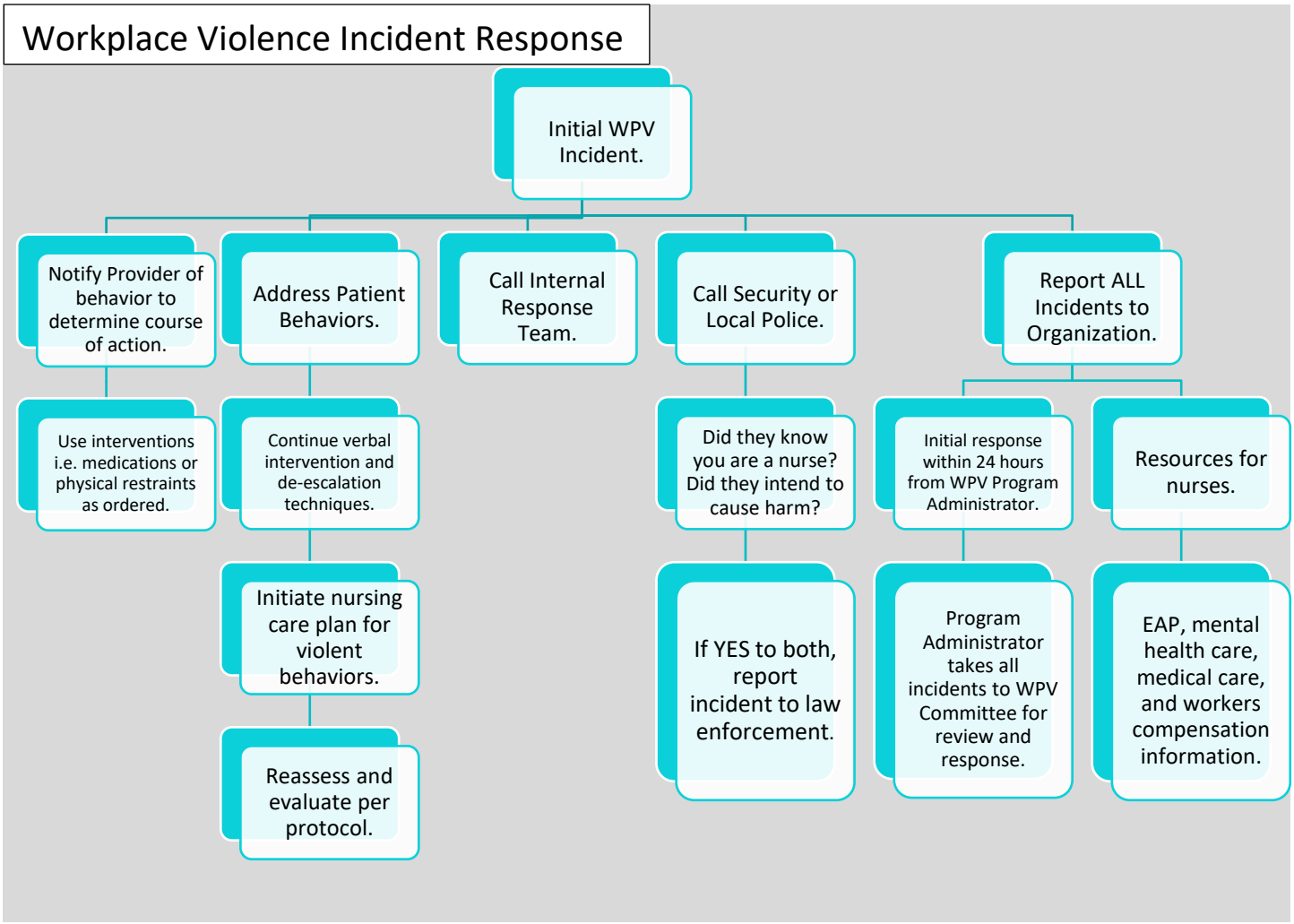
- Advocate for all licensed healthcare facilities to implement standards for WPV prevention programs.
- Advocate for policy that requires nurses providing direct care to be included in the facilities WPV prevention committee that reviews policies, reports, data analysis, and provides recommendations for risk reduction.
- Advocate for Wisconsin state policy change surrounding WPV toward nurses.

