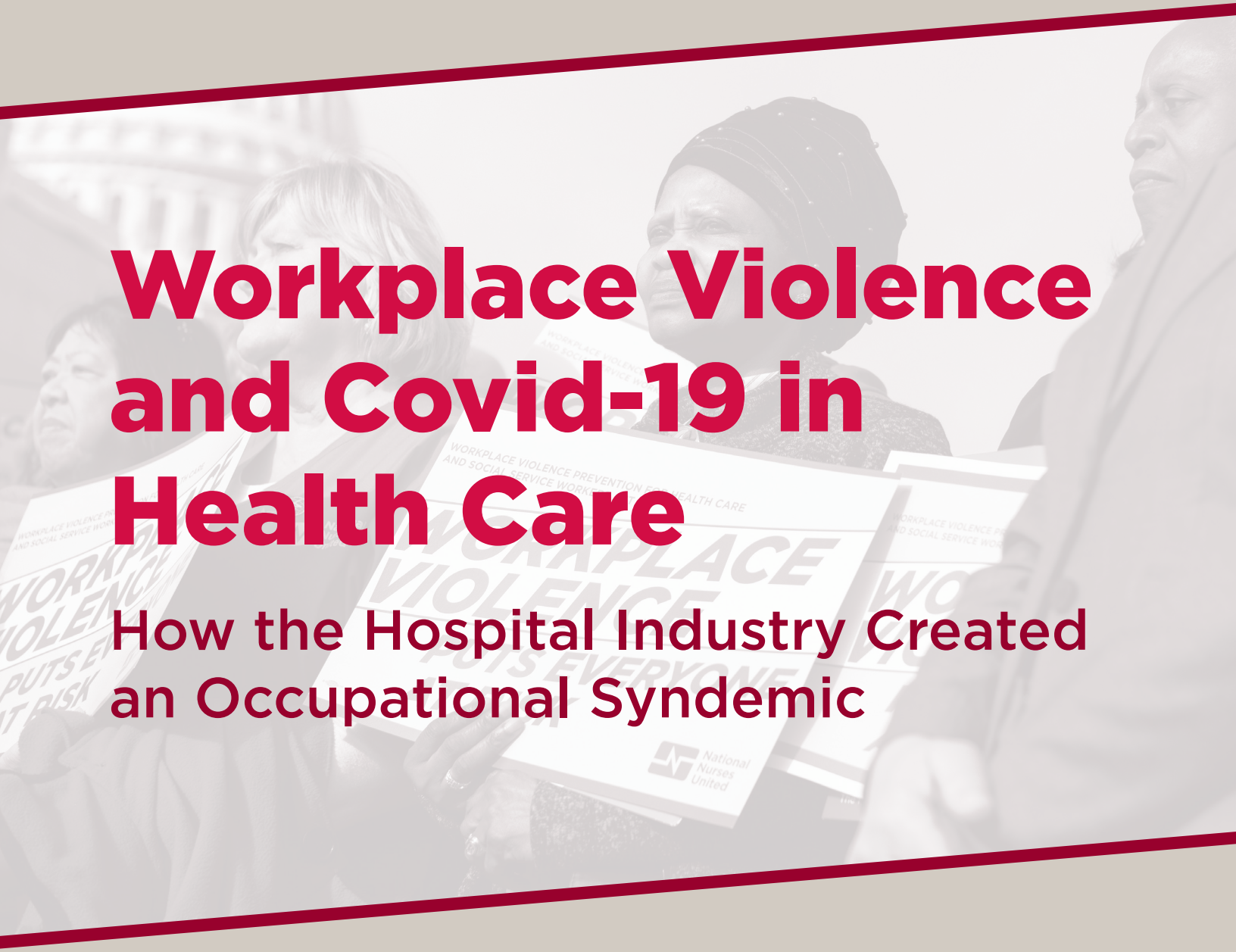

Workplace Violence and Covid-19 in Health Care

How the Hospital Industry Created an Occupational Syndemic

National Nurses United

www.NationalNursesUnited.org

November 2021

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How the Hospital Industry Created an Occupational Syndemic

Cover photo: Nov. 2019

Aug. 2020

CONTENTS

KEY POINTS

- Nurses and other health care workers have experienced both high rates of infection and death from Covid-19 and increasing rates of workplace violence during the Covid-19 pandemic.
- The high rates of Covid-19 and workplace violence directly result from the failure of health care employers to prepare for and respond to the Covid-19 pandemic to protect nurses and their patients.
- The continued neglect of workplace violence prevention by health care employers has led to increasing rates of workplace violence during the pandemic. Failure to implement effective workplace violence prevention plans during the pandemic has also inhibited Covid-19 infection control, contributing to high Covid-19 rates among health care workers.
- The hospital industry has seized upon the Covid-19 pandemic as an opportunity to accelerate its decades-long restructuring aims — corporate schemes to increase profits and excess revenues without regard for nurse and patient outcomes. The hospital industry claims there is a "nursing shortage," but the reality is that the hospital industry created this crisis.
- The hospital industry's prioritization of profits over patient care has precipitated the dual failures to prepare for Covid-19 and prevent workplace violence, which act synergistically to exacerbate the harm caused by each individually — creating an occupational syndemic (from "syn" — synergy and "demic" — epidemic). The concept of a syndemic was first used to describe how diseases can converge and exacerbate each other.

The high rates of Covid-19 and workplace violence directly result from the failure of health care employers to prepare for and respond to the Covid-19 pandemic to protect nurses and their patients.

- The occupational syndemic of Covid-19 and workplace violence amplifies the harms to nurses and other health care workers more frequently and severely than each occupational epidemic individually. In addition to physical illness and injuries from Covid-19 and workplace violence, nurses experience high rates of moral distress and mental health harm from the synergistically amplified impacts of their employers' failure to prevent workplace violence and Covid-19.
- Immediate action is necessary to protect nurses and other health care workers from workplace violence, Covid-19, and the occupational syndemic.
  - OSHA issued the Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS) in June 2021, which is in effect for until December. OSHA must issue a permanent Covid-19 Health Care Standard to continue to protect nurses, other health care workers, and their patients. OSHA must also expediently develop a separate, broader, and permanent infectious diseases standard to protect all workers from aerosol transmissible diseases in the workplace.
  - An enforceable national workplace violence prevention standard is necessary, which can be efficiently achieved by Congress passing the Workplace Violence Prevention for Health Care and Social Service Workers Act, sponsored by Rep. Joe Courtney and Sens. John Hickenlooper and Tammy Baldwin.
- Union nurses are leading the way to envision a society based on care, not corporate profits, through their solidarity and advocacy for patients.

EXECUTIVE SUMMARY

This report details stark evidence gathered by National Nurses United (NNU), the largest labor union and professional association for registered nurses in the United States, of how the dual failures of health care employers to protect nurses and patients from Covid-19 and workplace violence synergistically interact to amplify the harms caused by each individually. Data are presented and analyzed from seven surveys conducted by NNU in 2020 and 2021 with collectively more than 83,000 responses from nurses and other health care workers in every state.

Nurses and other health care workers have long experienced workplace violence at epidemic proportions. Data collected by NNU and analyzed in Section 1 show that the workplace violence epidemic in health care has accelerated since the beginning of the Covid-19 pandemic. As Mawata Kamara, RN, stated in an October 2021 media interview, "Violence has always been a problem. The pandemic really just added a magnifying glass."[1]

Section 2 presents data showing that the cause of increased workplace violence — in addition to high rates of Covid infection and death among health care workers — lies in the prioritization of profits over patient care by health care employers. The hospital industry in the United States has seized on the Covid-19 pandemic as an opportunity to accelerate its decades-long restructuring aims — corporate schemes to increase excess revenue without regard to nurse and patient outcomes. As a result, health care employers have consistently prioritized profits over patient care and employee health and safety during the Covid-19 pandemic, from locking up and rationing life-saving personal protective equipment (PPE), to canceling nurse shifts while Covid-19 units were dangerously short staffed, pushing adoption of remote monitoring and other automation technology, neglecting workplace violence prevention, to blaming nurses for workplace violence and Covid-19 infections.

As a result of their prioritization of corporate profits over patient care, health care employers failed to prepare for and respond to the Covid-19 pandemic to protect nurse and patient safety. This has led to high rates of Covid-19 infections and deaths among health care workers as well as increased workplace violence rates, as discussed in Section 2. Additionally, health care employers have continued to neglect workplace violence prevention

Aug. 2020

measures during the Covid-19 pandemic, leading to high rates of workplace violence in addition to inhibiting Covid-19 infection control, which also contributes to high rates of Covid-19 among health care workers.

