Prevention and Surveillance of Violence against Minnesota Healthcare Workers

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I. INTRODUCTION

In 2014, a small hospital in Maplewood, Minnesota made headlines. The country watched as a patient, sixty-eight-year-old Vietnam veteran, Charles Elliot Logan, took a metal pole to staff sitting at the nursing station. In a video released by the Maplewood Police Department, the patient is seen beating staff members with the metal object as they frantically tried to escape. Logan, admitted

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for “altered mental status,” was experiencing paranoia, and was known to nursing staff to be confused and delirious.4 Two nurses received injuries, including a collapsed lung and a fractured wrist. Logan died shortly after the incident while in police custody.5,6

Five years later, a similar story overtook hospital break rooms everywhere. In the spring of 2019, Jessie Guillory, a patient at Baton Rouge General Hospital, incited an altercation with a staff member at a nurse’s station.7 He then charged at a nurse, pinning her in a corner as he swung at her.8 A second nurse, Lynne Truxillo, intervened, pulling Guillory away from her co-worker.9 Turning his attention to Truxillo, he grabbed her by the neck, driving her head into a desk.10 In her attempt to escape from Guillory, Truxillo suffered injuries to her leg.11 After sustaining injuries, Truxillo finished her shift with abrasions to the back of her neck and a torn ligament in her knee.12 In a tragic ending, Truxillo died a few days later from bilateral pulmonary thromboembolisms as a result of blood clots forming in her leg due to her traumatic knee injury. Guillory was arrested and charged with manslaughter.13

The stories mentioned above are, of course, extreme examples of aggression and violence against nurses and other hospital staff. More commonly, healthcare staff are yelled at, threatened, bitten, urinated on, or struck by patients or visitors.14 A 2014 study found that 54% of nurses surveyed had experienced verbal violence by a patient in the past year, and 30% had experienced physical violence.15 When asked to think back over their careers, only 22% of surveyed nurses, 66% of whom had over ten years of experience, had not experienced physical violence while working as a nurse.16

4. Feshir, supra note 1.
5. NBC NEWS, supra note 3.
8. Id.
9. Id.
10. Id.
11. Id.
12. Id.
13. Id.
15. This study surveyed 762 nurses working in U.S. hospitals in both emergency departments and other inpatient settings. Speroni et al., supra note 14.
16. Id. at 220.
Over a quarter of nurses surveyed had experienced physical violence more than ten times.\textsuperscript{17}

After the incident in Maplewood, the conversation surrounding violence against healthcare workers in Minnesota surged. As a result, the Minnesota Nursing Association (MNA) increased efforts to pass state legislation aimed at preventing violence against healthcare workers and minimizing the impact when violent events occur.\textsuperscript{18} In 2015, the Violence Against Healthcare Workers Act was passed. This legislation is a foundation for reducing the current state of violence against healthcare workers. However, changes to enforcement and more comprehensive language are required to make a lasting and significant impact.

This paper focuses on the frequency of violence against healthcare workers, the public policy and administrative systems that impact violence against healthcare workers, and how these mechanisms can be improved to better protect Minnesota’s healthcare workers and patients. Part I of the article provides a preliminary overview of the current data regarding violence against healthcare workers in the U.S. and the impact this violence has on workers and the industry. In Part II, current policies for violence against healthcare workers and mechanisms for holding facilities accountable in Minnesota are discussed, establishing the framework for Part III, which argues what changes must happen in order to ensure the protection of healthcare workers statewide. The conclusion offers final thoughts on policy surrounding violence against healthcare workers generally.

\section{II. Part I: Background}

The National Institute for Occupational Safety and Health defines workplace violence as violent acts against persons working or on duty.\textsuperscript{19} To most accurately discuss this issue, workplace violence should be framed as a continuum encompassing a range of non-verbal, verbal, and physical behaviors that cause harm or threaten to harm people or, in general, cause fear and anxiety.\textsuperscript{20} The

\begin{itemize}
\item \textsuperscript{17} Id. (stating “for physical violence, 21.9\% experienced no incidents, and 50.8\% experienced 1 to 10 incidents (10\% had 11-20 incidents; 5.9\% had 21-30 incidents; 2.2\% had 31-40 incidents; 1.8\% had 41-50 incidents; and 7.3\% had more than incidents”).
\item \textsuperscript{18} Mathew Keller, \textit{Proposal Protects Healthcare Workers from Workplace Violence}, \textit{Minn. Nurses Ass’n} (Oct. 11, 2019, 8:34 PM), https://mnnurses.org/proposal-protects-healthcare-workers-from-workplace-violence/.
\item \textsuperscript{19} CENTERS FOR DISEASE CONTROL AND PREVENTION, OCCUPATIONAL HAZARDS IN HOSPITALS: VIOLENCE 1 (2002).
\item \textsuperscript{20} Joanne DeSanto Iennaco et al., \textit{Measurement and Monitoring of Health Care Worker Aggression Exposure}, 18 \textit{Online J. Issues Nursing} (2013),
\end{itemize}
continuum includes non-physical events, such as threatening or yelling, physical violence, such as hitting, biting, or urinating, to assaults leading to death. Researchers have identified two distinct types of violence: affective violence and predatory violence. Affective violence is violence caused by an involuntary physical response due to anger or fear. The aggressiveness that the patient demonstrates comes from a perceived threat that may stem from the patient's condition requiring healthcare in the first place. Attacks falling into this category are much more likely to go unreported, and may not even be perceived by the worker to be an assault, despite resulting in injuries. The second category of violence, predatory violence, is “premeditated behavior intended to cause injury” and is “cognitively planned without autonomous arousal and characterized by the absence of emotion or threat.”