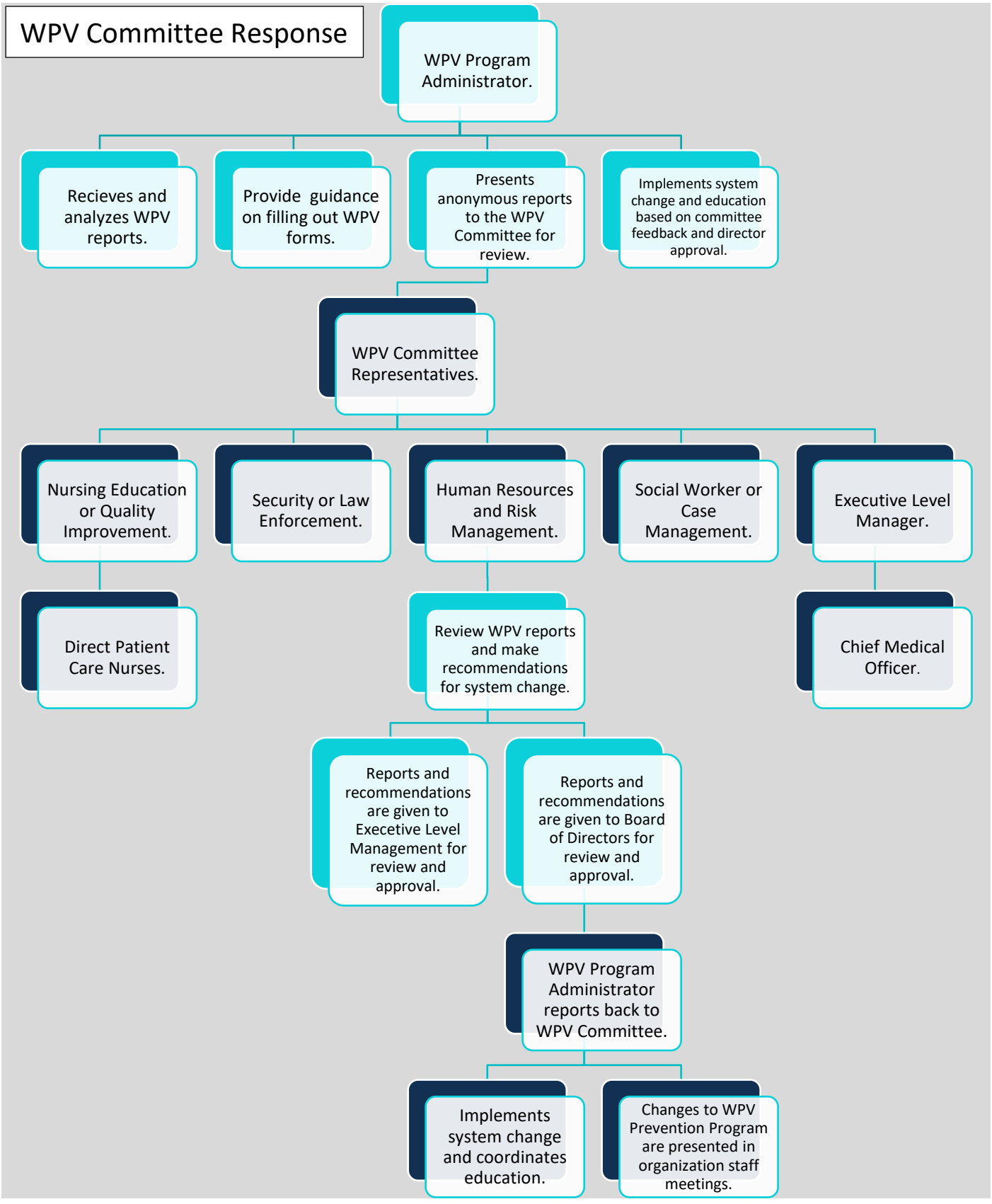
Conceptual Model: Process for Addressing WPV Incidents from Patients in Hospitals, Ambulatory Care, & Extended Care

Protective Factors for Avoiding WPV Incidents



Workplace Violence Incident Response




WPV Committee Response
WPV Program Administrator.
Recieves and analyzes WPV reports.
Provide guidance on filling out WPV forms.
Presents anonymous reports to the WPV Committee for review.
Implements system change and education based on committee feedback and director approval.
WPV Committee Representatives.
Nursing Education or Quality Improvement.
Security or Law Enforcement.
Human Resources and Risk Management.
Social Worker or Case Management.
Executive Level Manager.
Direct Patient Care Nurses.
Review WPV reports and make recommendations for system change.
Chief Medical Officer.
Reports and recommendations are given to Execetive Level Management for review and approval.
Reports and recommendations are given to Board of Directors for review and approval.
WPV Program Administrator reports back to WPV Committee.
Implements system change and coordinates education.
Changes to WPV Prevention Program are presented in organization staff meetings.