Further, nurses experience high rates of moral distress as a result of their employers' profit-oriented corporate schemes and failure to protect them during the pandemic. The increase in workplace violence also results in significant mental health impacts, in addition to the risk of physical injury. Impacts of moral distress and increased workplace violence synergistically intensify and are intensified by each other.

The interplay of the hospital industry's failure to effectively protect nurses and patients from the Covid-19 pandemic in addition to the workplace violence epidemic has created a syndemic — "synergistically interacting epidemics."[2] While the term "syndemic" is typically used to describe diseases, the concept is useful in understanding the current situation in health care workplaces. Multiple occupational hazards, which individually result in negative health outcomes, are interacting synergistically with enhanced negative results for nurses, other health care workers, and their patients **(Figure 1)**. The data analyzed in this report clearly reveal that nurses and other health care workers are experiencing an occupational syndemic. Health care employers' dual failures to protect nurses and patients from Covid-19 and workplace violence synergistically amplify the risks of physical illness and injury, moral distress and mental health harm, and other negative outcomes of each occupational hazard individually.

This situation is not inevitable. Immediate action by policymakers would improve protections for nurses, other health care workers, and their patients from the workplace violence and Covid-19 syndemic. NNU nurses led the campaign to advocate for — and win — a national enforceable standard on Covid-19 to protect their union and nonunion colleagues and patients across the country. The Federal Occupational Safety and Health Administration (OSHA) issued the landmark Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS) in June 2021. The Covid-19 Health Care ETS is set to sunset in December 2021, and OSHA must issue a permanent standard on Covid-19 in health care.[3] OSHA must also work expediently to issue a separate, broader infectious diseases standard to protect all workers from occupational exposure to aerosol transmissible diseases.

NNU nurses are also leading the campaign to win a national enforceable workplace violence prevention standard. Even in the midst of the Covid-19 pandemic, union nurses continued to advocate to pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (sponsored by Rep. Joe Courtney and Sens. John Hickenlooper and Tammy Baldwin) to create a national workplace violence prevention standard, which would mandate health care and social service employers to design and implement effective workplace violence prevention plans.

Bigger changes are also necessary. Union nurses are leading the way to create a society based on care, not profits. Advocating for the health and safety of their patients, union nurses have taken more than 3,000 collective actions during the Covid-19 pandemic and won lifesaving improvements in infection control at their facilities. Union nurses renewed their long-standing commitment to make health care a human right in the United States, to guarantee each patient the right to the care they need without regard for their ability to pay.[4] Through their solidarity with each other and dedication to caring and advocating for their patients, union nurses are showing us the way forward to create a society that takes care of everyone.

SECTION 1: RATES OF WORKPLACE VIOLENCE ARE INCREASING DURING THE COVID-19 PANDEMIC

Nurses and other health care workers have long experienced workplace violence at epidemic proportions. In 2018, the U.S. Bureau of Labor Statistics reported that health care workers accounted for 73 percent of all nonfatal workplace violence-related injuries and illnesses.[5] In 2019, registered nurses experienced more than three times the rate of nonfatal workplace violence-related injuries compared to other occupations.[6] Since 2010, the rate of workplace violence injuries in hospitals has increased 95 percent.[7]

In NNU's 2020 and 2021 survey data on workplace violence, nurses and other health care workers reported experiencing workplace violence at high rates during the Covid-19 pandemic. More than 8 in 10 health care workers (82 percent) reported experiencing at least one type of workplace violence during the Covid-19 pandemic. Nearly two-thirds of respondents (64 percent) reported having been verbally threatened during the Covid-19 pandemic and one-third (33 percent) reported being verbally harassed based on their sex or appearance. Nurses and other health care workers reported frequent occurrences of physical violence, including being pinched, scratched, slapped, punched, kicked, and having objects thrown at them **(Table 1)**.

Further, nurses reported that rates of workplace violence had increased during the Covid-19 pandemic. In NNU's most recent Covid-19 survey, published in September 2021, nearly one-third of nurses (31 percent) reported that workplace violence has increased recently. This represents an acceleration from previous surveys published in November 2020 and March 2021, which both found that about one-fifth of nurses (20 percent and 22 percent, respectively) reported an increase in workplace violence recently **(Table 2)**.

Dec. 2015

SECTION 2: THE HOSPITAL INDUSTRY'S PRIORITIZATION OF PROFITS OVER PATIENT CARE IS DIRECTLY TIED TO INCREASED WORKPLACE VIOLENCE, COVID-19, AND THE OCCUPATIONAL SYNDEMIC

For more than three decades, the health care industry has aimed to end the right of registered nurses to advocate in the exclusive interest of their patients through restructuring — a set of corporate schemes to achieve greater efficiency, productivity, and profit with little regard for patient safety and outcomes. Before the Covid-19 pandemic began, the health care industry was working to implement its restructuring aims,[8] including by embracing just-in-time resourcing, implementing lean staffing models that treat nurses and other health care workers as inventory items, distancing registered nurses from their direct patient care roles, pushing care to the lowest-cost and least-regulated settings, and displacing registered nurses' professional judgment with health information technology, automation, and remote monitoring tools, among other elements.

When the Covid-19 pandemic began, despite consistent advocacy by NNU nurses[9] and multiple emerging infectious disease events in recent decades, including Ebola, H1N1, MERS, and SARS, health care employers in the United States failed to prepare. Instead of protecting nurse and patient health and safety, the health care industry has seized upon the Covid-19 pandemic as an opportunity to accelerate its restructuring aims. From locking up and rationing lifesaving personal protective equipment (PPE), to canceling nurse shifts while Covid units were dangerously short staffed, pushing adoption of remote monitoring and other automation technology, neglecting workplace violence prevention, to blaming nurses for workplace violence and Covid-19 infections, health care employers in the United States have consistently prioritized profits and costs over patient care during the Covid-19 pandemic. This has had drastic impacts on the health and safety of nurses, other health care workers, and their patients.

HEALTH CARE EMPLOYERS FAILED TO PREPARE FOR AND RESPOND TO THE COVID-19 PANDEMIC TO PROTECT NURSE AND PATIENT SAFETY, RESULTING IN HIGH RATES OF COVID-19 AND INCREASED WORKPLACE VIOLENCE AMONG HEALTH CARE WORKERS

When the novel coronavirus began spreading in China and around the world in late 2019, U.S. health care employers were not prepared. Despite union nurse advocacy[10] and multiple emerging infectious diseases events in recent decades, from Ebola to SARS, health care employers prioritized profits and neglected preparations necessary to protect nurses and patients from novel pathogens. Nurses urged their employers to get ready, such as by stockpiling PPE and preparing surge and staffing plans for large numbers of patients with a novel infectious disease.

When Covid-19 began spreading in the United States in January and February 2020, health care employers failed to heed nurses' warnings about the need to immediately put measures in place to screen patients for Covid-19 and protect nurses and other health care workers with optimal PPE. NNU's first Covid-19 survey published in March 2020 found that only 30 percent of nurses reported that their employer had sufficient PPE stock on hand to protect staff during a surge. Only 14 percent of nurses reported that their employer had a surge plan in place to ensure safe staffing **(Table 3)**.

NNU's Covid-19 surveys document the consistent trend that health care employers prioritized profit and excess revenue over protecting nurses, other health care workers, and their

patients during the Covid-19 pandemic **(Table 3)**. In May 2020, 87 percent of nurses reported having to reuse a single-use disposable respirator or mask with a Covid-19 patient, and in July 2020, 54 percent of nurses who worked in hospitals said their employer had implemented a program to "decontaminate" single-use PPE between uses. Health care employers embraced unproven, dangerous decontamination methods to reuse single-use N95 respirators instead of providing safely reusable, more protective powered air-purifying respirators (PAPRs) and elastomeric respirators,[11] despite the fact that reuse of single-use N95 respirators was known to damage and undermine protection.[12]

Through November 2020 and March 2021, a majority of nurses continued to report having to reuse single use PPE. Even in September 2021, only 61 percent of nurses working in hospitals reported wearing a respirator for every Covid-positive patient encounter, a protection now mandated by the U.S. Occupational Safety and Health Administration's Covid-19 Health Care ETS.[13] See **Table 3** for more NNU Covid-19 survey results.