For years, nurses and other researchers have been investigating the prevalence and characteristics regarding violence against healthcare workers. In a paper published in 1999, researchers studied the number of assaultive incidents occurring at 166 Veteran Affairs (VA) facilities in the 1991 fiscal year with nearly 25,000 incidents discovered. Five years later, the Minnesota Nurses Study was published, measuring the magnitude and consequences of


21. See DeSanto Iennaco et al., supra note 20, at *2; CTRS. FOR DISEASE CONTROL AND PREVENTION, OCCUPATIONAL HAZARDS IN HOSPITALS: VIOLENCE 1 (2002).
23. Id.
24. Id.
25. Id.
26. Id.
28. Lehmann et al., supra note 27, at 385. This study was limited to events that were reported to the administration and there was evidence that many facilities did not keep track of incidents reported. Id.
violence experienced by Minnesota healthcare workers.\textsuperscript{29} That same year, the Centers for Disease Control and Prevention released a report on violence in healthcare as part of a series on occupational hazards.\textsuperscript{30} Ever since, a steady stream of research has supported the need for stronger prevention efforts, protections, and interventions for violence against healthcare workers.\textsuperscript{31}

Despite mounting evidence that demonstrates the need for intervention, the prevalence of violence against healthcare workers remains high.\textsuperscript{32} When nurses working in hospitals were asked about workplace violence of any type in the last year, 76\% of nurses stated they had experienced at least one event involving a patient or a patient’s visitor.\textsuperscript{33} For nurses working in emergency departments, that number increases substantially to 97\% of nurses reporting at least one violent encounter with a patient or patient visitor within the last year.\textsuperscript{34} However, nurses and hospitals are not the only targets of this violence. A 2010 study of approximately 2,900 nursing assistants\textsuperscript{35} working in long-term care facilities found that 34\% had sustained a physical injury from an assault by a resident they were caring for.\textsuperscript{36} Compared to other sectors, the prevalence of violence against healthcare workers is higher.\textsuperscript{37} According to the Occupational Safety and Health Administration (OSHA), serious workplace violence, defined as events that require days off from work, is four times more common in healthcare than in private industries.\textsuperscript{38} Of the approximate 25,000 workplace physical assaults that are reported to OSHA each year, approximately 70\% of them

\begin{footnotesize}
\begin{enumerate}
\item See generally, Violence: Occupational Hazards in Hospitals, Ctrs. for Disease Control and Prevention, supra, note 19.
\item See DeSanto Iennaco et al., supra note 20; OCCUPATIONAL SAFETY AND HEALTH ADMIN., GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOCIAL SERVICE WORKERS (2016).
\item See generally Speroni et al., supra note 14.
\item Id. at 227.
\item Id. at 221.
\item The term “nursing assistants” here means a nursing assistant certified (CNA) by their state. Tak, supra note 14, at 1938. The traditional role of nursing assists is to assist patients with activities of daily living and other health care needs, and are supervised by a nurse. Certified Nursing Assistant Guide, NURSE.ORG, https://nurse.org/resources/certified-nursing-assistant-cna/ (last visited Apr. 11, 2020).
\item Id. This figure excludes physical assaults that did not result in an injury and incidents of verbal violence or aggression. Id.
\item OCCUPATIONAL SAFETY AND HEALTH ADMIN., supra note 31, at 2.
\item OCCUPATIONAL SAFETY AND HEALTH ADMIN., WORKPLACE VIOLENCE IN HEALTHCARE: UNDERSTANDING THE CHALLENGE 1 (2015).
\end{enumerate}
\end{footnotesize}
occur in healthcare settings. Further, compared to private industry at 3%, injuries from serious workplace violence comprise approximately 10% of total serious injuries.

Defining non-physical behaviors can prove particularly difficult as they can contain both objective and subjective components and can depend on the workplace culture. With that in mind, the most common type of violence against healthcare workers is verbal assaults from patients, with 54% of nurses reporting an incident in the last year. Verbal assaults from patient visitors, physical assaults from patients, and physical assaults from patient visitors were reported at 33%, 30%, and 3.5%, respectively. Healthcare workers report a wide range of physically violent acts that they are experiencing. To name a few, 27% of nurses were kicked in the last year, 38% were grabbed, 15% were spat on, 12% punched, 11% slapped, and 3% had been urinated on. Twelve percent of nursing assistants surveyed reported sustaining a physical injury from a patient biting them.

Violence against healthcare workers occurs in all corners of healthcare: from pre-hospital care and emergency services personnel, throughout hospitals, to ambulatory care clinics, long-term care facilities, and in-home health care services. However, a few areas are at a higher risk for violence than others. OSHA identifies acute psychiatric facilities, long-term care facilities with geriatric patients, and high-volume urban emergency departments as areas that are more likely to experience higher rates of violence. OSHA also identifies an increased risk of violence when transporting patients or when working with patients alone. Design flaws, such as poorly lit hallways and rooms, reduced ability to visualize patient care areas, and poor ability to escape when a patient

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39. OCCUPATIONAL SAFETY AND HEALTH ADMIN., supra note 31, at 2 (stating “[b]etween 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings.”).

40. Id. (stating “[f]or healthcare workers, assaults comprise 10-11% of workplace injuries involving days away from work, as compared to 3% of injuries of all private sector employees.”).

41. CRITICAL INCIDENT RESPONSE GROUP, supra note 20, at 24.

42. Speroni et al., supra note 14, at 22.

43. Id.

44. See generally Speroni et al., supra note 14.

45. Id. at 220. The 4% of nurses that had been urinated on refers to urinating purposefully as an act of violence, and not coming in contact with urine in the general course of caring for patients.

46. Tak, supra note 14, at 1941.


48. OCCUPATIONAL SAFETY AND HEALTH ADMIN., supra note 31, at 3-4.

49. Id.
or family member becomes violent, also increase the risk of injury.\footnote{50} Further organizational risk factors include: a lack of policies and training of staff to recognize and deescalate potentially violent situations, understaffing, insufficient mental health and security staff, long waiting times, overcrowding, and uncomfortable accommodations.\footnote{51}

Violence against healthcare workers is an underreported occurrence.\footnote{52} Reports show that as few as 57\% of physical attacks and 40\% of verbal attacks are reported.\footnote{53} In the same study, of the incidents reported, 74\% \footnote{54} consisted of a verbal report to a supervisor, with no formal written report collected.\footnote{55} Why healthcare workers are not reporting the violence against them is a microcosm for the issue at large. Healthcare workers do not report violence because they feel as though violence is an expected part of their jobs, reporting is not worth their time because it does not result in meaningful change, they do not have time to complete a report in their workday, and if a patient or patient’s visitor became violent with them, it is because they were not performing their job correctly.\footnote{56} All too often, healthcare workers tolerate verbal abuse from each other, leading to workers feeling that they must also accept verbal abuse from patients.\footnote{57} However, it is critical that violence against healthcare workers is reported so that data can be utilized in developing and implementing prevention strategies.\footnote{58}

