HUB

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WEBINAR

# Creating Safe Spaces:

## Confronting Workplace Violence in Healthcare

Moderator

## Peter Reilly

North American Practice Leader - Healthcare

HUB International

## Gigi Acevedo-Parker

**EJD, MSN, NP, APRN, CNS-BC, HCRM, CPS**

Healthcare Clinical Risk Management Practice Lead

HUB International

## Sheldon Price, CRSP

Senior Risk Consultant (Canada)

HUB International

## Jim Greaves, FSR, PSS, CPG

Vice President, Risk Services

HUB International

# Agenda

1. Defining Workplace Violence (WPV)
2. The Scope and Cost of WPV
3. Identifying WPV Risks & Vulnerabilities
4. Sexual Abuse and Molestation
5. The Legal & Legislative Landscape
6. Creating Safety Frameworks

# Defining Workplace Violence

# What is Workplace Violence (WPV)?

*"Any act or threat of physical force, harassment, intimidation, or threatening/disruptive behavior occurring at the worksite"*

**Recognized under both OSHA (US) and OHS legislation (Canada)**

Specific requirements vary by jurisdiction: some US states (e.g., California) maintain their own, more stringent WPV standards, and Canada's definition is synthesized across 13 provincial, territorial & federal frameworks

# Prevalence of WPV in Healthcare

These are the four commonly recognized types of workplace violence in healthcare, by perpetrator relationship to the workplace:

### Type I

Criminal intent — no legitimate relationship (robbery, trespassing)

### Type II

Customer/client — a patient, client, customer, or visitor

### Type III

Worker-on-worker — a current or former employee

### Type IV

Personal relationship — spillover from an employee's personal relationship (e.g., domestic violence)

**Type II WPV**
Where the perpetrator has a legitimate relationship with the workplace as a patient, client, customer, or visitor – is the most prevalent form in healthcare

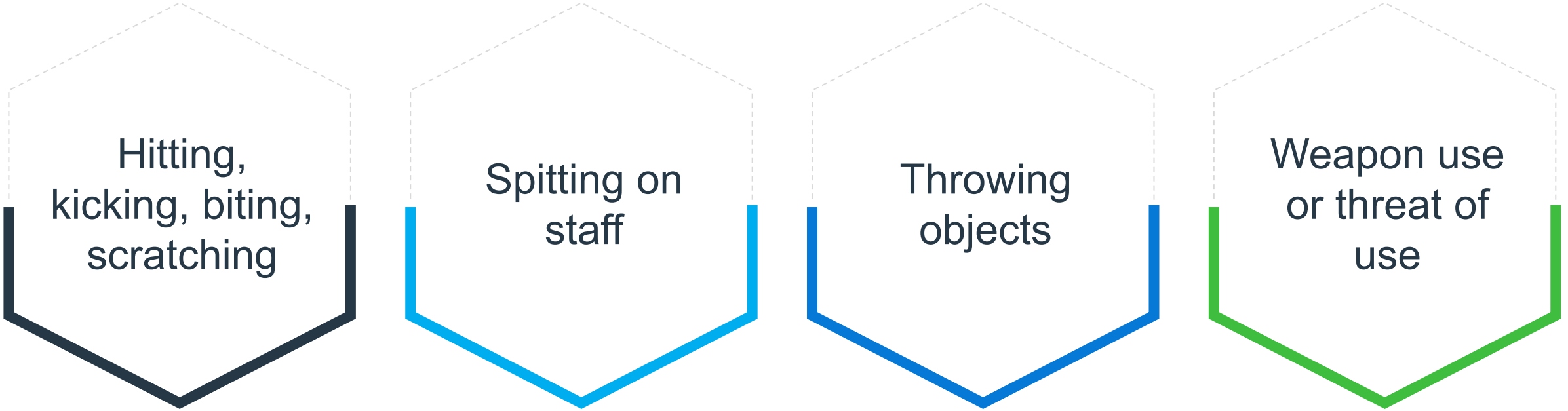
# Verbal and Psychological WPV

Threats (direct, conditional, veiled)

Screaming, berating, degrading language

Social media threats

# Physical Violence



# Sexual Abuse & Molestation

Unwanted touching, groping, or exposure

Boundary violations during exams, transport, or one-on-one care

Coercion or exploitation tied to caregiving/authority relationships

Staff-to-patient, patient-to-staff, and staff-to-staff misconduct

# Situational Triggers

- Behavioral health needs
- Treatment disagreement
- Substance intoxication
- Perceived disrespect
- Wait time frustration
- Visitor/family member escalation