Additionally, NNU's Covid-19 Surveys found that health care facilities do not effectively screen, test, or isolate patients for Covid-19 **(Table 3)**. For example, in NNU's September 2021 Covid-19 survey, only two-thirds of hospital nurses reported that all patients are screened for Covid-19 signs and symptoms before or upon arrival at the facility and less than one-third of nurses reported that all patients are tested for Covid-19, a step that is essential to identify the asymptomatic and presymptomatic infections that are a major driver of transmission.[14] This leads to increased transmission to health care workers and patients. Transmission to both staff and other patients within health care facilities has been documented to frequently occur from unidentified infections among admitted patients who were not screened or who were inadequately screened and tested for Covid-19.[15]

The prioritization of profits over patient care led to health care employers failing to protect nurses and their patients during the pandemic, leading to high rates of Covid-19 infection and death among health care workers. Due to inadequate testing and contact tracing **(Table 3)**, data on health care worker infections is lacking. For example, even in the September 2021 Covid-19 survey, nurses reported restricted access to Covid-19 testing — 58 percent of nurses report that only symptomatic staff can get tested and more than 1 in 4 (27 percent) reported that testing is limited or not available where they work. More than 75 percent of hospital nurses reported they are not notified of Covid-19 exposures in a timely fashion **(Table 3)**. However, it is clear that, among those who are tested, workers employed in health care consistently have constituted the greatest percentage of positive cases by occupation in the United States and around the world.[16]

Nurses diagnosed with Covid have faced lasting symptoms, also known as "long Covid." In NNU's September 2021 Covid-19 survey, nearly a quarter of nurses who contracted Covid-19 reported experiencing symptoms lasting from zero to three months, one-third had symptoms lasting three to nine months, 12 percent had symptoms lasting nine to 12 months, and 12 percent reported symptoms lasting longer than a year. The most common symptoms reported included tiredness or fatigue, joint or muscle pain, memory or concentration difficulties, headaches or migraines, and difficulty breathing or shortness of breath. Long Covid disrupts individuals' work and personal lives.[17]

NNU has tracked nurse and health care worker deaths from Covid-19 since March 2020 using public data sources when it became clear that the federal and state governments were not effectively tracking health care worker infections and deaths from Covid-19. As of Oct. 29, 2021, NNU has identified more than one million health care worker Covid-19 cases and at least 4,525 health care workers, including at least 455 registered nurses, who have died from Covid-19, approximately twice the number reported by the U.S. Centers for Disease Control and Prevention.[18, 19]

In addition to resulting in high rates of Covid-19 infection and death among health care workers,

nurses observe that health care employers' failure to prepare for Covid-19 has led to increased workplace violence. Nurses specifically observe that their employers do not always account for Covid-19 infection control precautions in workplace violence prevention plans, resulting in increased workplace violence. For example, one nurse reported that they "didn't have enough break room space for staff to eat while physically distanced so [the employer] required them to eat in their cars even at night. Cars are often broken into and vandalized in the parking lot. There is no safety plan."

When employers restrict staff access to PPE, this can contribute to workplace violence incidents and disrupt the ability of nurses and other staff to effectively respond. For example, one nurse reported:

> "An elder patient suddenly got confused, wanted to get up but was unstable so we didn't let him. Three nurses are holding him down, but he was very strong. I got slapped on my chest, but I was okay. We called security, but they couldn't get inside the room since the patient is Covid-positive, requiring a face shield and N95, which was not readily available at that time. PPE was locked up in a metal cabinet and only managers had the key. We had to call the manager from another unit before we could get the N95 and shield, so it took a while before we could get security to help us."

Nurses also report increased workplace violence when employers do not provide sufficient staff and training to effectively implement Covid-related protocols with patients and visitors. Instead, many employers assign these responsibilities, such as enforcing visitor restrictions or mask-wearing requirements, to nurses who already have patient care assignments. This disrupts nurses' ability to establish rapport with patients and family members, which ultimately contributes to increased workplace violence. For example, one nurse observed the interplay between their employer's lack of planning for Covid-19 infection control and workplace violence and increased Covid-19 transmission risk:

> "Some families take an extended period of time to deal with to keep them from escalating. Since we are often short-staffed this can result in other patients not getting the care they need or nurses not getting the breaks they need to give good care. Some families state they will not follow infection safety protocols. Some families break the rules and get past security which is not always good and can add to the risk for transmission of disease."

Being able to establish and maintain rapport with patients and their families is essential to nurses' ability to provide holistic, quality patient care and to being able to effectively deescalate agitated or aggressive behaviors by patients and visiting family members or friends.

Health care employers' prioritization of profits over patient care led to a failure to implement effective Covid-19 infection control, directly causing increased Covid-19 infection, death, and workplace violence among health care workers.

Nov. 2007

HEALTH CARE EMPLOYERS CONTINUE TO NEGLECT WORKPLACE VIOLENCE PREVENTION DURING THE COVID-19 PANDEMIC, LEADING TO HIGH RATES OF WORKPLACE VIOLENCE AND INHIBITING COVID-19 INFECTION CONTROL

Health care employers have long neglected workplace violence prevention, despite industry consensus and recognition of the hazards and effective prevention measures.[20] NNU's 2021 Workplace Violence Survey found that health care employers continue to neglect even the most basic of workplace violence prevention measures in 2020 and 2021 **(Table 4)**. Only 15 percent of nurses and other health care workers reported that their employer includes nurses and other employees in violence risk assessments — an element that has been shown by scientific research to be vital to effective workplace violence prevention plans.[21] Only about 1 in 3 nurses and other health care workers (35 percent) report that their employer provides a clear way to report incidents **(Table 4)**.

While health care employers' workplace violence prevention was inadequate prior to the Covid-19 pandemic, nurses observed that employers' disregard for workplace violence prevention has been exacerbated during the Covid-19 pandemic. For example, early in the pandemic, nurses reported that many employers implemented policies limiting visitor hours and numbers, which nurses reported has had a positive impact on workplace violence rates, but as one nurse observed, "visiting hours are limited only because of Covid-19. It's not related to our safety." Many employers have now removed restrictions on visitors. In NNU's September 2021 Covid-19 survey, nurses reported that increased workplace violence rates during the Covid-19 pandemic were related to fewer visitor restrictions, in addition to decreased staffing levels and changes in the patient population **(Table 3)**.

Nurses observed additional impacts of health care employers' disregard for workplace violence prevention during the Covid-19 pandemic:

- "A former employee returned to the Emergency Department using the ambulance entrance code. He arrived with firearms on his person. Another nurse and an Emergency Department tech diffused the individual and were able to remove the weapons from him. It took hours before we received any response from our manager despite the numerous calls sent out to him. The manager finally showed up the next morning. By that time, we were just physically and psychologically spent, we did not want to spend another minute trying to explain anything."
- "As for the incident regarding the patient's family member who threatened to bring in a gun, I feel that there was a terrible lack of transparency that led to rumors. I still don't know the whole true story. I was told by a coworker that the family member came to the door and threatened to come back with a gun. I asked the nursing supervisor if this was true, and she said that he actually had called on the phone and threatened to bring a gun. Either way, he threatened to harm people in my unit, and we were not informed of the threat to our safety. The next night, I was asked to work at the front door as a screener. I declined because I felt unsafe, although I have done this job in the past happily."
- "Recently, a patient's family member got upset with us. He threatened to seek me out outside of work and hurt my family if his mother passed. He did this behavior to many nurses. Screaming in our faces. The hospital did nothing. Our union finally stepped in and demanded the hospital to provide security at bedside and walking us to our cars."

Nurses and other health care workers explicitly connect health care employers' prioritization of profits over patient care to increasing workplace violence rates during the Covid-19 pandemic. As one survey respondent reported:

> "Poor outcomes for patients and nurses are considered normal. The [hospital] leadership claims to care, but there's no action taken by them to keep it from happening again. They are happy to put the burden of prevention on the bedside nurse, when it is the systemic problems that they refuse to address that actually lead to violence."

More specifically, nurses observe multiple ways in which health care employers' focus on profits and excess revenues have led directly to increased rates of workplace violence. Nurses connect their employers' restructuring measures, including crisis standards intended to change nursing scope of practice, to increased workplace violence. As one nurse described it, "My employer called off staff, but then left inpatient units extremely short, argued that they needed to 'restructure' nursing care and have 'helping hands,' task-based nursing."