The consequences of workplace violence are immense and these consequences impact all aspects of healthcare, from staff performance to patient outcomes and insurance reimbursement. Physical violence can result in broken bones, lacerations or contusions and turn a healthcare worker into a patient.\footnote{59} Further, after workplace violence occurs, physical symptoms can manifest in

\begin{itemize}
  \item \footnote{50} Id.
  \item \footnote{51} Id.
  \item \footnote{53} Mary J. Findorff et al., \textit{Reporting Violence to a Health Care Employer: A Cross-Sectional Study}, 53 AM. ASS’N OCCUPATIONAL HEALTH NURSES J. 399, 403 (2005).
  \item \footnote{54} Table 2 shows a total of 396 events reported at all (67 physical incidents and 329 non-physical) and of these 396, a total of 294 were only reported to a supervisor verbally (47 physical incidents and 247 non-physical). \textit{Id}.
  \item \footnote{55} Id.
  \item \footnote{56} Toon et al., \textit{supra} note 22.
  \item \footnote{57} \textit{THE JINT COMMISSION, Physical and Verbal Violence Against Health Care Workers}, 59 SENTINEL EVENT ALERT 1, 2 (2018).
  \item \footnote{58} Toon et al., \textit{supra} note 22.
  \item \footnote{59} Rosen, \textit{supra} note 27.
\end{itemize}
staff due to a decrease in intrinsic self-worth or self-confidence, including headaches and issues with sleep or gastrointestinal problems.  

Workplace violence can also affect victims psychologically, leading to symptoms of stress, anxiety, irritability, and depression. Multiple studies show that nurses may become fearful, angry, frustrated, and helpless after being a victim of physical violence and may show signs of posttraumatic stress. Patients also suffer when healthcare workers are the victims of violence. A 2011 study by Gates, Gillespie, and Succop showed that emergency department nurses who experienced physical violence had a decreased ability to focus on their work following the event than they had beforehand. Research also suggests that patients can experience delays in care when other staff are required to assist with violent situations involving other patients. At this point, there is no data to suggest definitively that healthcare workers make more medication errors due to workplace violence; however, it is likely difficult to retrieve accurate data in this area due to a fear of repercussions from self-reporting.

Besides the actual cost of treating injuries sustained by patients and staff, violence in hospitals is costly to organizations in less tangible and more attenuated ways. The Nurse Executive Center at Advisory Board identified violence and point-of-care safety threats as one of the current breakdowns in the foundation of a resilient workforce due to its contribution to stress and burnout. Mistakes from burnout due to stress on frontline hospital staff

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60. PROFESSIONAL ISSUES PANEL ON INCIVILITY, BULLYING, AND WORKPLACE VIOLENCE, AMERICAN NURSES ASSOCIATION POSITION STATEMENT ON INCIVILITY, BULLYING, AND WORKPLACE VIOLENCE 5 (2015).

61. Id.


64. This article studied a pediatric emergency department and interviewed nurses prior to and after violent events. Though anecdotal, one interviewee discussed how she had difficulty going back into patients' rooms later on in her shift if a violent event had occurred recently in that room, even though the patients and visitors that caused the issue had left. Gordon L. Gillespie et al., Violence Against Healthcare Workers in a Pediatric Emergency Department, 32 ADVANCED EMERGENCY NURSING J. 68, 69 (2010).

65. Id. at 79.

66. Advisory Board is a best practices firm that specializes in many fields, including healthcare. NURSE EXECUTIVE CENTER, ADVISORY BOARD, REBUILD THE FOUNDATION FOR A RESILIENT WORKFORCE: BEST PRACTICES TO REPAIR THE CRACKS IN THE CARE ENVIRONMENT 14 (2018).

67. Id. at 10.
directly impact patients. For example, for every 10% of nurses that report being burned out at an organization, the rate of urinary tract infections (UTIs) increases by about one per one thousand patients. UTIs do not sound as though they are something for hospitals or patients to fear. However, UTIs are associated with increased morbidity and mortality, and extended hospital stays.

Further, 50% of registered nurses (RN) consider leaving the profession due to stress. Losing just one RN typically costs an organization $90,000 and the average hospital loses $6.6 million per year due to nursing turnovers. Or, to add to the discussion of UTIs, services for UTIs that are acquired in the hospital are not covered by Medicare or Medicaid, so the resulting costs fall on the hospital.

III. PART II: VIOLENCE AGAINST HEALTHCARE WORKERS: CURRENT POLICY INTERVENTIONS AND INFLUENCES

Now that the prevalence and other characteristics of violence against healthcare workers has been outlined, the current policy interventions and influences can be understood. The legal landscape surrounding violence against healthcare workers spans both the state and federal systems, including legislative, executive, and judicial branches. This section will describe how OSHA, Centers for Medicare and Medicaid Services (CMS), and mandatory public reporting attempt to address violence against Minnesota’s healthcare workers, ending with an in-depth look at the current language of the Minnesota Violence Against Healthcare Workers Act.

