April 3, 2017

Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Submitted electronically to www.regulations.gov

Re: OSHA-2016-0014: Prevention of Workplace Violence in Healthcare and Social Assistance Settings

Dear Sir/Madam:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the Occupational Safety and Health Administration (OSHA) Request for Information (RFI) concerning the Prevention of Workplace Violence in Healthcare and Social Assistance Settings.

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

The OSHA Request for Information (RFI) notes that "Workplace violence against employees providing healthcare and social assistance services is a serious concern. Evidence indicates that the rate of workplace violence in the industry is substantially higher than private industry as a whole."

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

To this end:

> OSHA is considering whether a standard is needed to protect healthcare and social assistance employees from workplace violence and is interested in obtaining information about the extent and nature of workplace violence in the industry and the nature and effectiveness of interventions and controls used to prevent such violence. This RFI provides an overview of the problem of workplace violence in the healthcare and social assistance sector and the measures that have been taken to address it. It also seeks information on issues that might be considered in developing a standard, including scope and the types of controls that might be required.

ANA fully supports the creation of a standard to protect health care and social assistance employees from workplace violence. As the Government Accountability Office (GAO) notes, rates of workplace violence in health care and social assistance settings are 5 to 12 times higher than the estimated rates for workers overall.[2] This is a critical issue from ANA's perspective given that RNs are often the front line providers in health care and social assistance settings. The 2015 *ANA Position Statement on Incivility, Bullying, and Workplace Violence* professes a zero tolerance policy on violence of any kind:

> All RNs and employers in all settings, including practice, academia, and research, must collaborate to create a culture of respect that is free of incivility, bullying, and workplace violence. Evidenced-based best practices must be implemented to prevent and mitigate incivility, bullying, and workplace violence; to promote the health, safety, and wellness of RNs; and to ensure optimal outcomes across the health care continuum.

ANA also recognizes the contribution of other health care professions and notes that the position statement is relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy inter-professional work environment.[3]

Workplace violence has a demonstrable negative impact for the nursing profession and the overall health care field.[4] Multiple studies have shown that workplace violence can adversely affect the quality of patient care and care outcomes[5], contribute to the development of psychological conditions[6], and reduce the nurse's level of job satisfaction and organizational commitment.[7,8]

Any OSHA standard to protect health care and social assistance employees from workplace violence requires an ongoing commitment on behalf of both RNs and employers to create a safe and

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[2] U.S. Government Accountability Office. *Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence,* 10. Retrieved from http://www.gao.gov/assets/680/675858.pdf.

[3] American Nurses Association. (2015) *Position Statement on Incivility, Bullying, and Workplace Violence.* Retrieved from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence/Incivility-Bullying-and-Workplace-Violence.html.

[4] Spector, P. E., Zhou, Z. E., & Che, X. X. (2013). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. International Journal of Nursing Studies, 51(1), 72-84. doi: 10.1016/j.ijnurstu.2013.01.010

[5] Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). Violence toward nurses, the work environment, and patient outcomes. Journal of Nursing Scholarship, 42(1),13–22.

[6] Demir, D., & Rodwell, J. (2012). Psychosocial antecedents and consequences of workplace aggression for hospital nurses. Journal of Nursing Scholarship, 44(4), 376–384.

[7] Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., & Farr-Wharton, R. (2014). Abusive supervision and links to nurse intentions to quit. Journal of Nursing Scholarship, 46(5), 357–365. doi: 10.1111/jnu.12089

[8] Smith, L. M., Andrusyszyn, M. A., & Spence Laschinger, H. K. (2010). Effects of workplace incivility and empowerment on newly graduated nurses' organizational commitment. Journal of Nursing Management, 18(8), 1004–1015. doi: 10.1111/j.1365-2834.2010.01165.x

trustworthy environment in order to promote and create a culture of health and safety. Any standard should focus on the following:

I) Education and other strategies to identify and reduce vulnerabilities in order to prevent workplace violence:
   a. *Employee Strategies:* Include active participation in the development of the workplace violence prevention program, active participation in the education on and understanding of organizational workplace violence prevention policies, a general emphasis on using situational awareness in order to anticipate, prevent, and respond in crisis situations, awareness and knowledge of environmental controls, the incorporation of health and wellness strategies, and openness to constructive feedback.
   b. *Employer Strategies:* Include ongoing leadership commitment, a supportive and non-punitive work environment, the development of a comprehensive workplace violence prevention program aligned with OSHA's 2015 guidelines, the use of thorough background checks on potential employees, and optimal staffing levels.

II) Intervention intended to reduce the negative impact of workplace violence:
   a. *Employee Strategies:* Include participation in the implementation of a comprehensive workplace violence program, the use of crisis intervention and management strategies, the use of existing administrative and environmental controls and of an approved reporting system, and the reporting of any concerns regarding weaknesses in the system.
   b. Employer Strategies: Include the continual identification of strengths and weaknesses in the program, serious treatment and investigation of all reported cases of workplace violence, and the review of each reported episode with an inter-professional team.

III) Intervention intended to reduce the consequences of workplace violence:
   a. *Employee Strategies:* Include engagement in evaluation and improvement of the workplace violence prevention program, participation in post-incident meetings, the use of counseling programs after a workplace violence incident, referral of others to grief counseling or other health services when appropriate, and the expression of sympathy and support following an incident.
   b. Employer Strategies: Include evaluation and improvement of the program, acknowledgment of injury or loss following an incident, arrangement of immediate coverage if an RN needs to leave work following an incident, provision of ongoing support to facilitate the return to work for employees involved in an incident, provision of grief and bereavement counseling to others when appropriate, and the conduction of a root cause analysis following an incident.

It is critical that both RNs and their employers are engaged in the development, implementation, and improvement of workplace violence prevention programs. The level of engagement by both employee and employer is critical to the success of any workplace violence prevention program.

ANA welcomes an opportunity to further discuss the prevention of workplace violence in health care and social assistance settings in collaboration with OSHA and other health care stakeholders and the role of RNs in this effort. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director/Executive Vice President

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Office