Patients admitted to the hospital frequently need specialized care. For example, neonatal patients in a neonatal intensive care unit require different expertise than patients in adult units, and among adult units, there are multiple specialties — from cardiac care to orthopedics to surgical services, psychiatric nursing, and many more. But nurses report that hospitals increasingly ignore the expertise of experienced nurses, opting instead to treat nurses with diverse experiences as interchangeable, such as floating nurses to units without regard to expertise or competencies and implementing programs such as team-based nursing. Nurses observe that these restructuring schemes contribute directly to increased workplace violence:

> "Having patients not appropriate for our unit and managers expect nurses to care for a patient they don't have the skills to treat. For example, an [intermediate care unit] patient on a medical-surgical floor. A patient got combative, and we were told its part of the job to handle it. But we were not given the resources to do so. We were working short-staffed so there is not another team member to go into the patient's room with you. These conditions have caused me stress and anxiety and doubting myself and even considering leaving the nursing field."

> "Sometimes, we have staffing difficulties because although our census may be lower, the acuity level of the patients in that census is higher, and we need sufficient staff to monitor and deescalate early in order to avoid a behavioral code situation. We frequently feel that management does not understand that staffing a psychiatric unit is much different than staffing a medical unit, which is primarily done by simple ratio methodology of a certain number of patients per RN. We manage our patients holistically and take care of their medical needs to the extent we can on our floor, but we are primarily managing behavior and emotions, very different than managing task-driven medical needs such as IVs, wound care, cancer care, post-surgical care, etc. We must spend time talking with our patients throughout the shift, and these conversations can become lengthy especially if a patient is in a crisis."

As patients who need specialized psychiatric and mental health care are increasingly admitted to inpatient units, including general medical-surgical units and intensive care units, this nurse's observation about the impact of staffing on workplace violence apply to a larger proportion of nurses, in addition to those working on dedicated inpatient psychiatric units.

Nurses identify the ways that macro-restructuring changes, such as closing hospitals and units that are deemed "not profitable enough," lead to increased workplace violence:

> "My employer closed two hospitals during a pandemic. Our Emergency Room average wait time is 18 hours. By the time a patient is seen their anxiety is so high and so is their anger. A lot of the verbal abuse comes directly from management when staff ask how are we going to care for these patients. I've been a nurse for 30 years. I never thought I

would retire. I don't know if I'll get out of nursing all together or just get out of acute care. All I know is I've had enough!"

Nurses also observe that management has chosen to cut staffing on patient care units during the pandemic. Nurses document the ways these cuts lead directly to increased workplace violence:

"Current management has chosen to reduce staffing. We are on a locked down unit with patients with behavioral issues. We do not have enough staff to adequately manage or supervise the floor. Security officers have refused to come to our aid. Multiple injuries were reported to management, yet they continue to cut staff. It is unsafe for all, including patients."

"Patient readmitted for delirium, known for refusing medications. Patient was Covid-positive, on bilateral mitten restraints. Very irate with staff. Needed two or three staff members to help with peri care, wound care, and repositioning. Hits via punching, scratching, grabbing, and kicking. Screams and spits at staff. Refusing meds and meals. Assistant manager discontinued sitter without notifying me (primary RN)."

Many nurses also explicitly connect employer cost-cutting to increased workplace violence rates during the Covid-19 pandemic. For example, one nurse observed the ways that profit-driven cuts to support staff by their employer undermined workplace violence prevention and patient care:

"Our hospital has reduced the hours of techs and aides as a cost-cutting measure. There are not enough techs and aides to sit with patients who need a sitter, and not enough staff to respond appropriately when an assault happens. In one incident, an aide was sitting with two confused and combative men in the same room, and when one of them was assaulting her, it took several minutes for staff to answer the call light. In another incident, an aide was choked by a patient, the police were called, no action was taken, and the aide was told to go back into the room with the patient who had choked him and finish his shift. The behavioral health unit and the behavioral health overflow are often out of legal compliance in regards to patients who require 1:1 sitters, like minors."

This incident also illuminates a common situation where health care employers leave staff with no supports during a serious workplace violence incident. In these situations, staff sometimes turn to police as the only available option to get assistance responding to a violent incident. But police intervention often results in increased escalation with potentially deadly consequences for Black, Latinx, and other patients of color.[22] In addition to proactively preventing workplace violence, health care employers need to provide trained staff on site to provide a therapeutic response to violent incidents to maintain patient and staff safety.

Another nurse observed that, even when they are able to quantify the need for additional staff, their employer still refuses to provide additional staff. This results in increased workplace violence, placing nurses and their patients at risk of injury.

"I work on a mental health unit. We are warned in reports if a patient is on assault precautions. And do have an easy system to report to our supervisors and hospital administration (Patient Visitor Safety Report: PVSR). I think I can say our biggest problem lately is administration not allowing us extra staff when we have patients with difficult behaviors. We are able to quantify, justify our requests for additional staff by reporting recent events and behaviors. We have frequently been denied extra staff. It appears as if cost is more important than the safety of the patients or staff."

Nurses also related how staffing cuts inhibit effective response to workplace violence incidents. For example, one nurse reported, "Last fall they decreased our security officers significantly. They are spread too thin and unable to answer all incidents." In addition to proactively preventing workplace violence, staffing is essential to respond and deescalate workplace violence incidents when they occur.

Not only does employer neglect of workplace violence prevention and profit-driven cuts lead to increased workplace violence, but they also inhibit Covid-19 infection control. When employers fail to provide sufficient staff for nurses to care for patients safely, including to provide quality patient care, maintain infection control, and to prevent workplace violence, nurses and their patients are at increased risk of both infection and injury. For example, a nurse reported the following incident:

> "A patient tried to strangle and hit me in the back of my head. I was in an isolation room with double doors close to the clerk's station but there was no one on duty that day. I screamed for help, but nobody was there to come to my rescue until a nurse came to check on her patient and saw me fighting for my life and struggling to get away from the patient but unable to do so. The patient used my stethoscope and the collar of my ID to try to strangle me. I became very vocal about nurses not to put stethoscope around their neck and no use of collar to put around their neck for ID."

Other profit-driven cuts discussed above also contribute to higher rates of transmission amongst patients and staff, such as closing facilities leading to crowded waiting rooms and overcrowded inpatient units.

HEALTH CARE EMPLOYERS' DUAL FAILURES TO PREPARE FOR COVID-19 AND PREVENT WORKPLACE VIOLENCE EXACERBATE HARM

Nurses observe that employers' failures to prepare for the Covid-19 pandemic and to effectively prevent workplace violence are interrelated issues that act synergistically to exacerbate the harmful impacts of each issue alone — an occupational syndemic. Covid-related disruptions in health care have contributed to increased acuity among patients and longer wait times for care, which, when combined with lack of prevention by employers, leads to increased workplace violence. Nurses specifically observed:

> "So many of the people who are coming into our Emergency Department have long-standing unmanaged chronic medical or psychiatric issues that they were not able to get addressed during the pandemic."

> "Some patients who need to be transferred to other care settings such as post-acute care or skilled rehab, such as patients with dementia or alcohol-detox, need consecutive negative Covid tests before being transferred, leading to longer acute care stays, inappropriate levels/types of care, where hospitals fail to put in place protective plans."

Nurses directly tied the synergistic impacts of their employers' failure to prepare for Covid-19 and neglect of workplace violence prevention to increased workplace violence rates:

> "During the pandemic patients seem more anxious and angry. They require more time at the visits, and often are angry about not getting their pain meds refilled, or having their surgeries delayed, and they want to vent and it often turns to yelling and cursing. It's very stressful and I have to try and deescalate. They come to their clinic visit and have not been out of the house in the year, so want longer visits just to talk about other things, and the clinic does not support that. Men have been inappropriately flirting or saying dirty jokes and you have to redirect them to the reason why they are there. I just think overall this pandemic has affected behaviors and I feel like I have to be so hypervigilant at work and watch my back. It's more stressful now than it's ever been."

> "Covid surge in December 2020. Waiting room beyond capacity. Long wait times. Patient states he want to speak to me. I was the triage nurse. When I approached him, he pulled out a knife and proceeded to sharpen it. He stated, 'when is the doctor going to see me?' I did what I could to treat him soon. He was discharged within an hour."

> "Not adjust staff to match acuity and time to don PPE — I have never been yelled at so many times by patients due to the time it took to gown up to enter a room. Ratios stayed the same."

Additionally, nurses, like many other workers, report that racism-related violence has increased during the Covid-19 pandemic and that their employers have not effectively prepared or responded to these issues. For example, one nurse reported, "Patients making racial comments [has] increased." Another nurse observed:

> "Grief related to family members dying of Covid-19. Family members threw furniture at staff after their father died of Covid-19. They threatened staff and disparaged the nursing and medical care. Their mother was also a patient and ended up dying as well. Because of the threats to staff safety, security was required to be present during family visits. Asian colleagues reported feeling threatened, by the tone of the discourse with this family."