68. Id. at 9.
69. The reason for this is not precisely known. Id. Short-term use of indwelling urinary catheters is common in hospital patients. This catheter use is associated with urinary tract infections from insertion or management, and this risk increases the longer the catheter is in place. Providers must order catheters to be placed and removed, but nurses are in charge of their insertion, management, and removal. Catheters are placed inside the patient’s bladder using a sterile technique, which requires focus, time, and a calm patient. If the sterile technique is broken, the nurse needs to get new equipment and start over. It is easy to imagine a burned-out nurse breaking his or her sterile technique and not even noticing, or unfortunately, noticing and continuing with the procedure anyway. The connection here is nuanced but important.
71. Id.
72. Id.
A. Administrative Oversight

OSHA is a federal administration under the Department of Labor that issues standards intended to protect workers from serious injury or death.\(^\text{74}\) Beyond specific OSHA standards, the Occupational Safety and Health Act of 1970 that created OSHA has a General Duty Clause that requires employers to “furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”\(^\text{75}\) The clause is cited generally when the workplace hazard is not specifically addressed by an OSHA standard.\(^\text{76}\) States may adopt a State Plan so long as worker protections are as effective as OSHA.\(^\text{77}\) Minnesota has chosen to adopt its own OSHA program, and therefore employers under the jurisdiction of Minnesota OSHA (MNOSHA) must comply with the federal OSHA standards and other Minnesota statutes and rules that the program has chosen to adopt.\(^\text{78}\) MNOSHA has compliance officers that inspect workplaces for hazards and can issue citations. MNOSHA and OSHA offer resources and guidelines for violence prevention in healthcare settings but do not currently require specific standards. Therefore, in order for MNOSHA to intervene in the protection against violence for healthcare workers, the environment of a particular facility would need to rise to the level of a “recognized hazard.” MNOSHA has issued such citations in the past. In 2015, the Minnesota Department of Human Services was fined $63,000 for failing to protect staff at a state-run psychiatric hospital.\(^\text{79}\) The Minnesota Security Hospital is a secured facility housing mentally ill patients, including county inmates formally committed.\(^\text{80}\) The citations for exposing staff to “serious injury or death” were the result of an inspection after nine incidents.

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76. **Occupational Safety and Health Admin., supra** note 74, at 2.
80. **Minn. Dep’t of Labor and Indus., supra** note 78.
were reported in approximately eight weeks.\textsuperscript{81} The fine was later reduced to a total of $18,000.\textsuperscript{82} That is a $2,000 fine for each incident that MDH exposed a public servant caring for the state’s most vulnerable patients to serious injury or death. As discussed, experts describe the prevalence of violence against healthcare workers as endemic.\textsuperscript{83} Relying on MNOSHA to issue citations as a method of protecting Minnesota’s healthcare workers via the General Duty Clause is not a viable option. However, it does at least offer the ability to force physical and policy changes within institutions.

Another mechanism that impacts violence in healthcare is Medicare and Medicaid compliance. Medicare is the federal program that offers healthcare coverage for Americans over 65 years of age and a handful of other situations using federal and state funds.\textsuperscript{84} Medicaid is an optional program that states may participate in and operate themselves that offers healthcare coverage to low-income residents, again using a combination of state and federal funds.\textsuperscript{85} In order to receive Medicare and Medicaid reimbursement in general, there are requirements that organizations must meet in addition to specific reimbursement requirements on an individual patient level.\textsuperscript{86} Though the regulations and reimbursement standards do not directly address violence against healthcare workers, their influence cannot be overlooked. First, Medicare and Medicaid do not reimburse for hospital-acquired conditions.\textsuperscript{87} This means that any injuries and extended hospital stays as a result of violence in the
hospital are not covered by the programs and therefore the cost falls on the hospital. This is a powerful economic incentive for hospitals to protect patients, and therefore staff, from incidents that escalate to violence. However, other rules are likely contributing to violence.

As part of Medicare and Medicaid’s Conditions for Participation: Patient’s Rights, hospitals must follow specific guidelines for the use of restraints. The guidelines arose in 2006 after 142 deaths in American hospitals occurred in ten years. Overall, the guidelines are reasonable and evidence based. Despite this, the guidelines can also put staff, specifically nurses, in a difficult position. The guidelines require that use of restraints are based on individualized assessments and that the least restrictive method must be used to keep the patient safe. The guidelines also state that each patient has a right to safety. The staff must chose the least restrictive method of restraints to keep that patient safe and does not allow for staff to assess how they can keep all the patients that they are caring for safe. The least restrictive method is likely direct supervision by a staff member 100% of the time with no use of restraint. Now, staff are forced to choose between fulfilling the CMS guidelines and putting other patients at risk by an unrealistic allocation of staff time and resources, or safely using restraints for a limited time in order to keep all patients safe. As it stands, Minnesota has no mandated nurse-patient ratios and advocates are actively appealing to the Minnesota legislature for the state to intervene because the number of patients they are caring for at a time may be unsafe.

In 2003, Minnesota adopted the Adverse Health Event Reporting Law. The legislation was in response to a push for quality improvement in healthcare after the famous 1999 report, “To Err is Human” that brought to light breakdowns in hospital systems that lead to poor patient outcomes. The legislation requires hospitals and licensed surgical centers to report to the Minnesota
Department of Health (MDH) twenty-nine types of events. Each year details and trends of all events are published in a report including the names of each facility. Events are mostly patient-focused: falls, pressure ulcers, and surgical mistakes, such as wrong patient or wrong site. However, the legislation also requires the reporting of “[d]eath or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.” After an event is reported to MDH, the facility is required to perform a root cause analysis and create a written plan for preventing future incidents. MDH reviews the plans and if deemed unsatisfactory, the plans will be sent back to the facility for revisions. This process may occur up to three times.

MDH has expressed that the Adverse Health Event Reporting Law is not intended to be a regulatory tool, but instead a method for fostering quality improvement after an adverse health event, while still maintaining accountability. That being said, MDH still has the authority and obligation to investigate and enforce licensing and certification standards.

