PINPOINT©
De-escalation Technology

WORKPLACE VIOLENCE PREVENTION IN HEALTHCARE

Compliance, Culture, and Compassionate Technology.

A working guide to workplace violence, staff privacy, and the laws now shaping how hospitals must protect the people who protect all of us.

Table Of Contents

CHAPTER ONE

The Shift That Changed Everything

You don't need a study to tell you it's getting worse. You've felt it in the hallway.

I have walked more hospital corridors than I can count, not as a patient and rarely as a visitor, but as someone who has spent years standing beside the people who do this work every day. I have watched a charge nurse pause outside a door, take one breath, and arrange her face into calm before she turns the handle. I have sat in break rooms while techs and aides quietly compared notes on which rooms to enter with a partner instead of alone. Nobody wrote any of that down. It simply became the shape of the shift.

That pause outside the door is the story this guide is really about. Not the policy language, not the citation codes, though we will get to both. This is about the moment before the moment, the second where a nurse decides whether she feels safe enough to do her job the way she was trained to do it.

For a long time, that feeling was treated as a personal problem. Toughen up. Learn de-escalation. Watch your surroundings. But feelings like that are data. When the same hesitation shows up on the same unit, shift after shift, it is telling you something about the environment, not about the individual standing in the doorway.

> Healthcare workers now experience violence-related injuries at nearly five times the rate of the average private industry worker.

I have come to know this world through Pinpoint, where our team spends its days building technology meant to sit quietly on a badge or lanyard until the one moment it is needed. But long before any of that, this is a story about people. Nurses who love their patients and are exhausted by fear of the ones who might hurt them. Behavioral health techs who talk someone down from a crisis three times in a shift and then go home and can't sleep. Chaplains, food service workers, and security guards who all cross paths with the same unpredictable hallway.

This guide walks through why that hallway has gotten harder to work in, what the law actually requires of the people who run it, and why the technology meant to protect staff has to be built with as much respect for their privacy as for their safety. It starts, as most real problems do, with the numbers nobody wanted to say out loud for a long time.

CHAPTER TWO

The Weight We Carry

Ambient trauma, moral injury, and why burnout is not a personal failing.

There is a term we use often at Pinpoint: ambient trauma. It describes the quiet, cumulative weight carried by healthcare workers who live in a low, constant state of readiness for the next incident. It is not one bad night. It is the sum of every night where something almost happened, layered on top of the nights when it did.

Psychologists have long understood that the body keeps score of stress even when the mind tries to move past it. A nervous system that stays braced for danger, shift after shift, does not simply reset when the badge comes off at the end of the day. That hypervigilance follows people home. It shows up as trouble sleeping, a short fuse with family, a numbness that makes it hard to feel present anywhere, including at work. Clinicians sometimes describe this layered exhaustion as moral injury: the sense of being unable to provide the level of care and safety you know your patients and colleagues deserve, no matter how hard you try.

WHAT NURSES ARE TELLING US

84.8%

experienced at least one type of workplace violence last year

36.4%

said violence ontheir unit rose versus he year before

63.1%

reported anxiety, fear, or increased vigilance afterward

25.5%

said the violence made them consider leaving the profession

Source: National Nurses United, The State of Workplace Violence in Health Care in 2025 to 2026 (1,267 RNs, 28 states and D.C.)

Read those numbers slowly. One in four nurses who face violence at work start thinking seriously about leaving nursing altogether, not the hospital down the road, the profession itself. That is not a staffing hiccup. That is a pipeline problem years in the making, and it starts with a single unaddressed incident that never gets reported and never gets fixed.

Burnout, in this light, stops looking like a personality trait and starts looking like an entirely predictable outcome of an unaddressed hazard. When people are given the tools to act instead of just endure, something shifts. Agency is the antidote to helplessness. A nurse who knows she can summon help in seconds, and who trusts that help will actually come, is a nurse who can stay present with her patient instead of half her attention scanning the door. That trust has to be earned, and it starts with taking the hazard seriously enough to measure it.