The occupational syndemic caused by health care employers' prioritization of profits over patient care has placed patients, nurses, and other health care workers at heightened risk of Covid-19 and workplace violence.

HOSPITAL EMPLOYERS CLAIM THERE IS A "NURSING SHORTAGE," BUT THE REALITY IS THAT THE HOSPITAL INDUSTRY CREATED THIS CRISIS

On top of cutting staff to increase profits without regard for patient or nurse safety, the hospital industry is now decrying a "nursing shortage" and proposes that further restructuring schemes are needed. But the reality is that there is no "nursing shortage" in the United States; there is only a shortage of nurses willing to risk their licenses or the safety of patients by working under unsafe conditions the hospital industry has created.[23] There is a shortage of good jobs where nurses are respected, valued, and provided the conditions necessary to provide the best, safe patient care.

In order to maximize profits and excess revenues, hospitals continue to intentionally understaff every unit and every shift with fewer nurses than is actually required to safely and optimally care for patients. While these issues existed prior to the Covid-19 pandemic, they have been exacerbated and have reached crisis levels during the pandemic. Nurses connect short staffing directly to increased workplace violence incidents:

> "I have been punched, slapped, scratched, clawed, bitten, kicked, slammed into walls, have had patients fall on me, throw things, yell, threaten. I have been exposed to sexually inappropriate comments, patients purposely exposing themselves, and attempts at inappropriate sexual touching. Staffing levels generally contribute to problems and create unsafe situations. There is little support from management who want you to just manage all of these issues without complaint or without creating work for them. In many instances, you're taught to believe there's nothing that can be done and it's all just part of the job and the environment…"

> "Staffing was short. I was a sitter for two patients cohorted in the same room for safety. One patient stood up in bed. I placed my hands on his shoulders to stabilize him. He started hitting me. He was about to hit my face. I managed to turn away but ended up injuring my back. I reported the incident."

Short staffing means nurses are unable to provide the care patients need when they need it and are less able to effectively establish rapport with and deescalate patients, which is tied to increased workplace violence:

> "Patient got mad at her call light not being answered within minutes. She got upset at me as a charge nurse when I entered the room. She threw things at me."

> "Frequent verbal and occasional physical abuse. Combative, confused patients. Low staffing numbers, especially on evenings and weekends, contributes to stress levels of patients and staff. If RN is not available to meet an agitated patient's needs, the patient's agitation is accelerated. Nurses are not able to be with more than one patient at a time."

The reality is that there is no "nursing shortage" in the United States; there is only a shortage of nurses willing to risk their licenses or the safety of patients by working under unsafe conditions the hospital industry has created.

Nurses make these connections in multiple types of units across the hospital:

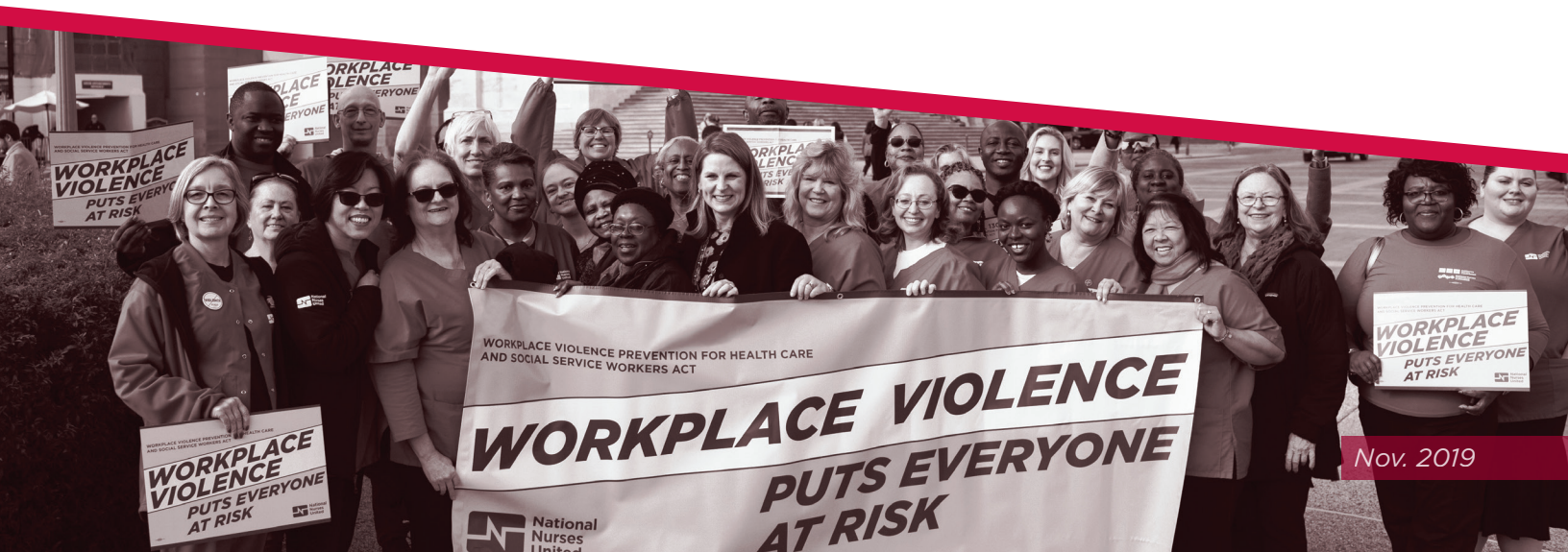
> "There has been an increase in patients with psychiatric issues being hospitalized. The appropriate psychiatric hospitals are full or are refusing to take these patients even though there is no health reason the patient needs to stay in the hospital. This leaves ill-equipped hospital staff, mostly nurses and nurse techs, to care for these patients for prolonged periods without the proper training, resources, or environment. Staff members are getting physically and mentally abused. Many staff members have left due to the abuse. I have recently left my position of five years and one of the major factors in my decision to leave has been the increased workplace violence."

Nurses directly tie their employers' cost-motivated short staffing to increased workplace violence and illuminate the harmful impacts on nurses:

> "We've had two nurses actually code (cardiac arrest) in the past two weeks. I know one died for a fact, but I don't know the disposition of the other. I am certain that the stress at the workplace contributed to both incidents. I work on a Neuro unit, so there are a lot of behavioral issues. I get assaulted often. Nothing ever changes. It's the same old song and dance every shift. Our staffing is worse than ever. I stayed over from my night shift and worked until 10:30 in the morning the other day because only two nurses showed up! I got cornered in a room by a patient that was threating to hit me. If another nurse didn't happen by and distract him so I could get out of the corner and the room, I am fairly sure I would have been attacked."

> "We are usually short staffed and there are not enough people around to help you. When changing diapers or bathing patients you can guarantee that you will struck, kicked, scratched and/or pinched. But you have no choice but to just get it over with. I can't leave my patients dirty, no matter how violent they are. So you brace yourself, try to anticipate them and dodge the attacks. I tune out the words they use, but who cannot hear someone say, 'You fat ugly bitch. You fucking hag,' when all I am trying to do is clean the poop off their bodies. The physical bruises heal, but the emotional bruises stay. I have sat outside the hospital, before going into work, and have had to fight off feelings of dread and anxiety, especially after having a bad night and knowing I am walking into another night of the same thing. When you tell the supervisor about what happens and they laugh at you saying, 'Come on, you're scared of an old lady/man?'"

It is clear that increased workplace violence and high rates of Covid-19 experienced by nurses and other health care workers is a direct result of their employers' prioritization of profits and excess revenues over patient care. Health care employers have created untenable conditions that are driving nurses away from the bedside through physical, mental, and moral injuries and illnesses.



Nov. 2019

SECTION 3: IMPACTS OF COVID-19 PANDEMIC-RELATED MORAL DISTRESS AND WORKPLACE VIOLENCE ARE SYNERGISTICALLY INTENSIFIED TO CAUSE INCREASED HARM TO NURSES AND OTHER HEALTH CARE WORKERS

Covid-19 and workplace violence are both deadly — and preventable — occupational threats to nurses and other health care workers. In addition to physical impacts described in Section 2, health care employers' failure to effectively protect nurses from Covid-19 and workplace violence also results in serious psychological and mental health harm. Nurses observe the effects of moral distress and mental health harm caused by health care employers' dual failure to protect them from Covid-19 and workplace violence and the synergistically intensified impacts of the occupational syndemic.