B. The Minnesota Violence Against Health Care Workers Act

The devastating events that took place at HealthEast's St. John's Hospital in 2014 are credited with prompting the movement that led to the passage of the Minnesota Violence Against Healthcare Workers Act (“the Act”) in 2015. Quietly behind the scenes, however, stakeholders in Minnesota had already begun the process of investigating how public policy could help decrease the incidence and severity of violence against healthcare workers. In 2013, a group of Minnesota healthcare facilities approached the Minnesota Department of Health (MDH) requesting help in dealing with frequent incidents of violence against their healthcare workers. They cited that the events did not meet what they felt was a level of severity warranting reporting under the Adverse Health Events Reporting law. Nevertheless, the behaviors left a negative impact on

95. MINN. STAT. § 144.7065 (2019).
96. See generally, MINN. DEP’T OF HEALTH DIV. OF HEALTH POLICY, supra note 93.
97. MINN. DEP’T OF HEALTH DIV. OF HEALTH POLICY, supra note 93, at 21.
98. MINN. STAT. § 144.7065 subdiv. 8 (2019).
99. MINN. DEP’T OF HEALTH DIV. OF HEALTH POLICY, supra note 93.
100. Id.
101. Id.
102. Id.
patient safety and staff morale.\textsuperscript{105} In response, MDH formed the Prevention of Violence in Healthcare Workgroup, consisting of health facilities throughout the state, the Minnesota Hospital Association (MHA), the Minnesota Nurses Association (MNA), Care Providers of Minnesota, and Leading Age Minnesota.\textsuperscript{106} As a result of the Prevention of Violence in Healthcare Workgroup, a gap analysis and toolkit were made available in August of 2014.\textsuperscript{107} The need to take stronger measures became clear, and in 2015, the fight to codify a policy preventing violence against healthcare workers began.

On February 19, 2015, a bill authored by Representative Joseph Atkins was heard in the Committee on Health and Human Services for the first time, with matching legislation coming from Senator Charles Wiger on February 23, 2015.\textsuperscript{108} The bills underwent many changes during the session, but ultimately, the Violence Against Health Care Workers Act passed in May 2015.\textsuperscript{109}

The Act begins with definitions that assist the legislation’s interpretation and are key in the discussion of what the Act does.\textsuperscript{110} First, the Act defines an “act of violence” as “an act by a patient or visitor against a health care worker that includes kicking, scratching, urinating, sexually harassing.”\textsuperscript{111} The definition does not include any verbal violence, threats of an act of violence, or attempts at an act of violence that did not result in touching the health care worker. Therefore, hospitals are under no duty to address this type of violence. A second defined term worth mentioning is “health care worker,” which covers both licensed and unlicensed professionals, volunteers, and contracted employees.\textsuperscript{112}

The second subsection addresses a hospital’s duties.\textsuperscript{113} This statute is limited to hospitals\textsuperscript{114} despite the fact research

\begin{itemize}
\item \textsuperscript{105} Id.
\item \textsuperscript{106} Id.
\item \textsuperscript{107} Id.; PREVENTION OF VIOLENCE IN HEALTHCARE WORKGROUP, MINN. DEP’T OF HEALTH, PREVENTING VIOLENCE IN HEALTHCARE: GAP ANALYSIS (2014), https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/docs/preventingviolenceinhealthcaregapanalysis.pdf; PREVENTION OF VIOLENCE IN HEALTHCARE TOOLKIT, MINN. DEP’T OF HEALTH (Oct. 19, 2019, 7:00 PM), https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html.
\item \textsuperscript{108} H.F. 1087, 89th Minn. Leg. (2015); S.F. 1071, 89th Minn. Leg. (2015).
\item \textsuperscript{109} MINN. HOSP. ASS’N, WORKPLACE VIOLENCE PREVENTION AT MINNESOTA’S HOSPITALS AND HEALTH SYSTEMS 1 (2019); Violence Against Health Care Workers Act, MINN. STAT. § 144.566 (2015).
\item \textsuperscript{110} Violence Against Health Care Workers Act, MINN. STAT. § 144.566 subdiv. 1(b).
\item \textsuperscript{111} Id.
\item \textsuperscript{112} Id. at subdiv. 1(d).
\item \textsuperscript{113} Id. at subdiv. 2.
\item \textsuperscript{114} See id.
\end{itemize}
demonstrates that violence against healthcare workers happens in a variety of settings and occurs at higher rates in long-term care facilities. The Act requires hospitals to “designate” a committee to “develop preparedness and incident response action plans to acts of violence.” The committee is not required under the statutory language to develop a violence prevention plan or to address the prevention of violence occurring in the first place. The Act also states that the committee may be an already established committee, and no new committee must be formed, implying that the statutory committee duties can be designated to an already established committee. Continuing in the second subsection, required staff trainings are established. Upon hiring and on an annual basis, a hospital must provide training on (1) “safety guidelines for response to and de-escalation of an act of violence;” (2) “ways to identify potentially violent or abusive situations;” and (3) “the hospital’s incident response reaction plan and violence prevention plan.” The first section of training addresses how to respond to violence that is already occurring and does not designate if the guidelines are published OSHA guidelines for responding to healthcare workplace violence, or if the hospital can arbitrarily establish such guidelines. Next, the training teaches employees how to recognize “situations” that may lead to violence. Like other ambiguous sections of the Act, it is not established what the employee is to do with the information that a potentially violent situation may occur. Third, the training establishes that employees be educated on the hospital’s incident response plan, which is to be created by the committee and a “violence prevention plan.” This is the only place where a violence prevention plan is mentioned in the Act. There is no mention of who must create a violence prevention plan, how the plan is to be created, or how it is updated.

Continuing with committee duties, an annual review must be conducted that addresses: (1) the effectiveness of its preparedness and incident response plans; (2) the most recent gap analysis as

115. Phillips, supra note 47; Tak, supra note 14; DeSanto Iennaco et al., supra note 20.
116. Violence Against Healthcare Workers Act, MINN. STAT. § 144.566 subdiv. 2(b).
117. Id. at subdiv. 2(c).
118. Id.
119. Id. at subdiv. 2(c)(1); OCCUPATIONAL SAFETY AND HEALTH ADMIN., supra note 31.
120. Violence Against Health Care Workers Act, MINN. STAT. § 144.566 subdiv. 2(c)(2).
121. Id.
122. Id. at subdiv. 2.
123. See id.
124. See id.
provided by the commissioner (of health); and (3) “the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred.”

The first section establishes that the committee must review the effectiveness of the plans, but does not address what defines effectiveness, nor does it require any revisions or updates to the plans. Second, the committee must review the gap analysis as provided by the commissioner; there is no requirement, however, that the committee actually uses the gap analysis in updating plans or accessing facility protocols. Finally, and perhaps the most difficult to understand, the Act requires the committee to review the “number of acts of violence” that occurred in the hospital. The Act does not establish any reporting or tracking of the number of acts of violence or even require that the number be recorded at all. Recall that assaults that result in death or serious injury of a patient or staff member must be reported to the Commissioner of Health via the Adverse Health Events Reporting Law. However, the type of event that must be reported under the Adverse Health Events Reporting Law does not match the "acts of violence" defined in the Act, and therefore some further data collection would ultimately be required in order to capture the number of acts of violence properly.

