PINPOINT©
De-escalation Technology

THE COST OF INACTION:

Workplace Violence and the Hospital Bottom Line

Workers' compensation, nurse turnover, absenteeism, and liability, mapped to what leadership can actually do about the cost of inaction.

What's Inside This Guide

Eight short chapters, four cost centers, and one working model for the conversation between finance and nursing leadership.

INTRODUCTION

Why This Belongs on the CFO's Desk, Not Just the Safety Committee's

The gap between an incident count and a budget line is exactly where this cost has been hiding.

Ask a hospital safety committee what workplace violence costs, and the conversation will probably start with incidents.

Ask the CFO the same question, and the answer becomes harder to find.

Not because the cost is insignificant, but because it rarely appears in one place.

The exposure itself remains widespread. In National Nurses United's 2025–2026 workplace violence survey, 84.8 percent of nurses reported experiencing at least one type of workplace violence in the previous year.

But what happens on the floor and what reaches leadership are not necessarily the same thing.

In the same national survey, only 38.4 percent of nurses said their employer provides a clear way to report workplace violence incidents.

That reporting gap matters financially.

An incident that never becomes a complete safety record can still become a missed shift. It can still require overtime coverage. It can still contribute to a workers' compensation claim, additional management time, a transfer request, or eventually another vacancy that nursing has to fill.

None of those expenses arrives with "workplace violence" written across the top.

They appear across workers' compensation reserves, staffing budgets, recruitment costs, legal review, compliance activity, and the day-to-day operational pressure of covering a unit when an experienced employee is no longer there.

Different departments see different pieces of the same event.

When the CNO talks about a nurse who transferred out of the ED after a violent encounter, and the CFO talks about a staffing agency invoice that keeps growing, they may be looking at two consequences of the same underlying risk.

That is the gap this eBook is designed to close.

The chapters ahead bring four cost centers into the same conversation: workers' compensation, nurse turnover, absenteeism, and liability. We will look at how each cost develops, where it tends to surface inside an organization, and what changes when workplace violence mitigation is considered as an operating investment rather than only a safety requirement.

The goal is not to give leadership another alarming number for the next board meeting.

It is to give finance, nursing, risk, and compliance a clearer view of what the organization may already be absorbing. Because once those costs are viewed together, the conversation changes.

It is no longer only:

"What will prevention cost?"

It becomes:

"What are we already paying for the risk of inaction?"

CHAPTER ONE

Anatomy of the Bill: Where the Money Actually Goes

A vague sense of risk doesn't budget. A breakdown does.

Most financial conversations about workplace violence begin with the incident itself, which makes sense from a safety perspective, but it creates a narrow view of the financial impact. A hospital may know exactly how many incidents were reported during a quarter, yet still struggle to explain what those incidents cost because the expenses rarely stay attached to the original event once they begin moving through the organization.

A nurse injured during an aggressive encounter may require medical treatment and time away from work, while the unit simultaneously begins dealing with an uncovered shift, overtime approval, schedule changes, and additional pressure on the staff who remain. Risk management may open a workers' compensation claim, nursing leadership may adjust assignments, a supervisor may spend hours documenting the event, and compliance may need to review whether the response followed established procedures. Each activity has a cost, although none of them necessarily appears in the same system, under the same department, or during the same accounting period.

That separation is what makes the total exposure difficult to see, because finance may recognize overtime as a labor expense, HR may recognize an absence or transfer request, risk may recognize a claim, and nursing may recognize a staffing disruption, while the original workplace violence incident has already disappeared from the conversation. The organization is still paying for the event, but it is paying through several different budgets.