NURSES EXPERIENCE MORAL DISTRESS DUE TO EMPLOYERS' DISREGARD FOR THEIR SAFETY DURING THE COVID-19 PANDEMIC

As reported in NNU's Deadly Shame report, acute moral distress is widespread among nurses during the Covid-19 pandemic.[24] Moral distress occurs "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[25] The failure of employers and public agencies to protect nurses and their patients from Covid-19 combined with health care employers' embrace of profit-motivated crisis standards has put nurses in untenable situations where they do not have the staffing and resources to provide the care their patients need.

NNU's Covid-19 surveys document significant impacts of the pandemic on nurses' mental health. In the September 2021 survey, more than half of nurses were afraid they would infect a family member with Covid-19, more than a third of nurses are having more difficulty sleeping than before the pandemic, and about 4 in 10 feel sad or depressed more often than they did before the pandemic. More than a third of nurses report feeling traumatized by their experiences caring for patients during the Covid-19 pandemic **(Table 5)**.

Further, health care employers intensify nurses' experiences of moral distress by blaming nurses for the negative impacts of the Covid-19 pandemic. Health care employers have claimed that "health care workers are more likely to be infected in the community or in breakrooms," seeking to shift the responsibility for infections away from the employer. Little data has been presented to support such claims, and the data that has been presented is deeply flawed. For example, one oft-cited paper published in the journal, *Clinical Infectious Diseases,* purported to find "no evidence for healthcare-associated transmission in the majority of [health care provider] infections evaluated."[26] The researchers used genomic sequencing of a mere 7.4 percent of Covid-positive health care workers at their facility to reach this conclusion — a logical travesty.

Another oft-cited paper published in the *Journal of the American Medical Association* purported to find that "exposures outside of the workplace, rather than exposures to patients with COVID-19, may be major drivers for SARS-CoV-2 infection among [health care providers] in the United States."[27] However, this cross-sectional study had multiple methodological issues, including excluding pertinent risk factors regarding workplace exposures because they were not standardized across all study sites, lumping Covid-facing and non-Covid-facing health care workers into the same category for analysis, and not differentiating between surgical masks and N95 respirators in assessing health care worker exposures leading to infection. The reality, as has been clearly laid

out in this report, is that health care employers prioritized profits and excess revenues and failed to protect nurses and their patients, which led to high rates of infection and death from Covid-19 among health care workers.[28]

Additionally, the hospital industry and its allies are perpetrating the narrative that the cause of nurses' moral distress during the Covid-19 pandemic is a lack of personal resiliency in the face of a crisis. For example, in an October 2020 blog, the American Hospital Association highlighted three main strategies to respond to nurses' experiences of burnout during the pandemic: "Code Lavender" programs that deliver support in the form of aromatherapy during "overwhelming situations," setting up quiet areas in facilities for staff decompression, and nurse training programs to improve "resiliency skills."[29] None of these programs recognize the systemic impact of short staffing and the hospital industry's prioritization of profit and excess revenues over patient care — aromatherapy does not make up for dangerous short staffing levels. Further, the use of the concept "burnout" instead of the more accurate "moral distress" belies the focus on the individual worker as the issue. Nurses report that Code Lavender, resiliency training, and similar programs are not only unhelpful but actively cause harm by locating the problem within the individual nurse.

Thus, the hospital industry not only causes high rates of moral distress among nurses and other health care workers when prioritizing profits and excess revenues over patients and nurses, but also ultimately blames those same nurses for experiencing harmful impacts, intensifying nurses' experiences of moral distress.

WORKPLACE VIOLENCE RESULTS IN SIGNIFICANT PHYSICAL AND MENTAL HEALTH IMPACTS TO NURSES AND OTHER HEALTH CARE WORKERS

Workplace violence can result in physical injuries — including broken bones and contusions — and even death. In NNU's Workplace Violence Survey, 2020-2021, more than a quarter of nurses and other health care workers (26 percent) reported experiencing a physical injury or other physical symptoms related to workplace violence incidents **(Table 6)**.

Workplace violence also results in nonphysical impacts that have serious and long-lasting impacts on nurses. More than half of nurses and other health care workers (59 percent) reported experiencing anxiety, fear, or increased vigilance following a workplace violence incident, and more than a quarter (26 percent) reported experiencing difficulty working in an environment that reminds them of a past incident. Strikingly, nearly 1 in 10 respondents (8 percent) reported that psychological impacts of workplace violence prevented them from working **(Table 6)**. Nurses reported additional impacts of workplace violence, including probable decreased immunity to illness, depression, hypertension, chest pain, rage, and helplessness.

Experiencing workplace violence and lack of employer prevention plans can also lead nurses to take time off work and to leave their jobs. In NNU's survey, more than 2 in 10 respondents (21 percent) reported taking time off work after a workplace violence incident, and nearly 2 in 10 nurses and other health care workers (16 percent) reported that they had changed or left a job because of workplace violence **(Table 6)**. The connections between workplace violence and the shortage of good nursing jobs is clear (Section 2).

Nurses also report significant impacts when their employers ignore or respond ineffectively to workplace violence incidents. Well over a third of nurses and other health care workers (42 percent) reported that their employer ignores nurses' reports of workplace violence incidents **(Table 7)**.

When health care employers do respond to violent incidents, nurses and other health care workers report that employer responses are often unhelpful or ineffective. NNU's survey found that less than half (39 percent) of nurses and other health care workers report that their employer investigates what happened after a

workplace violence incident. The majority of nurses and other health care workers (59 percent) report that their employer fails to change practices to reduce the risk of violence following an incident. Fully one quarter (25 percent) of nurses and other health care workers report that their employer blames or reprimands employees who report workplace violence incidents **(Table 7)**.

Many nurses surveyed by NNU observed the impacts when management ignores or fails to respond to workplace violence incidents. Nurses reported that managers frequently downplay workplace violence incidents and explicitly tell nurses that workplace violence is "part of the job." For example, one nurse stated, "As long as the patients don't actually cause bodily harm, the violence is considered expected and normal." Nurses described the impact this kind of response has on nurses and their patients:

> "Staff are hesitant to report injuries that occur as the culture of the unit is that these incidents are 'just part of the job.' Management often looks at incidents from a blame-based standpoint. This culture leads to burnout and long-standing psychological trauma amongst the staff. This in turn negatively affects the nurses' ability to safely and effectively perform their job."

High rates of workplace violence disrupt patient care, requiring nurses to spend more time responding to and deescalating violent incidents especially when employers' workplace violence prevention plans are lacking and employers short staff patient care units. This can lead and contribute to moral distress for nurses, especially when employers blame nurses for workplace violence. Experiencing workplace violence leads to both physical and mental health harm, which is exacerbated when employers ignore workplace violence incidents and blame staff instead of protecting them.

OCCUPATIONAL SYNDEMIC INTENSIFIES HARM FROM WORKPLACE VIOLENCE AND COVID-19 PANDEMIC-RELATED MORAL DISTRESS

Nurses observed that Covid-19 pandemic-related moral distress and impacts of workplace violence act synergistically to exacerbate the harmful impacts of each issue alone. Many nurses reported in surveys that the recent increase in workplace violence, in combination with intentional short staffing by their employers and moral distress caused by their employers' betrayal during the Covid-19 pandemic, is leading to many nurses retiring and leaving the bedside. In addition to the examples shared above on pages 12, 13, 14, and 18, one nurse observed:

> "I left my nursing job in September due to burnout and increasing violence among patients, more difficulty taking care of them, and not enough staff and support to take care of patients that keep getting sicker and need more care than staff that we have."

Another nurse reported:

> "I have been slammed into a door frame by a patient who was angry over a lack of pain meds. Saturday morning, I was threatened by a patient who then attempted to hit me because he was detoxing and couldn't understand that his meds were going in through his IV. When calling for security we have to be extremely careful because the administration tries to find a way to make it appear to be the fault of the staff. They take an approach of the 'customer is always right.' This attitude is why we have such a poor employee retention rate."

Other nurses declined to share any instances of workplace violence, stating that it was too hard and stressful to share details. This is an experience that has also been relayed by nurses attending NNU continuing education classes on workplace violence prevention and advocacy.

SECTION 4: UNION NURSES CALL FOR ENDING COVID AND WORKPLACE VIOLENCE, ADVANCING SOCIETY BASED ON CARE

The prioritization of profits over care is not inevitable. Immediate action is necessary to protect nurses and their patients, and more fundamental changes to reorient society towards care, not profits, are essential.