# The Scope and Cost of WPV

# Who Bears the Burden?

## United States

**10K +**
reported healthcare worker incidents annually

Nursing assistants with the highest rate of reported WPV

**81.6%**
of RNs report experience with WPV (NNU 2025)

**91%**
of ER Physicians have been a victim of WPV or know another physician that has been a victim (ACEP 2024)

**68%**
of front desk staff – often the first point of contact – report WPV (AHA 2025)

## Canada

**70–90%** of Canadian nurses experience or witness physical violence at work

**5–6x** more likely to face violence than workers in other industries

Verbal abuse and threats reported daily

# Cost of Workplace Violence By the Numbers

## United States

**$18B**
Annual financial cost of violence to US hospitals (AHA 2023)

**60%**
of all workplace assaults target healthcare workers, who make up only 13% of the US workforce

**70%+**
of all private industry workers' comp assault claims are in healthcare and social services

**23 days**
average lost workdays per WPV injury in healthcare

**2x**
turnover rate among violence-exposed nurses vs non-exposed

## Canada

**$1.5B**
Estimated annual cost to healthcare facilities in Canada (claims + indirect costs)

**$316K**
Average annual cost per Canadian healthcare facility

**85%**
Increase in WPV-related long-term disability claims in BC, 2018–2022 (vs. 20% for other industries)

# The Dark Figure: Underreporting

**“Part of the Job”** — Violence normalized as a routine, unavoidable part of the culture

**Documentation Burden** — Restraint logs, incident reports, and injury records all underestimate actual event rates

# Failure to Act: The Cost of WPV Litigation

Major psychiatric hospital system in Massachusetts — OSHA citation upheld; sanctioned for destroying surveillance video of workplace violence incidents

Major psychiatric hospital system in Colorado — cited for failing to implement WPV programs, reconfigure nurse stations, or maintain adequate staffing

Texas jury verdict, 2024 — $60M+ (incl. $50M punitive) for negligent hiring of a security guard and an evidence cover-up

Ohio verdict — $27M for failure to conduct background checks

Nuclear verdicts in the U.S. (≥$10M) rose 52% between 2023–2024; half of all 2023 healthcare verdicts exceeded $25M — and 49.8% of medical liability premium increases in 2023–2024 are tied directly to this trend

Source: AHA (2025), TransRe, CNA Insurance, U.S. Chamber of Commerce ILR, OSHA, NNU | HUB International Clinical Risk Consulting

# Identifying WPV Risks & Vulnerabilities

# What is a High Risk WPV Healthcare Setting?


- No structured WPV hazard assessment
- Incidents go undetected until they escalate
- No behavioral flagging; same patients injure staff across multiple encounters
- Untrained staff in de-escalation and/or de-escalation failures
- No post-incident protocol
- Staff attrition
- PTSD claims

# Why It's Escalating

Chronic understaffing → higher patient loads, more frustration

Rising substance-use and behavioral health crises → more volatile, unpredictable patient presentations

Eroding public trust and thinning institutional support

Limited institutional follow-through on systems to protect employees

# When Risk Factors Become Reality: Winnipeg, Manitoba

- 3 of 6 public-funded hospitals in Winnipeg — Canada's 6th-largest city (850,000 population) — are now ***grey-listed*** by the local nurses' union as unsafe workplaces
- The designation is a formal warning: it discourages nurses from taking work at these facilities
- The drivers: violence, security gaps, communication failures, and unsafe staffing levels

# Sexual Abuse and Molestation

The Unspoken Workplace Violence

# The Threat of Abuse and Molestation is Real

| General Healthcare | |
|---|---|
| **$12.6M** | Average Payout |
| **71%** | of lawsuits filed within 10 years of the incidents |
| **28%** | of the offenders has prior concerns reported |
| **23%** | of cases involved multiple victims |

| Academic Healthcare | |
|---|---|
| **$280.5M** | Average Payout |
| **85%** | of cases involve multiple victims |
| **99%** | of the offenders were male |
| **62%** | of the victims were female |