The remaining three sections address with whom the created plans must be shared with, the contacting of law enforcement, and penalties for non-compliance.

First, the hospital is required to make its action plans available to local law enforcement and to employee union representatives. There is no requirement for incorporating feedback from either of the specified groups on the plans. The next section requires that no one associated with the hospital “interfere with or discourage” a health care worker from contacting law enforcement regarding an act of violence. “Interfere” is defined in the first subdivision of the Act to mean “to prevent, impede, discourage, or delay a health care worker’s ability to report acts of violence, including by

125. Id. at subdiv. 2(d).
126. Id.
127. Id.
128. Id.
129. See id.
130. MINN. STAT. § 144.7065 (2019).
131. Compare id. at subdiv. 7 (2018), with MINN. STAT. § 144.566 subdiv. 1(b).
132. Violence Against Health Care Workers Act, MINN. STAT. § 144.566 subdiv. 2(e)–(g).
133. Id. at subdiv. 2(e).
134. Id.
135. Id. at subdiv. 2(f).
retaliating or threatening to retaliate against a health care worker.” 136 The Act is unclear, however, how the health care worker can use his or her time while working to do so or if they will not be paid during this time. 137 Finally, “the commissioner may impose an administrative fine of up to $250 for failure to comply with this subdivision.” 138 The commissioner is under no duty to impose any fine on a hospital who chooses not to follow the statutory guidelines, and the $250 fine is a ceiling, not a floor. 139 It is unclear if this penalty could be applied multiple times for ongoing non-compliance. The average registered nurse in Minnesota makes approximately $41/hour. 140 Using this as a baseline, a singular registered nurse working on any of the enumerated tasks required under the Act would cost the hospital more than receiving a $250 penalty imposed by the Commissioner of Health. 141

IV. PART III: REFORMING CURRENT SYSTEMS TO PROTECT HEALTHCARE WORKERS AND PATIENTS

As described above, Minnesota has many mechanisms that interact in an attempt to decrease violence in healthcare and to hold hospitals accountable. Over the last decade the groundwork has been laid for Minnesota to achieve true transformation of the culture of violence in healthcare. But the work is not done. This next section will outline how the current systems can be enhanced to work better for healthcare workers and patients. But it is important to keep in mind that even with perfect systems, the culture of accepting violence in healthcare and other public health issues associated with violence in healthcare would still persist. This section will also explore other policy interventions that tackle larger healthcare issues that impact violence in healthcare.

A. Administrative Oversight

Violence in healthcare is an endemic deserving of being treated as such by MNOSHA. Currently MNOSHA provides employers many educational resources for implementing a workplace violence

136. Id. at subdiv. 1(g), 2(f).
137. See Id.
138. Id. at subdiv. 2(g).
139. Id.
141. Using the information from Glassdoor, supra note 140, $41 over an eight-hour workday amounts to $320.
program, including many specific to healthcare settings. But as discussed supra, there are no specific standards for healthcare facilities to follow regarding violence protections besides the General Duty Clause. Based on the limited information available to the public, citations for violence under the General Duty Clause are rarely issued and when the General Duty Clause used, it is used to cite facilities after extreme incidents, and likely only after a long pattern of violence has been established. This is not good enough. Workers need to be protected from all attacks, not just those that could cause serious injury or death. Just because an incident did not result in tragedy does not mean a healthcare facility should not be held accountable or that a lasting negative impact on the staff and therefore patients will not be felt. It is critical that MNOSHA take ownership of this issue. The requirements in the Violence Against Healthcare Workers Act must be adopted as MNOSHA standards so MNOSHA can be responsible for its enforcement.

MNOSHA requires strict standards in certain situations and in industries known to have increased risks. For example, MNOSHA has specific standards for agriculture and construction industries. Perhaps that shows that MNOSHA standards are meant for industries that are traditionally known to be dangerous. But Minnesota has already added specific standards for another danger in healthcare that commonly injures staff: safe patient handling. Safe patient handling is the practice of transporting and repositioning patients in a manner that prevents staff injury. MNOSHA adopted these standards due to the high number of back injuries suffered by staff and as a way to break a stubborn healthcare culture that was complacent with staff injuries. Similar to the Violence Against Health Care Workers Act, a statute that detailed requirements for healthcare facilities was made into law in 2010. But in contrast to the Violence Against Health Care Workers Act, this legislation was added to the Occupational Safety and Health

143. OCCUPATIONAL SAFETY AND HEALTH ADMIN., supra note 74, at 2.
146. Id.
148. MINN. STAT. § 182.6553 (2010).
section of Minnesota code. In doing so, the legislation detailed strict mechanisms for enforcement by MNOSHA officials.\textsuperscript{149} Minnesota healthcare workers and patients deserve the same level of standard applied to violence as applied to safe patient handling.

Switching the standards to MNOSHA enforcement instead of the current ownership, MDH, would not be difficult and logistically makes sense. MDH is responsible for the licensing and certification of healthcare facilities and focuses on the health of patients, while MNOSHA is responsible for the safety and health of workers. MNOSHA is the expert on workplace hazards. Therefore, it is logical that they enforce statutes and regulations that reduce workplace hazards. MNOSHA already conducts assessments and trainings that aim to reduce workplace hazards, so violence prevention in healthcare could easily be applied as it was to safe patient handling.

The move to MNOSHA is necessary because MNOSHA can assist hospitals in reaching compliance with safe standards before incidents occur. The General Duty Clause as applied to violence in healthcare settings has historically been reactionary in nature and applied to severe cases in most public institutions.\textsuperscript{150} By having standards specific to workplace violence in healthcare settings, facilities have clear direction and intervention can occur before reaching the level of danger that would evoke the General Duty Clause. This would clearly lead to better outcomes and focus on prevention instead of reaction.