IMMEDIATE ACTION IS NECESSARY TO PROTECT NURSES AND THEIR PATIENTS FROM THE COVID-19 AND WORKPLACE VIOLENCE SYNDEMIC

Immediate action is necessary to protect nurses, other health care workers, and their patients from the syndemic of workplace violence and Covid-19. Because this is a syndemic, it is essential for both issues to be addressed expediently.

To protect nurses and their patients from Covid-19, NNU nurses led the campaign to advocate for — and win — a national enforceable standard on Covid-19 to protect their union and nonunion colleagues and patients across the country. The Federal Occupational Safety and Health Administration (OSHA) issued the landmark Covid-19 Health Care ETS in June 2021. Union nurses commend the Biden administration for acting to protect health care workers and are advocating to ensure employers comply with the ETS and that the standard is fully enforced in every state across the country.[30] The Covid-19 Health Care ETS is set to sunset in December 2021, and OSHA must issue a permanent standard on Covid-19 in health care. Further work is also needed on a separate, broader permanent infectious diseases OSHA standard to protect all workers from aerosol transmissible diseases, not just Covid-19, in the workplace.[31]

To protect nurses and their patients from workplace violence, NNU nurses are also leading the campaign to win a national enforceable workplace violence prevention standard. Even in the midst of the Covid-19 pandemic, union nurses continued to advocate to pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (sponsored by Rep. Joe Courtney and Sens. John Hickenlooper and Tammy Baldwin) to create a national workplace violence prevention standard, which would mandate health care and social service employers to design and implement effective workplace violence prevention plans.[32] Nurses built strong bipartisan support for the bill, which passed the U.S. House of Representatives in April 2021. The bill must now pass the Senate.

Immediate action is necessary to protect nurses, other health care workers, and their patients from the syndemic of workplace violence and Covid-19.

UNION NURSES ARE LEADING THE WAY TO CREATE A SOCIETY BASED ON CARE, NOT PROFITS

More fundamental changes are also necessary. Union nurses are leading the way to create a society based on care, not profits. Advocating for the health and safety of their patients, union nurses have taken more than 3,000 collective actions during the Covid-19 pandemic and won lifesaving improvements in infection control at their facilities that will protect patients, such as optimal PPE, a return to single-use PPE, and improved staffing. Union nurses are committed to continuing to build their collective power across the country "as a critical protection against the corporate practices, political failures, and systemic inequities that worsened the impact of Covid-19" on their patients and communities and that continue to make us vulnerable to the next pandemic.[33]

NNU nurses remain committed to win a single payer health care system, Medicare for All, to make health care a human right for all people in the United States and reorient the health care system towards care, not profits.[34] Union nurses have called for the elimination of all health disparities based on race, ethnicity, national origin, gender, gender identity, sexual orientation, age, disability, geographic location, or immigration status, and for reallocating money currently spent on policing, incarceration, and the military for national and state single-payer programs.

Through their solidarity with each other and dedication to caring and advocating for their patients, union nurses are showing us the way forward to create a society that takes care of everyone.

Apr. 2019

SECTION 5: METHODOLOGY AND DATA SOURCES

NNU frequently surveys nurses and other health care workers, both union members and nonunion workers, regarding health and safety issues in their workplaces. This report presents and analyzes data from multiple surveys conducted in 2020 and 2021.

WORKPLACE VIOLENCE SURVEY — 2020-2021

NNU's Workplace Violence Survey — 2020-2021 asked questions regarding nurses' experiences of workplace violence in the previous year, including types of incidents, impacts, prevention measures, and employer responses to workplace violence incidents. This survey was distributed electronically via continuing education classes and outreach to union and nonunion nurses and other health care workers through email and text messages. A total of 1,340 responses were gathered from 50 states and the District of Columbia between November 2020 and October 2021. The vast majority of respondents (98 percent) were nurses.[35] Most respondents (75 percent) work in a hospital. Respondents also work in outpatient clinics or medical offices (10 percent), skilled nursing facilities/long-term care (7 percent), home care/hospice (6 percent). A small number are retired (4 percent) or are currently not employed as a nurse (4 percent). Quantitative survey results are presented in Tables 2, 3, and 5. Qualitative responses were analyzed for common themes. Quotes from survey responses have been slightly edited to maintain anonymity and for clarity, but not to change meaning.

COVID-19 SURVEYS — 2020 AND 2021

To date, NNU has conducted six surveys of nurses and other health care workers regarding the Covid-19 pandemic, including infection control measures in their facilities, other health and safety hazards during the pandemic, and impacts of the Covid-19 pandemic on respondents.

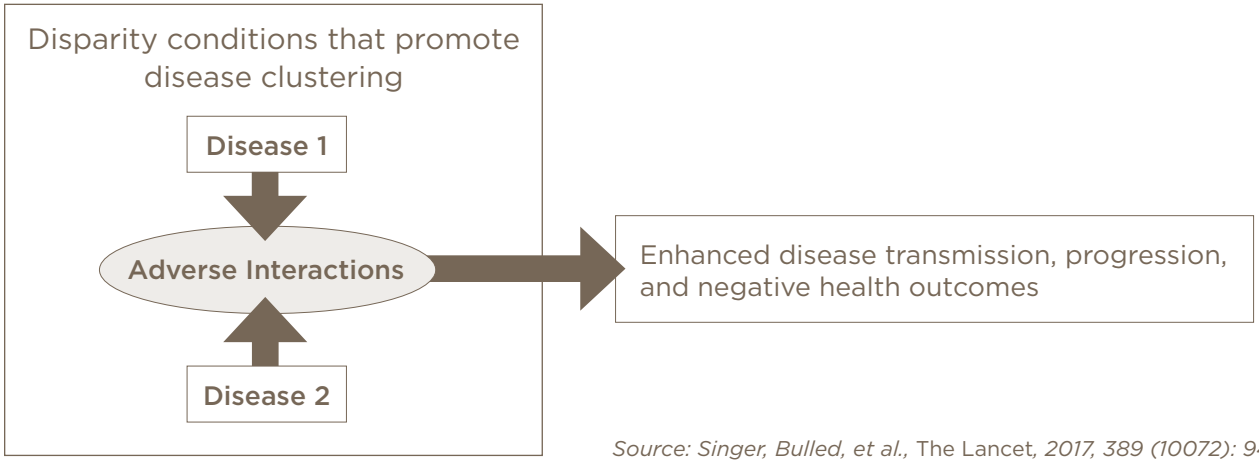
The first survey, published in March 2020, reported on responses from more than 6,500 nurses in 48 states, including the District of Columbia and one U.S. territory.[36]

- The second survey, published in May 2020, reported on responses from nearly 23,000 nurses from 50 states, the District of Columbia, and four U.S. territories collected between April 15 and May 10, 2020.[37]
- The third survey, published in July 2020, reported on responses from more than 21,200 nurses in 50 states, the District of Columbia, and three U.S. territories collected between July 7 and 27, 2020.[38]
- The fourth survey, published in November 2020, reported on responses from more than 15,000 nurses in 50 states, the District of Columbia, and two U.S. territories collected between Oct. 16 and Nov. 9, 2020.[39]
- The fifth survey, published in March 2021, reported on responses from more than 9,200 nurses in 50 states, the District of Columbia, and three U.S. territories collected between Feb. 2 and Feb. 28, 2021.[40]
- The sixth survey, published in September 2021, reported on responses from more than 5,000 nurses from 50 states, the District of Columbia, and one U.S. territory collected between June 1 and July 21, 2021.[41]

The fourth, fifth, and sixth NNU Covid-19 surveys asked questions regarding workplace violence. Quantitative survey results regarding workplace violence are presented in **Table 2**. Qualitative survey responses were analyzed for common themes. Quotes from survey responses have been edited to maintain anonymity and for clarity, but not to change meaning.