ONE INCIDENT, MULTIPLE COST CENTERS

How a single event spreads across multiple budgets

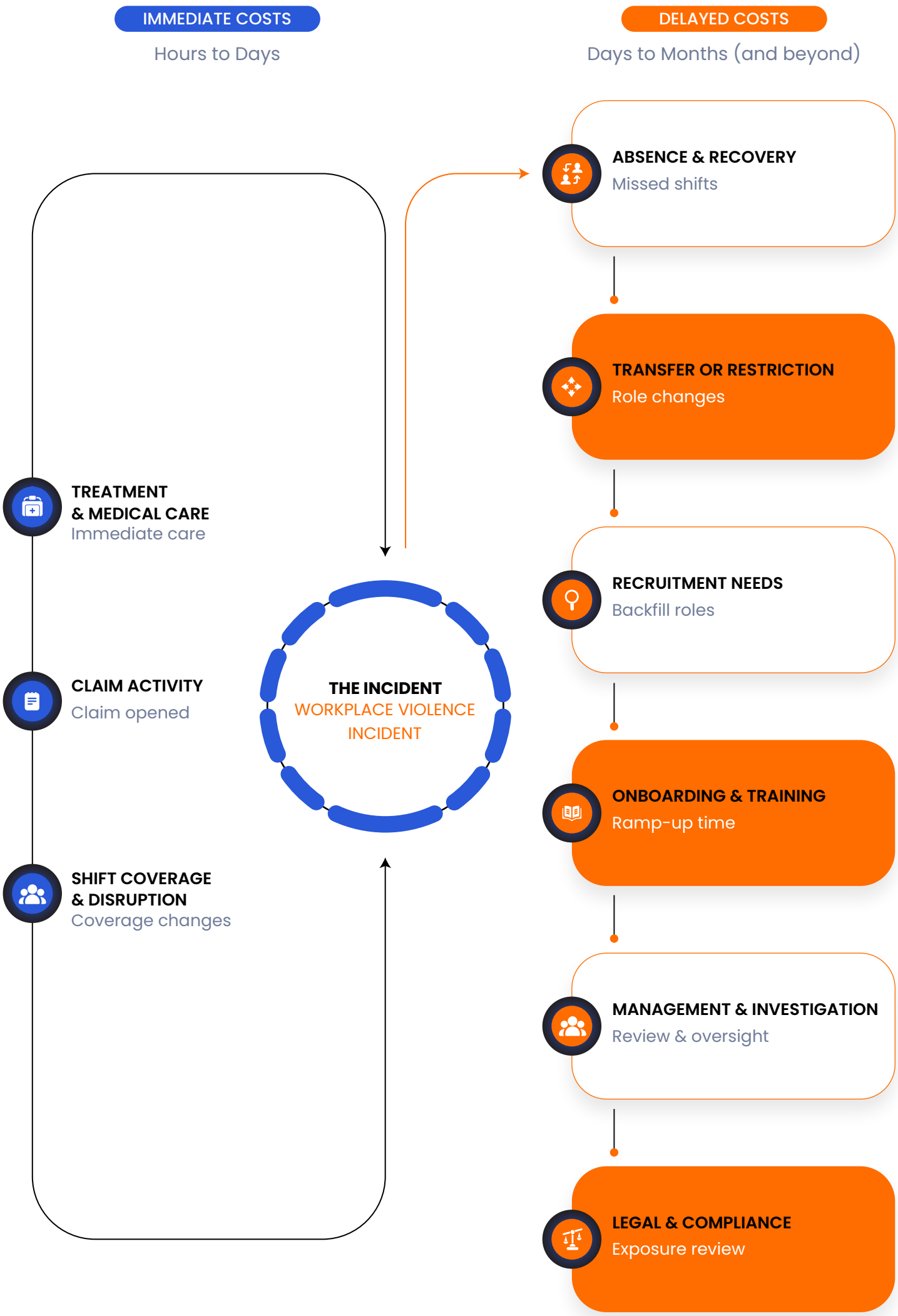
The most visible expenses are usually the ones closest to the incident, because medical treatment, claim activity, paid time away, and immediate shift coverage have an obvious connection to what happened. The harder costs appear later, once the event starts influencing staffing decisions and day-to-day operations. An experienced nurse may return to work but request a different assignment, reduce hours, transfer to another department, or decide that remaining in the same environment is no longer sustainable, and once that happens, the hospital begins carrying a different kind of financial burden.