REFERENCES

American College of Healthcare Executives. (2023, November). *Healthcare executives' role in mitigating workplace violence.* https://www.ache.org/about-ache/our-story/our-commitments/policy-statements/healthcare-executives-role-in-mitigating-workplace-violence

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

American Nurses Association. (2021, March). *Workplace violence.* https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/

American Nurses Association. (2024a, April 1). *ANA doubles down on advocacy work during workplace violence prevention awareness month.* https://www.nursingworld.org/news/news-releases/2024/ana-doubles-down-on-advocacy-work-during-workplace-violence-prevention-awareness-month/

American Nurses Association et. al. (2024b, April 1). *Workplace violence prevention for health care and social assistance standard* [Letter to OSHA]. https://www.nursingworld.org/globalassets/docs/ana/comment-letters/workplace-violence-standard-sign-on-4.1.24.pdf

American Nurses Association. (n.d.). *Protect yourselves, protect your patients.* https://www.nursingworld.org/practice-policy/work-environment/end-nurse-abuse/

American Society for Healthcare Risk Management. (n.d.). *Workplace violence toolkit.* https://www.ashrm.org/sites/default/files/ashrm/Workplace-Violence-Tool.pdf

Battery or Threat to a Health Care Provider or Staff Member. (2022, March 24). *2021 Wisconsin Act 209.* https://docs.legis.wisconsin.gov/2021/related/acts/209

Battery to a Nurse. (2020, February 6). *2019 Wisconsin Act 97; Statute 940.20*. https://docs.legis.wisconsin.gov/2019/related/acts/97

Centers for Medicare & Medicaid Services. (2024, September 9) *Quality, safety & oversight – regulations, certification & compliance*. https://www.cms.gov/medicare/health-safety-standards/certification-compliance

Ciocco, M. C. (2017). *Fast facts on combating nurse bullying, incivility, and workplace violence: What nurses need to know in a nutshell.* https://www.google.com/books/edition/Fast_Facts_on_Combating_Nurse_Bullying_I/B1LAAQAACAAJ?hl=en

Coccaro, E. F. (2020). The overt aggression scale modified (OAS-M) for clinical trials targeting impulsive aggression and intermittent explosive disorder: Validity, reliability, and correlates. *Journal of Psychiatric Research, 124*, 50-57, https://doi.org/10.1016/j.jpsychires.2020.01.007

Department of Workforce Development. (n.d.) *Retaliation protection for health care workers in Wisconsin.* https://dwd.wi.gov/eworkboard/health-protection/

Doran, M. (2022). Employee Assistance Programs: A misunderstood and underused resource for nurses. *JONA: The Journal of Nursing Administration, 52*(11), 625-627. https://doi.org/10.1097/NNA.0000000000001200

Fleishman, J., Kamsky, H., & Sundborg, S. (2019, May 31). Trauma-informed nursing practice. *OJIN: The Online Journal of Issues in Nursing, 24*(2), Manuscript 3. https://doi.org/10.3912/OJIN.Vol24No02Man03

Frenzs. (n.d.). *Brøset Violence Checklist*. https://www.frenzs.org/files/downloads/bvc-paperversion-frenzs-v2.pdf

Gularte-Rinaldo, J., Baumgardner, R., Tilton, T., & Brailoff, V. (2023). Mentorship ReSPeCT study: A nurse mentorship program's impact on transition to practice and decision to remain in nursing for newly graduated nurses. *Nurse leader, 21*(2), 262–267. https://doi.org/10.1016/j.mnl.2022.07.003

Health Care Violence Prevention Act. (2018, August 24). *State of Illinois Public Act 00-1051*. https://www.ilga.gov/legislation/100/HB/PDF/10000HB4100enr.pdf

Hendrickson, S. W. (2022). Changing attitudes about workplace violence: Improving safety in an acute care environment. *Journal of Healthcare Risk Management, 42*(2), 39-43. https://doi.org/10.1002/jhrm.21524

Hospital Association of Oregon. (2020, March). *Workplace safety initiative.* https://oregonhospitals.org/safety/

Laschinger, H. K. S. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *JONA: The Journal of Nursing Administration, 44*(5), 284-290. https://doi.org/10.1097/NNA.0000000000000068

Loughlin, B., Marnocha, S., Boyd, H., Jascor, M., & Dennik-Champion, G. (2021, December). *Report of the survey results: Verbal abuse toward nurses by patients/clients, families and visitors.* [Unpublished Report]. https://www.wisconsinnurses.org/workplace-violence-toward-nurses/

Luck, L., Jackson, D., & Usher, K. (2007). *STAMP: Components of observable behaviour that indicate potential for patient violence in emergency departments*. *JAN: Journal of Advanced Nursing, 59*(1), 11-19. https://doi.org/10.1111/j.1365-2648.2007.04308.x

Mahoney, J. (2023). Communication tips for nurse leaders. *American Nurse Journal, 18*(10), 22-24. https://doi.org/10.51256/ANJ102322

Morris, G. (2024, March 26). *Mental health resources for nurses.* https://nursejournal.org/resources/nurse-mental-health-resources/

National Institute for Occupational Safety and Health. (2013). Online workplace violence prevention course for nurses. DHHS (NIOSH) Publication Number 2013-155. https://www.cdc.gov/niosh/docs/2013-155/default.html