FIGURES AND TABLES

Figure 1. **Syndemic Model**



Source: Singer, Bulled, et al., The Lancet, *2017, 389 (10072): 941-50.*

Table 1. **Violence Experienced in Past Year, NNU's Workplace Violence Survey — 2020–2021**

Violence experienced in past year	Health care workers reporting (n=1,340)
Objects thrown at you	35%
Pinched or scratched	38%
Slapped, punched, or kicked	35%
Spat on or exposed to other bodily fluids	28%
Verbally threatened	64%
Physically threatened	34%
Groped or touched inappropriately	18%
Verbally harassed based on your sex or appearance	33%
I have not experienced workplace violence	19%
Other	18%

Table 2. **Workplace Violence Rates, NNU Covid-19 Surveys — 2020–2021**

NNU Covid-19 Survey	Nurses reporting slight or significant increase in work-place violence recently	Factors associated with increased workplace violence
Fourth survey, Nov. 2020	20%	Decreasing staffing levels Changes in the patient population Visitor restrictions
Fifth survey, March 2021	22%	Decreasing staffing levels Changes in the patient population Visitor restrictions
Sixth survey, Sept. 2021	31%	Decreased staffing levels Changes in the patient population Fewer visitor restrictions

Table 3. **Health Care Employers Failed to Prepare and Respond to the Covid-19 Pandemic to Protect Nurse and Patient Safety, NNU Covid-19 Surveys**

NNU Covid-19 Survey	Highlights from Results*
March 2020	Only 44 percent of nurses reported that their employer provided them information about novel coronavirus and how to recognize and respond to possible cases. Only 29 percent of nurses reported that there was a plan in place to isolate a patient with a possible novel coronavirus infection. Only 30 percent of nurses reported that their employer had sufficient PPE stock on hand to protect staff if there was a rapid surge in patients with possible coronavirus infections. Only 14 percent of nurses reported that their employer had an overflow plan to place additional, trained staff to enable safe care provision to patients on isolation for possible novel coronavirus.
May 2020	87 percent of nurses reported having to reuse a single-use disposable respirator or mask with a Covid-19 patient. 28 percent of nurses had to reuse a so-called "decontaminated" respirator with confirmed Covid-19 patients. Only about 16 percent of nurses reported being tested for Covid-19.
July 2020	87 percent of hospital nurses reported reusing at least one type of single-use PPE. 54 percent of nurses who worked in hospitals say their employer had implemented a program to "decontaminate" single-use PPE between uses. Only 23 percent of nurses reported being tested for Covid-19. Only 31 percent of nurses reported that every patient was screened for Covid-19. 27 percent of nurses who worked in hospitals reported that staffing had gotten much worse recently.

November 2020	More than 80 percent of nurses reported they were still reusing at least one type of single-use PPE. Only 42 percent of nurses in hospitals reported that they had ever been tested for Covid-19. Over 70 percent of nurses reported that their employers did not inform them of exposures in a timely manner. 44 percent of nurses who worked in hospitals reported that all patients were screened for Covid-19. 42 percent of hospital nurses reported that staffing had gotten slightly or much worse recently.
March 2021	81 percent of nurses reported they were still forced to reuse single-use PPE. Nearly 75 percent of hospital nurses reported wearing a respirator for every Covid-positive patient encounter. 54 percent of nurses overall and 61 percent of nurses in hospitals reported that they had ever been tested for Covid-19. 52 percent of nurses who worked in hospitals reported that all patients are screened for Covid-19. 47 percent of nurses reported that staffing had gotten slightly or much worse recently.
September 2021	61 percent of hospital nurses reported wearing a respirator for every Covid-positive patient encounter. 58 percent of nurses reported that only staff who are symptomatic can get tested. Nearly 20 percent reported access to testing is limited at their facility and 7 percent said testing is not available where they work. More than 75 percent of hospital nurses are not being notified of exposures to Covid in a timely way. Only two-thirds of hospital RNs report that all patients are screened for Covid-19 signs and symptoms before or upon arrival at the facility. Less than a third of hospital RNs reported that every patient is tested for Covid before or upon arrival at the facility. For visitors, screening and testing was reported to occur at even lower rates: Only 53 percent of hospital RNs report that every visitor is screened for Covid-19 signs and symptoms before or upon arrival at the facility and a mere 4 percent of RNs reported that all visitors are tested for Covid before or upon arrival. More than 57 percent of nurses report that staffing has gotten slightly or much worse. 49 percent hospital nurses report that their facility is using excessive overtime to staff units. Nearly a quarter of RNs who contracted Covid experienced symptoms from zero to three months, a third had symptoms lasting three to nine months, 12 percent had symptoms lasting nine to 12 months, and 12 percent more than a year. The most common symptoms reported included tiredness or fatigue, joint or muscle pain, memory or concentration difficulties, headaches or migraines, and difficulty breathing or shortness of breath.

*For full results:

- First survey: Survey of Nation's Frontline Registered Nurses Shows Hospitals Unprepared For COVID-19, March 5, 2020 https://www.nationalnursesunited.org/press/survey-nations-frontline-registered-nurses-shows-hospitals-unprepared-covid-19.
- Second survey: New survey of nurses provides frontline proof of widespread employer, government disregard for nurse and patient safety, mainly through lack of optimal PPE, May 20, 2020, https://www.nationalnursesunited.org/press/new-survey-results.
- Third survey: National nurse survey reveals devastating impact of reopening too soon, July 28, 2020, https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-devastating-impact-reopening-too-soon.
- Fourth survey: National nurse survey exposes hospitals' knowing failure to prepare for a Covid-19 surge during flu season, Nov. 12, 2020, https://www.nationalnursesunited.org/press/national-nurse-survey-4-exposes-hospitals-knowing-failure-prepare-covid-19-surge.
- Fifth survey: National RN survey highlights continued hospital failures to prioritize nurse and patient safety during pandemic, March 10, 2021, https://www.nationalnursesunited.org/press/fifth-survey-of-national-nurses-highlights-continued-hospital-failures.
- Sixth survey: National nurse survey reveals that health care employers need to do more to comply with OSHA emergency temporary standard, Sept. 27, 2021, https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers.

Table 4. **Employer prevention measures, NNU's Workplace Violence Survey — 2020–2021**

Employer prevention measures	Nurses and other health care workers reporting (n=1,340)
Provides training on workplace violence	58%
Uses a charting or room-flagging system to indicate patients with increased risk for violence	22%
Provides a clear way to report incidents	35%
Has security guards available at all times to respond to violent incidents	41%
Uses metal detectors	4%
Uses security cameras	26%
Limits visiting hours	18%
Includes nurses and other employees in violence risk assessments	15%
I'm not sure	14%
None of these	10%
Other	15%

Table 5. **Mental Health Impacts on Nurses During the Covid-19 Pandemic, NNU Covid-19 Surveys**

NNU Covid-19 Survey	Mental health impacts on nurses during the Covid-19 pandemic
July 2020	42 percent of nurses reported feeling stressed more often than before the pandemic. 38 percent felt more anxious than they did before the pandemic. 29 percent felt sad or depressed more often.
November 2020	Half of hospital nurses reported they had more difficulty sleeping than before the pandemic. Nearly 80 percent of hospital nurses felt more stressed than before the pandemic. Nearly three-quarters of nurses felt more anxious. 62 percent of nurses felt more sad or depressed.
March 2021	43 percent of hospital nurses had more trouble sleeping than before the pandemic. More than 61 percent of hospital nurses felt more stressed than before the pandemic. 57 percent of hospital nurses felt more anxious. 51 percent felt more sad or depressed. More than 58 percent of hospital nurses feared that they would contract the virus and infect a family member.
September 2021	Nearly 42 percent of hospital nurses fear they will contract Covid. Slightly more than 50 percent are afraid they will infect a family member. 35 percent are having more difficulty sleeping than before the pandemic. 53.5 percent feel stressed more often than before the pandemic. About 42 percent feel sad or depressed more often than they did before the pandemic. More than a third feel traumatized by their experiences caring for patients.

Table 6. **Impacts of workplace violence, NNU's Workplace Violence Survey — 2020–2021**

Impacts of workplace violence	Nurses and other health care workers reporting (n=1,340)
Physical injury or other physical symptoms (e.g., headaches, stomach aches, etc.)	26%
Took time off work	22%
Anxiety, fear, or increased vigilance	59%
Difficulty working in environment that reminds of me past incident	26%
Applied for workers' compensation	6%
Changed or left job	16%
Physical injury prevents me from working	4%
Psychological effects prevent me from working	8%
No injury/no effect	24%
Other	15%

Table 7. **Employer response to workplace violence, NNU's Workplace Violence Survey — 2020–2021**

Employer response to workplace violence		Nurses and other health care workers reporting (n= 1,340)
Investigates what happened	Yes	39%
	I don't know	27%
	No	34%
Provides access to counseling	Yes	30%
	I don't know	28%
	No	43%
Trains or retrains employees	Yes	42%
	I don't know	19%
	No	39%
Changes practices to reduce the risk of violence	Yes	20%
	I don't know	21%
	No	59%
Discourages employees from reporting incidents	Yes	15%
	I don't know	21%
	No	63%
Reprimands or blames employees	Yes	25%
	I don't know	22%
	No	53%
Ignores it	Yes	42%
	I don't know	23%
	No	35%

ENDNOTES

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