A second mechanism that can be reformed is the Adverse Health Event Reporting system. It is widely accepted that requiring public reporting can have a positive effect on outcomes.\textsuperscript{151} Using Minnesota’s own system as an example, since requiring reporting of surgical errors, the incidence of errors and the surrounding culture has changed immensely.\textsuperscript{152} Minnesota must apply these lessons to violence in healthcare.

First, the violent events that must be reported to MDH under the Adverse Health Events Reporting Law only involve assaults or other incidents that result in serious injury or death.\textsuperscript{153} To make matters worse, there is no public standard for what qualifies as a serious injury. It is inherently obvious that hospital administrators are going to stretch the definition of “serious” as far as possible. The consequences then go beyond underreporting. The key point of the AHE Reporting system is that hospitals must find the reason for the

\begin{thebibliography}{1}
\bibitem{149} MINN. STAT. § 182.666 (2019).
\bibitem{150} See Chris Serres, \textit{supra} note 79.
\bibitem{151} See MINN. DEP’T OF HEALTH DIV. OF HEALTH POLICY, \textit{supra} note 93, at 1.
\bibitem{152} \textit{Id.} at 3.
\bibitem{153} \textit{Id.} at 21.
\end{thebibliography}
breakdown and properly respond. If the event does not need to be reported, the event does not need to be properly investigated and therefore the issues underlying the incident are never addressed, leaving staff still vulnerable to repeated incidents.

Second, the word “assault” also causes issues as it is associated with the criminal interpretation. As described supra, many hospital staff do not view violence perpetrated by patients as “assaults.” 154 This language must be changed so that all appropriate acts of violence are captured and therefore receive proper follow up. But, the benefits of accurate reporting go beyond individual changes. More accurate and comprehensive reporting for Minnesota means more accurate and comprehensive data that can be used to create better prevention plans, and it only adds to our understanding of the problem. The 2019 AHE Reporting system’s report acknowledged that healthcare has changed since 2003 and announced that MDH is committed to starting conversations with stakeholders in 2019 to discuss how to make today’s healthcare environment safer. 155 Minnesota must take this opportunity to better respond to violence in the AHE Reporting system going forward.

As mentioned, Medicare and Medicaid may be contributing to violence in healthcare but exactly how and to what extent is not well understood. Federal lawmakers have expressed the desire for CMS to explore how to improve hospital violence and how CMS and OSHA can work together on regulatory guidance for hospital employees. 156 The first step is funding these efforts. Congress must appropriate funds to CMS to explore its role in violence in healthcare and explore regulation changes with input from the public on how CMS guidelines can best protect patients without putting healthcare workers at risk.

B. The Minnesota Violence Against Health Care Workers Act

The Violence Against Healthcare Workers Act is a good start for improving violence in Minnesota’s healthcare systems and protecting our workers, but it lacks clarity and real accountability for hospitals. By expanding language, clarifying requirements, and providing for appropriate reinforcement, the Act can better protect Minnesota’s healthcare workers and patients.

First, the Act’s definition of “act of violence” leaves out important types of violence that are having an impact on healthcare.

154. Toon et al., supra note 22.
155. MINN. DEP’T OF HEALTH DIV. OF HEALTH POLICY, supra note 93, at 1.
workers and the definition should therefore be expanded. The current language only includes kicking, scratching, urinating, sexually harassing, inflicting great bodily harm, and knowingly transferring a communicable disease. The current language does not reach verbal threats or attempted violence that did not end in contact. Verbal threats of violence should be covered by this statute because of the known impact these threats can have on workers. Threats impact workers and are therefore likely impacting patients. It is important that these incidents receive the same attention and focus as the other acts of violence captured by the Act.

Further, circumstances leading to threats of violence may be different from circumstances that lead to other types of violence. Therefore, by not including threats in required data collection, the opportunity to learn from threats of violence is lost. If data is required to be collected and analyzed by a designated committee for patterns, solutions can be developed. This data would also allow for tracking the impacts of preventive measures.

Similarly, attempted violence should be included in the Act. An act of attempted violence is still a traumatic incident that is likely impacting workers and therefore likely impacting their patients, too. These incidents are also disruptive, and by not capturing them, the true time and impact that violence has on the facility is lost. Both attempted violence and the next topic, verbal violence, will lose the benefits of data collection as described in regard to threats of violence.

Verbal violence without physical contact may not appear severe enough to some to warrant inclusion in the Act. However, this theory completely overlooks the many benefits of inclusion. As with other types of violence not currently included in the Act, verbal violence is still disruptive and impacts healthcare workers. And perhaps, most importantly, studying the data of verbal violence compared to incidents of verbal violence that escalated to physical violence gives valuable insight into which de-escalation methods are shown to be effective in which situations. Although facility committees would have many more incidents to review each year, improvement cannot truly start until the full extent of the problem is understood.

A second necessary amendment to the Act is to expand the types of facilities that are covered. Current language only impacts hospitals, despite evidence that violence occurs in all corners of

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157. Violence Against Health Care Workers Act, MINN. STAT. § 144.566 subdiv.1(b).
158. Id.
159. MINN. STAT. § 609.221 subdiv. 1 (2019).
160. MINN. STAT. § 609.2241 (2019).
161. See Gates, supra note 63.
162. See id.
healthcare. The Act must include surgical centers, outpatient clinics, urgent cares, long-term care facilities, mental health treatment centers, and skilled nursing facilities. Violence against healthcare workers is not limited to just hospitals, therefore the Violence Against Health Care Workers Act should not be limited to just hospitals. Further, MNOSHA is already addressing safe patient handling in clinics and nursing homes, showing that it is clearly feasible to adapt policy to fit various healthcare settings.\(^{163}\)

The current language of the Act requires hospitals to: (1) develop “preparedness and incident response action plans,”\(^{164}\) (2) provide training, and (3) conduct an annual review. Although the relevant federal agency, OSHA, does not have specific standards for violence in healthcare, it does issue evidence-based guidelines for conducting effective Violence Prevention Programs that are updated every eight to twelve years.\(^{165}\) Although many of the parts to a comprehensive program are required in the Act, the guidelines can be better adapted to more effectively protect staff. The most recent OSHA guidelines suggest a four-pronged Violence Prevention Program with the overall theme of achieving management commitment and worker participation applying to each piece. Per the OSHA guidelines, the four main programs components are: (1) conduct a worksite analysis that identifies hazards, (2) develop hazard prevention and control plans, (3) conduct training, and (4) properly keep records and evaluate the program regularly.\(^{166}\) The Act must be updated to require each of the four elements of effective Violence Prevention Programs.