CHAPTER THREE

By The Numbers

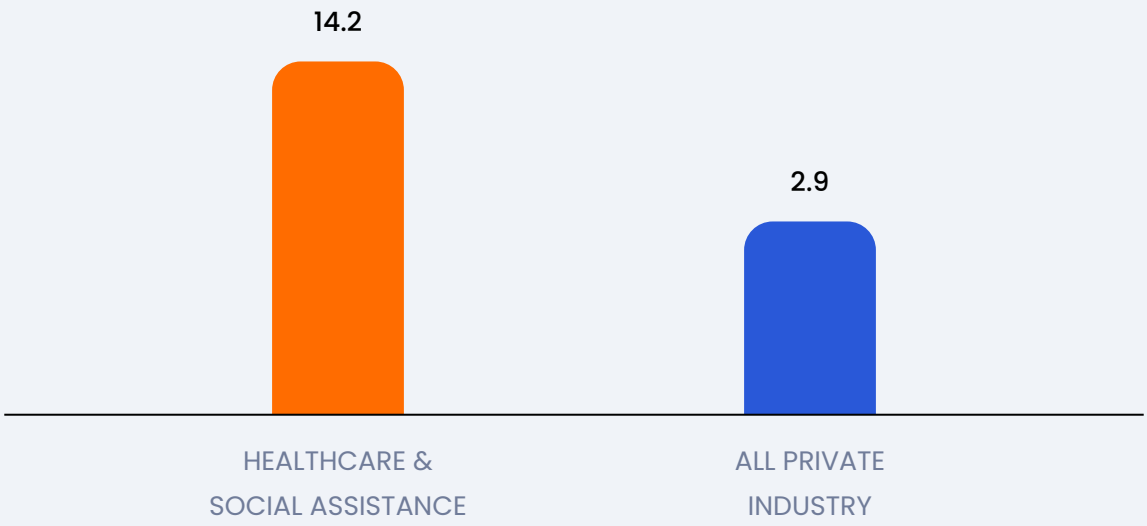
The scope of the crisis, and what it costs to ignore it.

Every administrator I have sat across from asks some version of the same question: how bad is this, really, compared to everything else competing for budget and attention this quarter? So let's be precise about it.

Healthcare and social assistance workers experience violence-related injuries at a rate of 14.2 per 10,000 full-time workers, compared with 2.9 across private industry overall, according to 2021–2022 Bureau of Labor Statistics data. That is nearly five times the private-industry rate. The same BLS data show that the health care and social assistance sector accounted for 72.8 percent of all private-industry workplace-violence cases requiring days away from work, job restriction, or transfer over that two-year period. A 2024 peer-reviewed study in Health Affairs Scholar, using BLS data, found that workplace-violence incidents at general medical and surgical hospitals increased 158 percent between 2011 and 2021/2022.

INJURY RATE: HEALTHCARE VS. ALL PRIVATE INDUSTRY

Workplace-violence cases per 10,000 full-time workers



SOURCE

U.S. Bureau of Labor Statistics, Workplace Violence, 2021–2022.

Here is the part that should worry every safety director even more: much of this violence never enters the official record. A widely cited 2015 study found that only 12 percent of healthcare workers who reported experiencing a violent incident had documented it through their hospital's official reporting system. In National Nurses United's latest survey, just 38.4 percent of nurses said their employer provided a clear way to report workplace-violence incidents. Your incident log, in other words, is likely to show only part of the problem. Staff may remain silent because they do not believe reporting will lead to meaningful action, or because filing a report competes with immediate patient-care responsibilities.

The financial burden is also substantial. The American Hospital Association estimates that workplace and community violence cost U.S. hospitals $18.27 billion in 2023. This included $3.62 billion in pre-event prevention and preparedness costs and $14.65 billion in post-event costs. Within the post-event total, the report estimated $541.3 million in staffing costs and $79 million in work-loss costs. Separately, the 2026 NSI National Health Care Retention and RN Staffing Report estimates that turnover for one bedside registered nurse costs an average of $60,090. Based on hospital performance reported in the survey, hospitals lost an average of $5.19 million to RN turnover in 2025.

THE COST OF DOING NOTHING

$18.27B

Total annual cost of violence to U.S. hospitals

$541.3M

Staffing-related costs: absenteeism, loss of productivity, and turnover

$60,090

Average cost to replace a single bedside RN

$5.19M

Average annual RN turnover cost for an average hospital

SOURCE

American Hospital Association, The Burden of Violence to U.S. Hospitals (2023 data; report published March 2025); NSI Nursing Solutions, 2026 NSI National Health Care Retention & RN Staffing Report.