# How and When Does Abuse Occur

**Access**

**Privacy**

**Control**

# Safe Environment

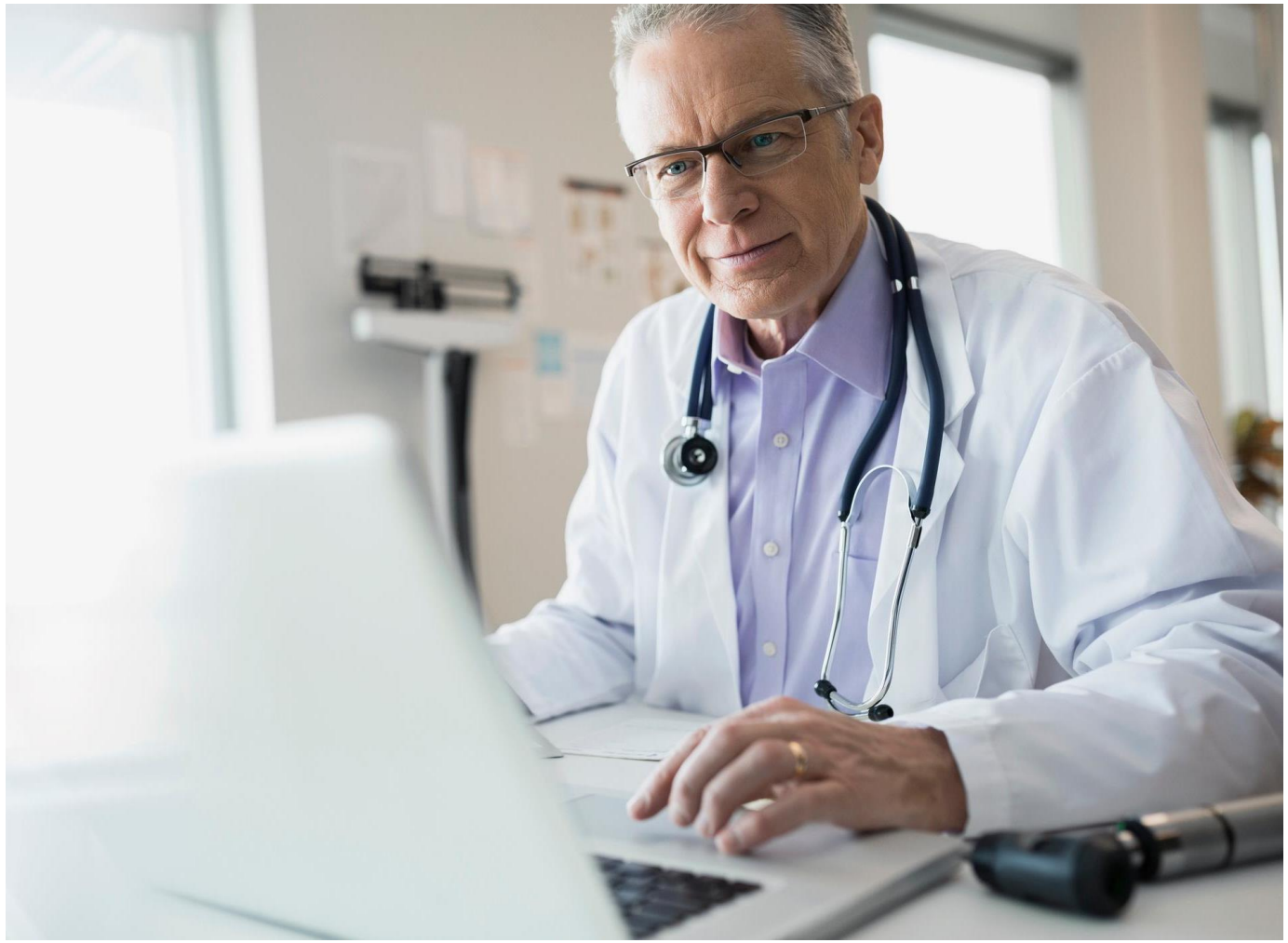
- Policies
- Screening & Selection
- Training
- Monitoring and Supervision
- Internal Feedback Systems
- Consumer Participation
- Responding
- Administrative Practices

# Non-Contact and Digital Abuse

The Rise of Non-Contact and Digital Abuse

Social Media Policies

Risks Evolve



# Failure to Act: Landmark Abuse Cases

Weill Cornell — over $1 billion in settlements (2026)

Major Behavioral Health Hospital in Illinois — $535 million jury verdict (2024)

UCLA — nearly $700 million across multiple settlements (2023)

USC — over $1.1 billion in combined settlements (2018 & 2021)

Johns Hopkins — $190 million settlement (2014)

Beebe Medical Center — $124 million settlement (2012)

**Together, these cases exceed $3.6 billion in combined settlements**

# The Legal & Legislative Landscape

# The Legal and Legislative Landscape in the US

## Federal Pending and Enforced

The **Save Healthcare Workers Act** would make assaulting a hospital worker a federal crime. A bipartisan bill designed to protect healthcare workers from violence.