A vacancy may require overtime while recruitment is underway, temporary staff may be used to protect coverage, managers may spend additional time rebuilding schedules, and the eventual replacement still needs to be recruited, onboarded, trained, and brought up to speed on the unit. The hospital has now moved far beyond the original injury or incident report, even though the later expenses may still be connected to that same event. When those costs are treated as ordinary staffing expenses, rather than part of the wider impact of workplace violence, leadership can underestimate how much exposure is actually being carried.

The same issue exists when an employee stays. Time away from work may still require short-notice coverage, assignments may need to be adjusted, supervisors may spend additional time managing the aftermath, and colleagues may absorb more responsibility while the unit returns to normal. There can also be a quieter operational effect when staff become more cautious in certain rooms, assignments, or interactions after a serious event, particularly when they are uncertain about how quickly assistance will arrive if another situation escalates.

These effects do not always produce a clean financial record, yet they still affect staffing capacity, management time, workflow, and the amount of pressure placed on the people who remain on the floor. A workers' compensation claim may eventually close, while the staffing and operational consequences continue well beyond it.

HOW THE COST UNFOLDS OVER TIME



Liability introduces another layer, because a serious event can require leadership to establish what happened, how quickly assistance was available, whether previous concerns had been documented, what controls were already in place, and what changed afterward. That work can involve nursing leadership, risk management, compliance, legal teams, security, and senior management, which means the cost of the event includes more than the possibility of a settlement or citation. It also includes the organizational time required to reconstruct the incident, review records, respond to questions, update procedures, and demonstrate that known risks are being addressed.

This is where the financial comparison between prevention and inaction can become distorted. A prevention program usually arrives in front of leadership as a visible number, equipment has a price, installation has a price, training requires time, and additional safety infrastructure has to compete with other priorities for budget. The cost of inaction rarely arrives with the same clarity because it is distributed across claims, staffing, recruitment, absenteeism, management time, legal review, and operational disruption, with some expenses appearing immediately and others emerging months later.

A fair comparison therefore cannot stop at asking what a safety investment costs, because that number is being compared with an exposure that may never have been assembled into one view. The more useful question is what the organization is already spending across workers' compensation, turnover, absenteeism, staffing disruption, and liability, then how much of that exposure could reasonably be influenced by stronger prevention, faster assistance, better reporting, and clearer documentation.

The chapters that follow take those cost centers one at a time, beginning with workers' compensation, then moving into nurse turnover, absenteeism, and liability. Each appears differently on the hospital's books, each is usually owned by a different part of the organization, and each becomes easier to understand once leadership stops looking at workplace violence as a single incident and starts looking at the financial trail it leaves behind.

CHAPTER TWO

Workers' Compensation: The Line Item That Keeps Climbing

The claim you can see is rarely the full exposure you're carrying.

Workers' compensation is usually the first financial consequence of a serious workplace violence incident that leadership can identify clearly, because unlike overtime, turnover, or lost productivity, the claim has a file, a reserve, medical activity, and an identifiable employee attached to it. That visibility can also create a false sense that the cost is fully understood, when in reality the amount recorded at the beginning of a claim may be only the first indication of what the organization will eventually carry.

The current U.S. workers' compensation market shows why claim counts alone do not tell the full financial story. Research released by the Workers Compensation Research Institute in April 2026, covering claims with more than seven days of lost time across 18 study states, found that total workers' compensation claim costs increased by an average of 6 percent per year from 2022 through 2025 in the median study state. WCRI found that the increase was spread across several major cost components, including medical payments, indemnity benefits, and benefit delivery expenses, while rising wages, higher medical prices, longer periods of temporary disability, and increasing claim-administration costs all added pressure.

That trend becomes even more relevant when frequency and severity are separated. NCCI's 2026 State of the Line estimates that average medical lost-time claim severity increased about 4 percent in 2025 compared with 2024, while average indemnity cost per claim also increased about 4 percent. NCCI also found that overall medical cost per claim rose 6 percent between Accident Year 2024 and 2025, with price and utilization each contributing 3 percent to the increase.