Facilities with the weakest alert infrastructure tend to show the highest violence rates. That correlation matters because it means this is a variable leadership can actually move. Staffing shortages and rising patient acuity will not be solved overnight. Giving staff a reliable, trusted way to summon help the moment something goes wrong is something a facility can act on this quarter, not next decade.

CHAPTER FOUR

The Federal Baseline

What OSHA actually requires, and what it doesn't, yet.

Here is the honest answer, and it surprises most people the first time they hear it: federal OSHA has no dedicated, enforceable standard specifically governing workplace violence prevention in healthcare, not as of this writing. The agency's proposed rule has moved into Long-Term Action status on OSHA's regulatory agenda, meaning no federal standard is expected within the next year at minimum.

That does not mean facilities are off the hook. OSHA continues to cite healthcare employers under the General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health Act, whenever an employer knew violence was a recognized hazard at its facility, had a feasible way to reduce it, and failed to act. Inspectors lean heavily on OSHA's 2016 guidance document, publication 3148, as the reference framework for what a reasonable prevention program looks like, even though that document itself is voluntary.

State requirements also matter. OSHA currently approves 29 State Plans, but only 22 cover private-sector employers; the remaining seven apply solely to state and local government workers. Comprehensive State Plans, including those in California, Washington, Oregon, and Michigan, may adopt and enforce requirements that are at least as effective as the federal OSHA framework, and some states have established more specific workplace-violence protections.

Congress has not been silent on this either, even if it has not yet acted. The Workplace Violence Prevention for Health Care and Social Service Workers Act, reintroduced in the current Congress as S.1232 and H.R.2531, would direct the Secretary of Labor to issue an interim final standard within a year of passage, built at minimum on OSHA's existing 2015 guidelines. I would love to tell you that means a federal rule is close. It doesn't. Similar bills have circulated in prior sessions of Congress without reaching a floor vote, and with OSHA's own proposed rule parked in long-term status, nobody I talk to inside compliance circles expects federal movement in the next year, possibly longer. The realistic posture for a safety director is to treat the General Duty Clause and OSHA Publication 3148 as the floor you must clear today, while watching state legislatures, not Washington, for what tomorrow's floor will look like.

FIVE ELEMENTS OF AN OSHA-ALIGNED PREVENTION PROGRAM

01 MANAGEMENT COMMITMENT & WORKER PARTICIPATION
Leadership funds the plan; frontline staff help write it.

02 WORKSITE ANALYSIS & HAZARD IDENTIFICATION
Incident logs, near misses, and unit-specific risk reviews.

03 HAZARD PREVENTION & CONTROL
Access controls, staffing thresholds, wearable duress alerts.

04 SAFETY & HEALTH TRAINING
De-escalation and alert activation, documented and refreshed yearly.

05 RECORDKEEPING & PROGRAM EVALUATION
Logged per 29 CFR 1904, reviewed and used to update the plan.

SOURCE

OSHA Publication 3148, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

A written plan that never leaves the shared drive protects no one. What actually holds up during an OSHA inspection, or in litigation after an incident, is a living record: a walkthrough of every unit, interviews with staff about where they feel least safe, and controls that are specific rather than aspirational. "Staff know to call for help" is a weak control. "Staff wear a device that notifies security within seconds and identifies their room" is the kind of specific, documented control that inspectors and courts take seriously.

CHAPTER FIVE

Accreditation as Enforcement

What The Joint Commission is actually looking for during survey.

If OSHA is the quiet backstop, The Joint Commission is the far more immediate pressure most hospital leaders feel. Since it does not issue fines, its enforcement runs through accreditation itself, which is tied to a hospital's ability to participate in Medicare and Medicaid. That gives its standards real teeth.

The Joint Commission defines workplace violence broadly: verbal, nonverbal, written, or physical aggression, intimidation, bullying, sabotage, sexual harassment, and physical assault, whether directed at staff by patients, visitors, or each other. New and revised standards took effect January 1, 2022, for all accredited hospitals and critical access hospitals, and were extended to behavioral health care and human services organizations on July 1, 2024.