No dedicated federal WPV standard exists — so OSHA's General Duty Clause is the primary federal tool, actively enforced, with citations now exceeding $165,000 per violation

20+ states now require WPV prevention plans, site assessments, training, and reporting — California's framework is currently the most developed nationally

# The Legal and Legislative Landscape in Canada

OHS violence prevention policies are now mandatory in every province.

Psychological hazard control is now law in Quebec (Oct 2025) and takes effect in BC in 2027.

The Federal Criminal Code has been amended twice to specifically protect healthcare workers:

Unlike the US, third-party lawsuits over workplace violence are rare in Canada — workers' compensation is typically the exclusive remedy, channeling most claims through the provincial WCB system rather than civil court

**Bill C-3 (2022)** makes it illegal to intimidate a healthcare worker or obstruct access to a health facility, punishable by up to 10 years in prison.

**Bill C-321 (2024)** requires courts to treat assault on a healthcare worker as an aggravating factor at sentencing.

# Creating Safety Frameworks

# A Comprehensive WPV Prevention Program - US

- Management Commitment (WPV prevention plan, zero-tolerance policy with enforcement pathway, board-level accountability)
- Training (de-escalation training for all staff, security-clinical co-response training)
- Hazard Assessment/Analysis (site-specific risk assessments by unit/setting)

# A Comprehensive WPV Prevention Program - Canada

## Management Commitment

- Develop a written workplace violence policy and review it annually, with senior leadership sign-off

## Training

- Ensure all workers are trained on the program

## Hazard Assessment/Analysis

- Conduct a workplace violence risk assessment — evaluate risk specific to the workplace, and reassess as conditions change
- Investigate and deal with incidents and complaints of workplace violence; review and revise the risk assessment and program after investigation findings

## Worker Disclosure & Protections

- Disclose to workers the history of violent behavior by a patient, client, or resident if a worker can be expected to encounter that person and is at risk of physical injury
- Workers may refuse unsafe work where workplace violence is a threat

# Practical Next Steps

## Evaluating and Strengthening Your Organization's Approach to WPV

- Immediately, audit your incident reporting system: are near-misses captured?
- Confirm your jurisdictions current WPV legislation status (state, provincial, or territorial)
- Conduct a unit-by-unit hazard risk assessment, using OSHA's healthcare WPV checklist (US), your provincial OHS WPV risk assessment requirements (Canada), or a custom risk assessment tool
- Evaluate your de-escalation training program
- Engage your risk committee to present prevalence data and cost exposure
- Establish a WPV dashboard, reported quarterly to leadership
- Benchmark annually against orgs such as CPI or ASHRM in the US, HIROC or the Canadian Federation of Nurses Unions (CFNU) in Canada
- Engage a qualified risk consultant before acting on jurisdiction-specific compliance questions

# Practical Next Steps: Sexual Abuse & Molestation

1. **Assess Current Operations**
   Evaluate access, privacy, and control exposures across every unit, service line, and third-party contact point
2. **Review Current Protocols**
   Chaperone policy, screening, credentialing, incident reporting, and training against what's actually in place today
3. **Conduct a Gap Analysis**
   Measure your program against best-in-class prevention standards
4. **Review Findings with Stakeholders**
   Clinical leadership, HR, compliance, and risk
5. **Develop & Implement**
   SAM-specific policies, procedures, and a response playbook — built for your operations, not boilerplate
6. **Review Regularly**
   Reassess at least annually, and immediately after any law change, major incident, or operational shift