In other words, fewer claims across the broader workers' compensation system do not automatically mean lower financial exposure for an individual hospital. NCCI continues to describe healthcare as a higher-frequency workers' compensation industry, and its most recent industry analysis recorded a slight increase in healthcare lost-time claim frequency in Accident Year 2024. For finance and risk leaders, the useful question is therefore not only how many claims are being opened, but how severe those claims become, how long employees remain away from normal duties, and how much medical and wage-replacement expense accumulates before the file closes.

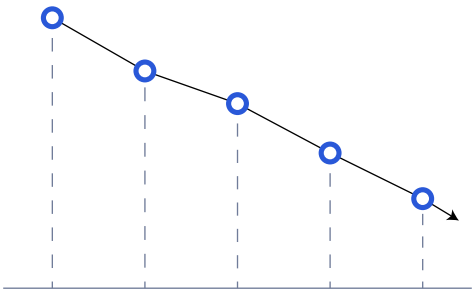
FEWER CLAIMS DOES NOT ALWAYS MEAN LOWER COST

COST DRIVERS

- MEDICAL
- INDEMNITY
- DURATION
- ADMIN / LITIGATION

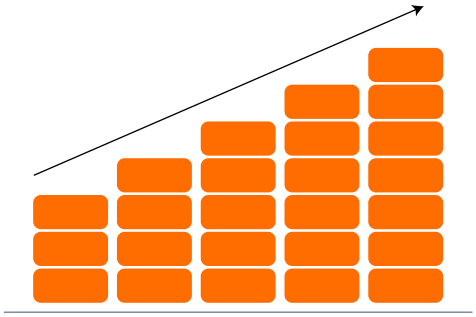
CLAIM FREQUENCY

FEWER CLAIMS



COST PER SERIOUS CLAIM

HIGHER COST PER CLAIM



TOTAL EXPOSURE CAN STILL RISE

FEWER CLAIMS → HIGHER COST PER CLAIM → EXPOSURE CAN RISE

Workplace violence can add another level of complexity because the injury does not always stop with the physical event. A nurse may be treated for a strain, contusion, fracture, or another physical injury, while also dealing with fear, anxiety, sleep disruption, or a trauma response after returning to work. NIOSH notes that healthcare workers exposed to workplace violence may experience post-traumatic stress disorder, depression, anxiety, burnout, anger, and fear, which means the recovery process can involve more than the physical injury visible on the initial report.

That does not mean every psychological consequence automatically becomes a compensable workers' compensation condition, because mental injury standards vary by state and by the circumstances of the claim. NCCI identified workplace-related mental injuries as an active area of state workers' compensation legislation in 2025, and the issue remains part of its legislative monitoring in 2026. For hospitals, the practical concern is that cases involving both physical recovery and psychological effects may require additional treatment, return-to-work planning, or modified duties, although the compensability of those conditions depends on applicable state law.

WORKERS' COMP CLAIM TRENDS

Recent U.S. workers' comp data

-2%

LOST-TIME CLAIM FREQUENCY

2025 vs. 2024

+4%

MEDICAL LOST-TIME CLAIM SEVERITY

2025 vs. 2024

+4%

INDEMNITY CLAIM SEVERITY

2025 vs. 2024

+6% ANNUALLY

TOTAL WORKERS' COMP CLAIM COSTS

2022–2025, median WCRI study state

Duration is also financially important because longer periods of temporary disability can increase indemnity benefits paid on a claim. NCCI estimates that average indemnity claim severity increased about 4 percent in 2025 compared with 2024, with recent increases driven largely by wage growth, while WCRI's 2026 research found that longer temporary disability duration was also placing upward pressure on indemnity benefits per claim. For a hospital, the formal workers' compensation payment is only one part of the impact, because an extended absence may also create staffing and scheduling costs elsewhere in the organization.

Documentation becomes important at this point, not because technology determines whether a claim will be accepted, but because disputes over what occurred, where it occurred, the sequence of events, and the response can become harder to resolve when the organization has little contemporaneous information. A report completed from memory several days later serves a very different purpose from a record that can establish when an alert was initiated, where it originated, and how the response unfolded. If causation, treatment, or compensability is later questioned, clearer records give the employer, carrier, employee, and counsel a stronger factual starting point.