THE COMPLIANCE TIMELINE, AND WHAT HAPPENS IF YOU MISS IT

JAN 2022

Hospital standards take effect

Requirement for Improvement (RFI)

JUL 2024

Behavioral health & human services included

Conditional accreditation

JAN 2026

Existing rules folded into a Performance Goal

Denial or revocation, CMS participation at risk

SOURCE

The Joint Commission, National Performance Goals and R3 Report Issue 42, 2024 to 2026

In practice, surveyors look for three anchor standards. EC.02.01.01 requires an annual worksite analysis with documented action to resolve what it finds. EC.04.01.01 requires an ongoing process to monitor, investigate, and internally report incidents. HR.01.05.03 requires staff to receive ongoing, documented education and training. Since these standards took effect, The Joint Commission has cited hospitals on well over a hundred requirements for improvement tied to workplace violence, each one requiring correction within sixty days. On January 1, 2026, The Joint Commission folded these same requirements into a new National Performance Goals chapter, replacing the old National Patient Safety Goals structure. It is a reorganization more than a rewrite, but it raises the bar in practice: goal-based framing makes gaps easier for a surveyor to spot, and documentation now has to show the program is actually running, not just written down.

Facilities that treat this seriously tend to have three things in common: a designated program leader with real authority, incident data that actually gets reviewed by the governing body, and a technology layer, most often a staff alert system, that a surveyor can point to as a documented, specific control rather than a vague statement of intent.

CHAPTER SIX

The Patchwork

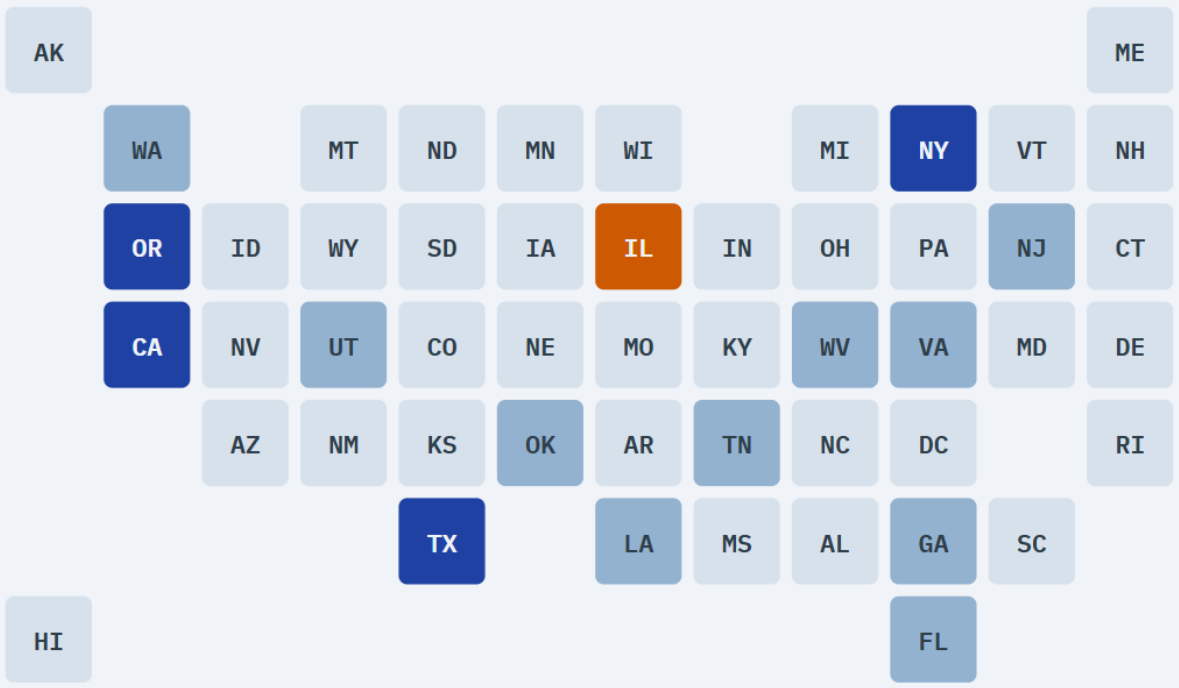
State laws are moving faster than federal rulemaking. Here is what to track.

With no dedicated federal standard, states have stepped into the gap, and quickly. For a multi-state health system, the result is a genuine patchwork, with real enforcement teeth attached in several places.