# Q&A

# Upcoming Events

**hubinternational.com**/events/

**WEBINAR – Employee Benefits**

## AI in Employee Benefits:

Managing Compliance in an Era of Automated HR

**Wednesday, September 23 | 12 PM CT**

# Thank you

For more information visit **hubinternational.com**

# APPENDIX

# Glossary of Terms

- **Access, Privacy, Control** — The three conditions that must typically converge for sexual abuse to occur
- **Aggravating Circumstance** — Legal factor increasing sentencing severity; in Canada, assault on a healthcare worker now qualifies (Bill C-321, 2024)
- **Grooming Behavior** — A manipulation pattern used to build trust and access to a victim
- **Hazard Assessment** — Structured, site-specific review identifying WPV risk factors before an incident occurs
- **Non-Contact / Digital Abuse / Social Media** — Abuse without physical contact — explicit messaging, image sharing, online grooming
- **OHS (Occupational Health and Safety)** — Canada's provincial/federal framework governing WPV prevention
- **OSHA (Occupational Safety and Health Administration)** — The U.S. federal agency responsible for workplace safety regulation
- **OSHA General Duty Clause** — U.S. requirement that employers maintain a hazard-free workplace, including violence
- **Praesidium Safety Equation** — 8-part safe-environment framework: Policies, Screening, Training, Supervision, Feedback, Participation, Responding, Administration
- **Psychological Hazard** — Recognized occupational hazard covering moral injury, vicarious trauma, and harassment
- **Statute of Limitations** — Legal filing deadline for civil claims; many jurisdictions have extended it for abuse cases
- **Two-Adult Rule** — Requiring a second adult present during one-on-one exams or interactions
- **Type I–IV WPV** — A commonly recognized 4-part classification by perpetrator relationship; Type II (patient/visitor) is most common in healthcare
- **WCB (Workers' Compensation Board)** — Canada's provincial system for workplace injury claims; most WPV claims flow through WCB rather than civil court
- **WPV (Workplace Violence)** — Any act or threat of violence, harassment, or intimidation at the worksite
- **Zero-Tolerance Policy** — A policy setting no acceptable threshold for workplace violence, with clear enforcement

# Regulatory References - US

## Federal

- OSHA — Workplace Violence topic page (overview, prevention programs, enforcement)

## Enacted State Law

- California — Title 8 CCR §3342, Violence Prevention in Health Care
- Connecticut — Public Act 11-175 (2011), Workplace Violence Prevention and Response in Health Care Settings
- Kentucky — HB176 (2023), health care workplace safety requirements
- Texas — Health and Safety Code Chapter 331, Workplace Violence Prevention
- Washington — RCW Chapter 49.19, Safety — Health Care Settings

## Pending Legislation

- Alaska — SB 49, Workplace Violence Protective Orders

# Civil Statutes of Limitations for Childhood Sexual Abuse*

| State | Civil statute of limitations |
|---|---|
| Alabama | 2 yrs from injury (no discovery rule) |
| Alaska | No limit for felony CSA; discovery rule applies |
| Arizona | By age 30 (majority + 12 yrs) |
| Arkansas | 3 yrs from discovery (2021 revival window struck down, Feb. 2025) |
| California | No limit (abuse on/after 1/1/2024); 2-yr lookback opened 1/1/2026 (AB 250) |
| Colorado | No limit (misconduct on/after 1/1/2022) |
| Connecticut | By age 51 (age 21 + 30 yrs) |
| Delaware | No limit; pending bill (HB 75) could expand further |
| District of Columbia | By age 40, or discovery + 5 yrs (abuse before 35) |
| Florida | Majority + 7 yrs, or discovery + 4 yrs; no limit if victim <16 |
| Georgia | By age 23, or discovery + 2 yrs |
| Hawaii | Age 18 + 8 yrs, or discovery + 3 yrs |
| Idaho | Majority + 5 yrs, or discovery + 5 yrs |
| Illinois | No limit (if not time-barred before 1/1/2014) |
| Indiana | 7 yrs from act, or 4 yrs after dependency ends |
| Iowa | Majority + 5 yrs, or discovery + 5 yrs (H.F. 1036, signed 5/15/2026) |
| Kansas | Age 18 + 13 yrs, or conviction + 3 yrs |
| Kentucky | 10 yrs from act / discovery / age 18 / conviction |
| Louisiana | No limit |
| Maine | No limit (2021 revival of expired claims struck down 2025) |
| Maryland | No limit (Child Victims Act 2023; retroactive, upheld 2025) |
| Massachusetts | 35 yrs from act, or discovery + 7 yrs |
| Michigan | By age 28, or discovery + 3 yrs (reform bill pending in House, not yet law) |
| Minnesota | No limit if abused under 18 (adults: 6 yrs) |
| Mississippi | 3 yrs from act or removal of disability |