Workers' compensation data shows only part of the exposure, because many threats, near misses, and lower-severity incidents never become formal claims. Finance and risk leaders get a clearer picture by reviewing claim history alongside incident reports, absence, overtime, return-to-work activity, and unit-level safety patterns, helping identify where repeated exposure may be building before it becomes another costly lost-time claim.

CHAPTER THREE

Nurse Turnover: The Cost That Compounds Quietly

She doesn't file a complaint. She updates her resume.

If workers' compensation is the cost that appears on a claims report, nurse turnover is the one spread across recruitment, staffing, onboarding, and lost productivity. That makes it easier to underestimate, even when the financial impact is significant.

The 2026 NSI National Health Care Retention & RN Staffing Report estimates the average cost of turnover for one staff RN at $60,090. That expense begins before a replacement is hired, as hospitals may need to cover open shifts, adjust schedules, use overtime, or rely on temporary staffing while recruitment is underway.

Workplace violence can add another layer to that retention pressure. National Nurses United's 2025–2026 survey found that 25.5 percent of nurses had considered leaving the profession because of workplace violence. The figure does not suggest that violence explains every resignation, but it does show that safety can influence whether experienced nurses remain in the workforce.

SAFETY PRESSURE → RETENTION RISK → REPLACEMENT COST

SAFETY PRESSURE

25.5%

considered leaving the profession because of workplace violence

RETENTION RISK

Turnover intent builds

REPLACEMENT COST

$60,090

Average staff RN turnover cost

The financial effect extends beyond replacing the employee who leaves. A vacancy can increase the workload carried by the remaining team, make schedules harder to stabilize, and place greater pressure on managers trying to maintain adequate coverage. If departures become concentrated in the same units, those pressures can become recurring rather than temporary.

There is also a recruiting consequence. Hospitals are competing for experienced clinicians within connected local labor markets, and perceptions around safety, staffing support, and how incidents are handled can influence where nurses choose to work. A facility struggling to retain experienced staff may therefore face a harder recruitment environment at the same time it is trying to fill more vacancies.

This is where turnover begins to compound. One departure creates a staffing gap, the gap increases pressure on the remaining team, and prolonged pressure can make retention more difficult. In higher-risk units, that cycle can gradually turn a safety concern into a broader workforce and operating-cost issue.

For finance, nursing, and risk leaders, the question is not whether every resignation can be attributed to workplace violence. It is whether repeated safety concerns are contributing to avoidable departures, and whether reducing that exposure could help protect both workforce stability and the hospital's operating margin.

CHAPTER FOUR

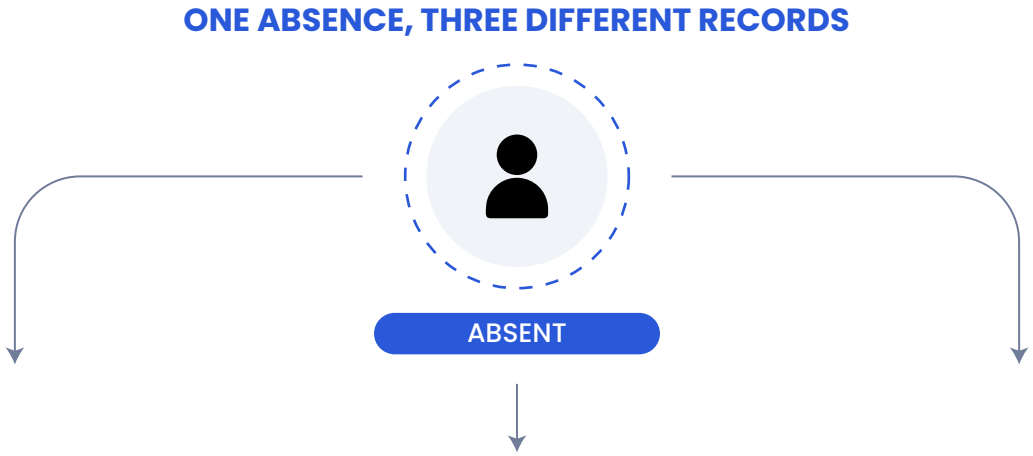
Absenteeism and the Productivity Drain No One Line-Items

Some of this cost never generates a payroll record at all.