First, the Act should require a comprehensive worksite analysis that identifies hazards to staff regarding potential violence. The OSHA guidelines, in accordance with recent evidence, suggest that conducting such an analysis is important because it “identifi[es] the types of hazard prevention and control measures needed to reduce or eliminate the possibility of a workplace violence incident occurring.”\(^{167}\) It is logical that a workplace violence prevention or response plan is most effective when it is based on a thorough worksite assessment.\(^{168}\)

Second, in order to meet OSHA guidelines that suggest detailed hazard control, the Act must require hospitals to: (1) reduce known

\(^{163}\) \textit{Minn. Dep’t of Labor and Indus., supra} note 145.

\(^{164}\) Violence Against Healthcare Workers Act, \textit{Minn. Stat.} § 144.566 subdiv. 2(b).

\(^{165}\) \textit{Occupational Safety and Health Admin., supra} note 31, at 1.

\(^{166}\) \textit{Id.} at 5.

\(^{167}\) \textit{Id.} at 8.

\(^{168}\) The OSHA guidelines suggest that “information is generally collected through: (1) records analysis; (2) job hazard analysis; (3) employee surveys; and (4) patient/client surveys.” \textit{Id.} at 9.
hazards regarding violence as feasibly possible,\textsuperscript{169} (2) develop a violence prevention plan, and (3) develop an incident response plan.\textsuperscript{170} Current language in the Act does not require worksites to reduce known hazards\textsuperscript{171} or create a violence prevention plan.\textsuperscript{172} The Act quite literally does not require any concrete action on violence prevention, only incidence response. Although incidence response plans may help decrease the severity of an act of violence in its outcome, the Act is devoid of language that holds hospitals accountable for their role in preventing violence in the first place. Minnesota’s healthcare workers deserve to have their employers work diligently to decrease violence in their facilities.

The third element of a comprehensive violence prevention plan is comprehensive training.\textsuperscript{173} The Act’s current language is already in line with OSHA’s guidelines and does not necessarily need to be amended at this time.

The fourth element of a comprehensive and effective Violence Prevention Program is proper record keeping and program evaluation. The current language requires the “effectiveness of its preparedness and incident response action plans” be reviewed annually.\textsuperscript{174} This language should be amended to require review of the hazard reduction methods implemented after the last worksite analysis, the effectiveness and utilization of the violence prevention plan, and the effectiveness and utilization of the incident response plan. The current language of the Act also requires a review of the “the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred.”\textsuperscript{175} This particular provision is interesting because collection of that data is not required in the Act but review of the information is. The Act should clearly state that data collection is required and the data that is collected should be comprehensive. The only way to truly identify patterns and measure intervention effectiveness is through detailed recordkeeping. Possible requirements include time of day, all relevant patient diagnoses and medications, incident and lead up details, possible triggers, attempted interventions and de-escalation techniques.

\textsuperscript{169} The OSHA guidelines include an extensive list of possible methods to reduce known hazards. See generally, id.  
\textsuperscript{170} See id. at 12–16.  
\textsuperscript{171} As discussed, OSHA requires that workplaces reduce known hazards, but this requirement is regarding hazards that could result in serious injury or death and not all acts of violence. Occupational Safety and Health Act of 1970. 29 U.S.C. § 654(a)(1) (2019).  
\textsuperscript{172} Recall, the Act does require that a violence prevention plan be reviewed annually but its actual development is not listed as a hospital duty. Minn. Stat. § 144.566.  
\textsuperscript{173} See id. at subdiv. 2(c).  
\textsuperscript{174} Id. at subdiv. 2(b).  
\textsuperscript{175} Id. at subdiv. 2(d)(3).
physician involvement and other factors which staff deem relevant to measuring effectiveness. In order to capture data most accurately, all involved staff should be required to submit records an incident. All of the data should be required to be reviewed by a designated committee and then analyzed for patterns and identification of places of improvement. The results of the review and suggestions for improvement should be required to be implemented to the extent feasible and this cycle should continue at least annually.

Overall, the most important change that must be made to the Act is to the last subsection that provides the consequences for noncompliance. It is beyond insulting to all healthcare workers that the only consequence for completely disregarding the Act is that a hospital may be fined $250. This nominal amount provides a message to healthcare organizations that following the statute is not important and likely does not apply financial pressure on wealthy hospital systems faced with the option of paying thousands of dollars to restructure their system, or pay a minuscule fine for noncompliance every year.

As outlined supra, the Violence Against Health Care Workers Act is better enforced by the MNOSHA to keep workers and patients safe and to hold facilities accountable.

V. CONCLUSION

This article reviews some of the major administrative systems and important legislation that impact violence in Minnesota’s healthcare facilities with a specific emphasis of violence against healthcare workers. There are many other ways that public policy could potentially intervene to reduce such violence. For example, requirements for nursing school curriculum and reimbursements of continuing medical education fees could shape a healthcare workforce that is both aware of the negative impacts of violence against workers and implementing up-to-date prevention strategies. On a larger scale, public policy is needed to ensure that patients have access to the care they need to treat issues that manifest as violence in the first place. Public health issues, such as the opioid crisis and lack of access to mental health and long-term care facilities, are likely playing a large role in the rise of violence in healthcare in the first place. Efforts to address these issues must go hand-in-hand with more direct policy addressing the violence, like the Act.

Minnesota has the infrastructure in place to easily adopt policy that can greatly reduce violence against healthcare workers and does not need to wait for changes to occur at the federal level. By making thoughtful and precise changes, the magnitude of violence in

176. Id.
healthcare can change. Minnesota’s healthcare workers deserve better.