National Lieutenant Governors Association. (2024, April 24). *NLGA consensus resolution on workplace violence prevention in health care* [Resolution]. https://nlga.us/wp-content/uploads/NLGA-Consensus-Resolution-On-Workplace-Violence-Prevention-in-Health-Care-2.pdf

Nursing Solutions, Inc. (2024). *2024 NSI national health care retention & RN staffing report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

O'Brien, C. J., van Zundert, A. A. J., & Barach, P. R. (2024). The growing burden of workplace violence against healthcare workers: Trends in prevalence, risk factors, consequences, and prevention – A narrative review. EClinicalMedicine, 72, 102641. https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(24)00220-7/fulltext

Occupational Safety and Health Administration. (2016). *Guidelines for preventing workplace violence for healthcare and social service workers.* https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Occupational Safety and Health Administration. (2023, May 1). *Report of the small business advocacy review pane on OSHA's potential standard for prevention of workplace violence in healthcare and social assistance.* https://www.osha.gov/sites/default/files/OSHA-WPV-SBAR-Panel-Report.pdf

Pestka, E. L, Hatteberg, D. A., Larson, L. A., Zwygart, A. M., Cox, D. L., & Borgen, E. E. J. (2012). Enhancing safety in behavioral emergency situations. *MedSurg Nursing, 21*(6), 335-341. https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/docs/enhancingsafetybehavemergsituations.pdf

Pollack, J. (2020). *Conflict resolution playbook: Practical communication skills for preventing, managing, and resolving conflict.* https://www.google.com/books/edition/Conflict_Resolution_Playbook/bV0XEQAAQBAJ?hl=en&gbpv=0&kptab=overview

Press Ganey. (2022, September). *On average, two nurses are assaulted every hour, new Press Ganey analysis finds.* https://www.pressganey.com/news/on-average-two-nurses-are-assaulted-every-hour-new-press-ganey-analysis-finds/

Somani, R., Muntaner, C., Hillan, E., Velonis, A. J., & Smith, P. (2021). A systematic review: Effectiveness of interventions to de-escalate workplace violence against nurses in

healthcare settings. *Safety and Health at Work, 12*(3), 289–295. https://doi.org/10.1016/j.shaw.2021.04.004

Suffolk Mental Health Partnership NHS Trust. (2011, January). *Zero tolerance policy*. https://www.web.health.state.mn.us/facilities/patientsafety/preventionofviolence/docs/zerotolerancepolicy.pdf

The Joint Commission. (2015, August). OSHA & worker safety: Guidelines for zero tolerance. *Environment of Care News, 18*(8), 8-11. https://www.jointcommission.org/-/media/jcr/jcr-documents/about-jcr/osha-alliance/august_2015pdf.pdf

The Joint Commission. (2021, June 18). *R3 report issue 30: Workplace violence prevention standards.* https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/

The Joint Commission. (2024). *Find accredited organizations.* https://www.jointcommission.org/who-we-are/who-we-work-with/find-accredited-organizations/#first=100&numberOfResults=50&f:State=[Wisconsin]

Tritz, K. L., & Wright, D. R. (2022, November 28). Workplace violence – hospitals [Memorandum]. https://www.cms.gov/files/document/qso-23-04-hospitals.pdf

U. S. Bureau of Labor Statistics. (2024, October 8). *Workplace violence 2021 – 2022 factsheet.* https://www.bls.gov/iif/factsheets/workplace-violence-2021-2022.htm

U. S. House. 118th Congress. (2023, April 18). *H.R.2663, Workplace violence prevention for health care and social service workers act.* https://www.congress.gov/bill/118th-congress/house-bill/2663

U. S. Senate. 118th Congress. (2023, April 18). *S. 1176, Workplace violence prevention for health care and social service workers act.* https://www.congress.gov/bill/118th-congress/senate-bill/1176

Van Den Bos, J., Creten, N., Davenport, S., & Roberts, M. (2017, July 26). *Cost of community violence to hospitals and health systems*. [Milliman Research Report]. https://www.aha.org/system/files/2018-01/community-violence-report.pdf

Violence Against Health Care Workers. (2024). *Minnesota Statute Chapter 144.566.* https://www.revisor.mn.gov/statutes/cite/144.566

Wisconsin Nurses Association. (2019, February). *Workplace violence: It's not part of the job!* [Webinar PowerPoint]. https://www.wisconsinnurses.org/workplace-violence-toward-nurses/

Zahner S. J., Pinekenstein, B., Merss, K., LeClair, J., Alnuaimi, N. & Krainak, K. (2023, June). *The Wisconsin 2022 RN survey report.* https://wicenterfornursing.org/wp-content/uploads/2023/07/2022-RN-Report.pdf