Absenteeism rarely appears as a dedicated workplace violence expense. It is more likely to surface as a short-notice call-out, an uncovered shift, overtime approval, or a schedule that has to be rearranged after an employee needs time away following an incident. Because those expenses are absorbed into normal staffing budgets, the connection to workplace violence can easily disappear.

The impact is not limited to employees who miss a shift. National Nurses United's 2025–2026 survey found that 63.1 percent of nurses reported anxiety, fear, or increased vigilance due to workplace violence, showing how the effects of an incident can remain present even when an employee continues working.

The immediate financial impact is coverage. Patients still require care, so an unexpected absence can mean overtime, float-pool support, temporary staffing, or additional scheduling pressure on the existing team. The expense may be recorded as labor or staffing cost rather than violence-related loss, even though the absence began with an incident.



Design this as a single continuous ripple or expanding-wave visual, not stat cards, circles, or another three-step box diagram. The central idea should be that one absence creates costs beyond the employee who missed the shift.

There is also a quieter productivity effect when an employee returns to work but continues dealing with anxiety, fear, heightened vigilance, or other psychological effects associated with workplace violence. CDC and NIOSH recognize these consequences among healthcare workers, although assigning a precise dollar value to reduced on-shift capacity would require hospital-specific data.

For leadership, the useful signal is therefore the pattern rather than one isolated call-out. Reviewing absence and scheduling data alongside incident reporting can help identify whether the same units or working conditions are repeatedly generating lost work time and additional coverage requirements. The objective is not to attribute every absence to workplace violence, but to make a cost visible when the available data shows a credible connection.

CHAPTER FIVE

Liability: What “We Didn't Know” Costs in Court

A single incident can turn every gap in documentation into an exposure all at once.

Liability is the cost center that can remain quiet until one serious incident forces an organization to explain what it knew, what safeguards were in place, how staff were trained, and whether established procedures were actually followed. At that point, incomplete documentation can become part of the exposure.

Federal OSHA still does not have a healthcare-specific workplace violence standard, but workplace violence can be addressed through the General Duty Clause. OSHA’s enforcement guidance considers whether employees were exposed to a serious hazard, whether the hazard was recognized, and whether feasible measures existed to reduce it. In healthcare, where workplace violence is a recognized occupational hazard, those questions make prevention efforts and documentation especially important.

California goes further. For healthcare facilities, Title 8, Section 3342, Violence Prevention in Health Care, is more directly relevant than the general SB 553 requirements. It requires covered healthcare employers to maintain a written workplace violence prevention plan, assess hazards, investigate incidents, train employees, maintain records, and correct identified risks. California regulations currently allow penalties of up to $25,000 for each violation classified as serious.

Other states add their own requirements. New Jersey’s Violence Prevention in Health Care Facilities rules require covered facilities to maintain violence prevention programs that include risk assessment, training, prevention measures, and procedures for investigating and reporting incidents. In New York, the Department of Health adopted The Joint Commission’s workplace violence definition for hospital and nursing-home activities in January 2026, while existing NYPORTS reporting obligations continue for serious assault-related events.

The Joint Commission creates another layer of accountability for accredited organizations. Its current workplace violence requirements call for designated leadership, staff education, policies for preventing and responding to violence, incident reporting and trend analysis, post-incident support, governing-body reporting, and worksite analysis followed by mitigation of identified risks.