California SB 553 established broad workplace-violence prevention requirements for most California employers not already covered by a more specific standard. Signed on September 30, 2023, and enforceable since July 1, 2024, it requires covered employers to establish, implement, and maintain a written workplace-violence prevention plan tailored to workplace hazards, provide employee training, maintain a violent-incident log, and review the plan at least annually and after workplace-violence incidents. Cal/OSHA may cite noncompliance, with penalties depending on the classification and circumstances of the violation; the maximum penalty for a serious violation is $25,000. California healthcare employers covered by Title 8, Section 3342 are generally subject to the state's existing healthcare-specific workplace-violence standard rather than SB 553's general-industry requirements. Cal/OSHA is developing a permanent general-industry, non-healthcare standard that must be adopted by December 31, 2026.

Illinois SB 1435 would amend the Hospital Licensing Act and University of Illinois Hospital Act to require hospitals to provide employees with panic buttons attached to their staff identification cards. Although the bill text lists July 1, 2025 as its proposed effective date, it has not completed the legislative process. As of March 27, 2026, the Illinois General Assembly listed it as re-referred to the Senate Assignments Committee. It should therefore be described as pending legislation, not an enacted mandate.

THE STATE LAW MAP, AT A GLANCE



- Comprehensive healthcare WPV law enacted (CA, TX, OR, NY)
- Panic-button mandate pending (IL)
- Alyssa's Law enacted, school precedent
- No healthcare-specific mandate identified

SOURCE

Sources: California Labor Code §6401.9; Texas SB 240; Oregon SB 537; New York A203B/S5294B; Illinois SB 1435 (pending, Illinois General Assembly bill tracker)

It is worth understanding Alyssa's Law even though it was written for schools, not hospitals. First enacted in New Jersey in 2019 and Florida in 2020, it requires silent panic alert systems connected directly to law enforcement. Trackers vary on the exact count depending on how they treat pending bills, but by mid-2026 at least eleven states, including New Jersey, Florida, Texas, Tennessee, Oregon, and Washington, have enacted some version of it. Safety directors at healthcare facilities in those states are already fielding a familiar question from administrators: why don't we have something like this for our own staff? Legislative patterns tend to migrate from schools to healthcare on a three to five year cycle, which means facilities that already have staff alert infrastructure in place are ahead of the next wave of mandates, not scrambling to catch up.

The practical lesson for a multi-state system is simple: build to the strictest standard you are subject to, and the lighter requirements elsewhere tend to take care of themselves.

CHAPTER SEVEN

Privacy Is Not a Luxury

What the ACLU and California's newest privacy law both say about tracking employees.

Here is the tension nobody talks about enough: the same instinct that makes a facility want to protect its staff can, if built the wrong way, become its own source of harm. Continuous location tracking of employees is not a hypothetical privacy concern. It is a documented one, with its own legal and psychological literature.

The American Civil Liberties Union has argued for years that workplace monitoring should be narrowly tailored in time, place, and manner, that employers should be transparent with workers about what is being monitored, and that even legitimate monitoring should never create an atmosphere of pervasive surveillance or intimidation. That is not an abstract principle. The ACLU has pointed to research on electronic monitoring showing that employees who know they are being continuously tracked report measurably higher stress, more anxiety, and physical symptoms tied to sustained hypervigilance, the same physiological pattern we described in ambient trauma back in Chapter Two. In other words, a surveillance-based safety system can quietly recreate the exact harm it was meant to solve.

> A badge that only speaks when a nurse presses it protects her. A badge that reports her location all day long monitors her. The difference matters, legally and clinically.

California has already turned part of this principle into enforceable law. Until January 1, 2023, employee-related data was largely carved out of the California Consumer Privacy Act, although limited obligations still applied. That exemption became inoperative on January 1, 2023, after the California Privacy Rights Act amendments took effect, and California employees, applicants, and similar personnel now generally have access to core CCPA rights, including the rights to know, correct, delete, and, in certain circumstances, limit the use and disclosure of sensitive personal information. The statute expressly includes precise geolocation data within the definition of sensitive personal information. Accordingly, if a hospital is a covered CCPA business and operates a continuous real-time location system on California-resident staff, it may be handling regulated sensitive personal information, with related notice, access, correction, deletion, and retention obligations under the law.