| State | Civil statute of limitations |
|---|---|
| Missouri | Age 21 + 10 yrs, or discovery + 3 yrs |
| Montana | By age 27, or discovery + 3 yrs |
| Nebraska | No limit (assault on/after 8/24/2017) |
| Nevada | No limit (abuse under 18) |
| New Hampshire | No limit |
| New Jersey | Majority + 37 yrs, or discovery + 7 yrs |
| New Mexico | By age 24, or 3 yrs from disclosure to provider |
| New York | By age 55 (Child Victims Act); NYC 18-mo lookback opens 3/2026 |
| North Carolina | By age 28, or conviction + 2 yrs |
| North Dakota | 21 yrs from accrual (clock starts at age 15) |
| Ohio | By age 30 (majority + 12 yrs) |
| Oklahoma | By age 45 |
| Oregon | By age 40, or discovery + 5 yrs |
| Pennsylvania | By age 55 (majority + 37 yrs) |
| Rhode Island | 35 yrs from act, or discovery + 7 yrs |
| South Carolina | By age 27, or discovery + 3 yrs |
| South Dakota | 3 yrs from act/discovery; no non-perp claims after 40 |
| Tennessee | Age 18 + 15 yrs (post-7/1/19), or discovery + 3 yrs |
| Texas | No limit — serious child sex offenses (SB 1167, 2025, retroactive) |
| Utah | No limit vs. perpetrator (non-perp: majority + 4 yrs) |
| Vermont | No limit |
| Virginia | 20 yrs from cause of action |
| Washington | No limit for abuse on/after 6/6/2024 (HB 1618); pre-6/6/2024 abuse: 3 yrs from act/discovery, tolled to age 18 |
| West Virginia | Majority + 18 yrs, or discovery + 4 yrs |
| Wisconsin | By age 35 |
| Wyoming | Majority + 8 yrs, or discovery + 3 yrs |

*Updated August 20, 2026

● No civil deadline (file any time, some/all claims)

● Deadline tied to victim's age

● Fixed years from the act and/or discovery

# Regulatory References - Canada

## Federal

- House of Commons HESA Committee — 2019 federal study on violence facing healthcare workers
- Canadian Medical Association — National guidance on preventing violence in health care

## British Columbia

- BC Nurses' Union — Risk assessment tools, reporting guidance, and workers' rights

## Alberta

- Alberta Health Services — Policies for preventing, reporting, and responding to workplace violence

## Manitoba

- MASH — Healthcare-specific program for physical and psychological safety

## Ontario

- Ontario.ca — Legal guide to WPV prevention for hospitals, long-term care, and home care

## Quebec

- CNESST — Official guide to Law 27's occupational health and safety modernization requirements

# Quebec Law 27

## Law modernizing the occupational health and safety regime

### ARE YOU PREPARED FOR THE CNESST'S DEADLINE?

**When:** Law 27 went into effect in October 2025. As we approach October 2026, employers should be finalizing compliance steps. Penalties can apply for any non-compliance.

**UPDATE:** to align with the 3-year planning cycle, CNESST has extended the date to submit the final prevention plan to October 2028.

**Who:** All employers with a workforce in Quebec (including remote workers)

**How:** Employers will be required to:

- Facilitate the creation of employer representation systems
- Identify and measure the psychosocial risks in your workplace
- Implement policies to prevent psychological harassment and injuries in the workplace
- Document your actions and prepare for possible inspections

### HOW HUB HELPS YOU COMPLY WITH LAW 27

**We estimate organizations will need 3 to 6 months** to implement compliance steps.

**Guided Approach**

HUB will support your internal team(s) through each step of the Law 27 compliance process, including:

- Bi-weekly guidance meetings with task list
- Communication support
- Risk assessment and prevention plan review

**Managed Approach**

HUB will lead and manage most activities. An internal working team will be responsible for:

- Collecting and sharing documents and data
- Providing feedback
- Implementing the prevention/action plan

### OUR EXPERTISE

HUB's Health & Performance includes CMHA-certified psychological health and safety experts who help organizations proactively identify, address, and mitigate psychosocial risks — building healthier, more resilient workplaces.