THE COMPLIANCE LAYERS A HOSPITAL MAY NEED TO ANSWER TO

01 **FEDERAL OSHA**
Recognized hazards

02 **STATE REQUIREMENTS**
California, New Jersey, New York

03 **JOINT COMMISSION**
Accreditation expectations

04 **HOSPITAL DOCUMENTATION**
Plans, training, logs, response records

The financial exposure is therefore not limited to a settlement or regulatory penalty. A serious event can bring legal review, internal investigation, regulatory scrutiny, document requests, corrective work, and leadership time. Hazard assessments, training records, incident logs, corrective actions, and reliable alert and response records can help establish what the organization knew and how it responded.

CHAPTER SIX

Mitigation: The Math When You Invest Ahead of the Incident

The business case does not require perfect prevention. It requires measurable reduction in exposure.

The financial case for mitigation becomes stronger when leadership stops treating prevention as a stand-alone expense and compares it with the costs the hospital is already carrying. Workers' compensation, nurse turnover, absence, overtime, temporary coverage, legal review, and compliance activity may sit in different budgets, but they can all be influenced by the same workplace violence exposure.

That makes facility-level data more useful than another national cost estimate. A hospital can begin with what it already knows, including violence-related claims, replacement costs, staffing adjustments, time away from work, and the administrative burden created by serious incidents. The objective is not to assume that mitigation eliminates those costs. It is to determine how much exposure would need to be reduced for the investment to make financial sense.

THE FACILITY-LEVEL MITIGATION MODEL

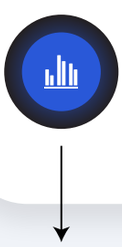
A simple model to measure the financial impact of prevention.

ESTABLISH ANNUAL EXPOSURE

- Workers' compensation
- Turnover
- Absence & coverage
- Legal & compliance costs

01

Capture the true annual financial burden of workplace violence on your facility.



MODEL POTENTIAL AVOIDED COST

Annual Exposure X realistic reduction assumption

02

Apply a realistic reduction based on your environment, history, and mitigation plan.

CALCULATE ANNUAL NET BENEFIT

Potential Avoided Cost
-annual mitigation operating cost

03

Determine the net financial impact delivered each year after ongoing costs.

ESTIMATE PAYBACK PERIOD

Initial mitigation investment
÷ monthly net benefit

04

Understand how quickly the investment pays for itself in real operating months.

This approach also reflects how workplace violence mitigation works operationally. A prevention program is rarely aimed at only one outcome. Training may strengthen preparedness, reliable staff alerting can support faster access to assistance, incident records can improve visibility into recurring patterns, and stronger documentation can support compliance and post-incident review. The value of the investment therefore has to be evaluated across the organization rather than against a single budget line.

For Pinpoint, that is especially relevant because the system is positioned as more than a device purchase. Its room-level response accuracy, privacy-first non-tracking design, incident reporting, and standalone architecture are intended to address clinical, compliance, operational, and IT concerns within the same safety program.

CHAPTER SEVEN

What Workplace Violence Mitigation Looks Like with Pinpoint

The difference is not simply wearable versus fixed. It is what happens when someone actually needs help.

Wearable panic buttons and RTLS systems are not new to healthcare. The real difference is how those systems identify location, move an alert through the facility, record the incident, and handle staff privacy. Pinpoint approaches each of those functions differently.

The system starts with a wearable badge, so access to assistance moves with the staff member rather than depending on reaching a fixed wall-mounted device. When the badge is activated, Pinpoint's hardwired infrared infrastructure identifies the room where the alert originated, giving responders a precise location during the incident.

That location capability does not require continuous staff tracking. Unlike broader RTLS platforms that may maintain ongoing location information for people or assets, Pinpoint uses a privacy-first, non-tracking approach. Location becomes relevant when an alert is activated, giving the hospital room-level response information without turning the safety system into an employee monitoring platform.

HOW PINPOINT USES LOCATION DIFFERENTLY

Incident-triggered room-level location, not continuous staff tracking

WEARABLE BADGE

Staff carries a discreet wearable badge.

01

ALERT ACTIVATION

One-touch SOS or de-escalation alert is triggered when help is needed.

02

RF + HARDWIRED INFRARED

RF carries the alert. Hardwired infrared confirms room-level location.

03

No continuous tracking outside the incident.