CONTINUOUS TRACKING VS. NON-TRACKING DURESS ALERTS

CONTINUOUS RTLS TRACKING	CONTINUOUS RTLS TRACKING
Logs staff movement all day, every day	Silent unless a staff member presses it
May qualify as sensitive personal data	No location data exists until activation
Raises HR and morale complications	Aligns with ACLU narrow-tailoring principle
Requires ongoing IT & network management	Hardwired, independent of Wi-Fi and Bluetooth
Higher staff distrust, lower adoption	Higher staff trust, higher daily adoption

None of this means location technology is the enemy. It means the design choice matters as much as the intent behind it. A system that shares a room location only at the moment a nurse asks for help respects both the letter of emerging privacy law and the spirit of what the ACLU has been asking employers to do for decades: protect people without watching them.

CHAPTER EIGHT

Why We Built Pinpoint

And why it is not like the other panic button systems on the market.

Everything in this guide, the injury data, the OSHA framework, the Joint Commission standards, the state law patchwork, the privacy research, is the reason Pinpoint exists. For more than three decades, our staff alarm systems have been built around one belief: a nurse should never have to choose between being protected and being watched.

Most panic button technology on the market falls into a few categories, each with a real tradeoff. Fixed-point systems, like wall-mounted or under-desk buttons, are hardwired and reliable, but only within reach of the device itself, and nurses rarely stay in one room. Smartphone-based systems travel with the user but depend on GPS, Wi-Fi, or cellular signal that is often unreliable deep inside a hospital, and they add another device for a busy clinician to manage. Continuous RTLS wearables offer high location precision, but they track staff movement all day long, require complex infrastructure to maintain, and, as we covered in the last chapter, raise exactly the privacy concerns regulators and staff are now pushing back on.

PANIC BUTTON SYSTEMS, COMPARED

CRITERIA	FIXED-POINT	SMARTPHONE	RTLS WEARABLE	PINPOINT
Moves with staff	No	Yes	Yes	Yes
Works without Wi-Fi/Bluetooth	Yes	No	No	Yes
Tracks staff continuously	No	No	Yes	No
Room-level accuracy on alert	Limited	Variable	Yes	Yes
Daily IT maintenance required	Low	Moderate	High	Near zero
Battery life	n/a	Daily charge	Months	5 to 7 years

Pinpoint sits in a fourth category we consider the only genuinely "set it and forget it" option: a wearable, non-tracking panic button. Staff wear it exactly like their ID badge. It shares a precise room-level location only in the instant it is pressed, and it never logs movement in between. Because it runs on dedicated, hardwired infrastructure rather than Wi-Fi or Bluetooth, it delivers alerts in under 85 milliseconds with no dead zones, operates like a commercial fire alarm system, requires no daily IT upkeep, and runs 5 to 7 years on a single battery. More than fifty health systems already trust it across hospitals, behavioral health facilities, and residential rehabilitation centers.

We built it this way on purpose. A hospital adopting Pinpoint can document a specific, auditable hazard control for OSHA and Joint Commission reviews, satisfy state requirements like California's SB 553, and get ahead of pending mandates like Illinois SB 1435, all without creating the exact surveillance concerns that the ACLU and California's own privacy law now caution against. That is the whole idea: protection that a nurse actually wants to wear, because it was built to defend her safety and her privacy in equal measure.

STOP THE BURNOUT. START THE HEALING.

When you remove the threat of violence and the anxiety of constant surveillance, the culture of your facility changes. Staff feel valued, protected, and trusted. That is an investment in the mental health and longevity of the entire workforce, not just a line item.

SCHEDULE A DEMO

ABOUT PINPOINT INC.

For more than 30 years, Pinpoint has developed staff safety technology specifically for healthcare and other high-risk care environments. Its wearable two-button system allows employees to request de-escalation support or urgent assistance while identifying the precise room or zone where help is needed.

Unlike continuous location-tracking platforms, Pinpoint identifies location only when the device is activated, helping facilities strengthen response capability without compromising staff privacy. Its supervised, hardwired infrastructure operates independently of Wi-Fi and Bluetooth, providing dependable coverage across hospitals, behavioral health facilities, and residential care settings.

GET IN TOUCH

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