COORDINATED RESPONSE

Alerts are sent at the same time across configured response channels:

- Lights
- Audio
- Mobile
- Desktop

04

INCIDENT RECORD

Event information is captured for reporting, review, and trend analysis.

05

The infrastructure is also designed to operate independently of the hospital's WiFi network. Hard-wired receivers provide the location layer without making the core safety workflow dependent on wireless coverage, while keeping the system separate from hospital IT infrastructure. That matters in environments where reliability, cybersecurity review, and IT workload can influence whether a safety system is practical to deploy.

SYSTEM ARCHITECTURE

- Wearable badge
- RF alert transmission
- Hardwired infrared receivers
- Room-level accuracy during an active alert
- Standalone, WiFi-independent architecture

WHAT MAKES IT DIFFERENT

- Wearable, not wall-bound
- Location identified during an active incident
- Privacy-first, non-tracking design
- Incident-based reporting
- Supports review, documentation, and compliance processes

WHY IT MATTERS

- Faster directional response
- Better visibility for nursing, safety, and risk teams
- Stronger incident documentation
- Useful support for broader compliance workflows

An alert should also leave something useful behind. Pinpoint captures incident-based event information through its management and reporting capabilities, creating a record that can be reviewed after the immediate response. That gives nursing, safety, risk, and compliance teams better visibility into when alerts occur, where they occur, and the patterns that may need further attention.

Those records can also support the broader documentation hospitals maintain for workplace violence prevention. OSHA expectations, Joint Commission requirements, and state-level rules increasingly emphasize hazard assessment, training, incident reporting, review, and documented corrective action. Pinpoint does not replace those responsibilities, but incident-based reporting can provide another reliable source of information within the hospital's compliance process.

The same approach can be applied across behavioral health, emergency departments, psychiatric care, medical-surgical units, CPEPs, residential treatment, and other patient-facing environments where staff may need immediate assistance. The underlying workflow remains consistent: the employee carries the alert capability, the incident produces a precise location, responders receive actionable information, and the event creates a record for review.

That is what separates Pinpoint from a basic wearable panic button or a conventional RTLS deployment. It brings together wearable activation, hardwired infrared accuracy, non-tracking privacy, rapid notification, incident-based reporting, and compliance-supporting documentation as one workplace violence mitigation system.

For hospitals now examining the financial, operational, and compliance costs of workplace violence, the next question is not whether another device should be purchased. It is whether the current response system gives staff the access to help, location accuracy, incident visibility, and documentation the organization actually needs.

THAT IS THE CONVERSATION PINPOINT IS BUILT TO HAVE.

ABOUT PINPOINT

Pinpoint has spent more than 30 years developing safety technology for people working in high-risk environments. The company was founded in 1992 after early development of a staff safety solution shaped by frontline healthcare workers facing workplace violence in the UK. That clinical origin continues to influence how Pinpoint designs its systems today, around the realities of staff movement, escalation, response, and patient-facing care.

Since then, Pinpoint has expanded from the UK into North America and now works with healthcare organizations across the United States, Canada, and other international markets. Today, Pinpoint reports that its technology protects more than 1 million people across 3,000+ locations globally, with its systems used by 50+ major healthcare systems across the UK, U.S., and Canada. Dedicated U.S. operations were established in 2022, building on the company's earlier North American expansion.

Healthcare remains central to the business. Pinpoint supports hospitals, behavioral health facilities, residential rehabilitation centers, psychiatric environments, emergency departments, and other clinical settings where staff safety and rapid assistance are operational priorities. Its wider healthcare product portfolio includes staff duress systems, patient safety technology, nurse call capabilities, mobile and desktop alerting, visual alert infrastructure, patient safety check tools, and management software.

What has evolved over those three decades is the technology. What has stayed consistent is the problem Pinpoint was created to address: giving healthcare staff a practical way to get the right level of assistance when an interaction begins to escalate.

GET IN TOUCH

- Address: 290 Motor Pkwy, Hauppauge, NY 11788
- Phone: (631) 402-5155
- Email: info@pinpointeds.com

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