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States Fill Gaps in Hospital Workplace Violence Laws—Requiring Law Enforcement Officers, Weapons Detection Screening Policies in Hospitals, and More

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While we wait for long-anticipated federal regulations from the Occupational Safety and Health Administration (OSHA) addressing the issue of workplace violence in health care, activity continues at the state level.

California and North Carolina are among those currently filling the gaps—with the latter bringing law enforcement officers into hospital emergency departments to address the problem, and the former legislating to keep weapons out (through screening devices).

These laws are the latest developments in the national landscape of initiatives designed to address workplace violence in health care facilities. Though a federal OSHA standard is slated to issue by year-end, it remains to be seen whether that will happen and what effect, if any, the 2024 presidential election might have on those plans.

California AB 2975

AB 2975, approved by California Governor Gavin Newsom on September 27, amends the existing Section 6401.8 of the Labor Code, a framework for the state's Occupational Safety and Health Standards Board to require hospitals to address workplace violence. That section already establishes standards mandating that a workplace violence prevention plan be in effect at all times in all patient care units; setting forth minimum requirements for the plan; requiring a system for responding to and investigating incidents of violence or risk of violence; requiring assessments at least annually; and requiring written records/reporting of violent incidents.

The new law charges the Board with amending existing standards by March 1, 2027 to require that a hospital implement a weapons detection screening policy. This weapons detection screening policy:

- must require the use of weapons detection devices that automatically screen a person's body positioned at the entrance to the emergency department and the labor and delivery entrance,

if separate (although not the ambulance entrance);
- must include security mechanisms, devices, or technology designed to screen and identify instruments capable of inflicting death or serious bodily injury;
- must include the use of more than handheld metal detector wands (with exceptions for small and rural hospitals, those that exclusively provide extended hospital care to patients with complex medical and rehabilitative needs, and those with space limitations);
- must assign appropriate personnel, other than a health care provider, to implement the policy, including the monitoring/operation of devices and training;
- must include training for personnel responsible for implementing the policy, including a minimum of eight hours of training on:
    - hospital policies/procedures on response to the detection of a dangerous weapon;
    - how to operate the hospital's weapons detection devices;
    - de-escalation; and
    - implicit bias.
- must include reasonable protocols addressing how the hospital will respond if a dangerous weapon is detected and alternative search and screening for patients, family, or visitors who refuse to undergo weapons detection screening;
- must include a required posted notice that the hospital conducts screenings for weapons upon entry but that no person shall be refused emergency medical screening pursuant to the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

California hospitals will need to comply 90 days or less after the standard is adopted, although it is unclear when that will happen.

The California Hospital Association, on behalf of more than 400 hospitals and health systems, expressed opposition to AB 2975 in June. While appreciating the attention given to the issue of preventing workplace violence, hospitals were concerned that the measures could deter patients from seeking care or potentially escalate security incidents.

"AB 2975 would remove hospital discretion and instead direct the CAL/OSHA Standards Board to require metal detection devices at the public entrances of all California hospitals, regardless of whether the risk of harm warrants the security measure," a CHA official wrote to legislators.

N.C.G.S.A. § 131E-88

A North Carolina law, meanwhile, requires law enforcement officers in hospital emergency departments as of October 1, 2024. Section 131E-88 was passed as part of House Bill 125 and included the Hospital Violence Protection Act.

The law requires licensed hospitals having emergency departments to conduct security risk assessments and develop/implement security plans with protocols ensuring that at least one law enforcement officer is present at all times. The security plan must include:

- training for law enforcement officers that is appropriate for populations served by the emergency department;
- training for law enforcement officers based on a trauma-informed approach to identify and safely address situations involving patients, family members, and other persons who pose a risk of harm to themselves or others;
- safety protocols based on:
    - standards established by a nationally recognized organization with experience

educating and certifying professionals involved in managing and directing security and safety programs in health care facilities;
    - the results of a security risk assessment of the emergency department;
    - identified risks of the emergency department, considering trauma level designation, overall patient volume, incidents of violence against staff and level of injuries sustained from such violence, and more.
- safety protocols that include at least one law enforcement officer in the emergency department or on the same campus at all times, absent an exemption; and
- training requirements for law enforcement officers in the use of/response to weapons, defensive tactics, de-escalation techniques, appropriate patient intervention activities, crisis intervention, and trauma-informed approaches.

There is an exemption to the law enforcement officer requirement if a hospital in good faith determines that a different level of security is necessary and appropriate, based on findings in the security risk assessment. In that circumstance, the security plan must be approved by the county sheriff, the county emergency management director, and the municipal police chief, if applicable.

As the hospitals are paying for this requirement, this exemption could be a way out if, for example, small rural hospitals find the cost burdensome. Nevertheless, the initiative was passed with broad bipartisan support.

Other provisions of the law relate to training and the reporting of a hospital's security risk assessment to the state Department of Health and Human Services.

Pennsylvania

Workplace violence legislation in Pennsylvania, HB 2247, was laid on the table on October 2, meaning it may be considered at a later date.

That "Health Care Workplace Violence Prevention Act" was introduced in April and is similar to what other states have done in this area. It would require health facilities to establish a workplace violence prevention committee to, among other things:

- perform an initial risk assessment evaluation and annually thereafter;
- meet quarterly to review incidents of workplace violence;
- prepare a report from the risk assessment evaluation and establish a written program to mitigate risks based on the assessment, with annual updates;
- develop and maintain a detailed, written violence prevention plan;
- comply with training, reporting, and recordkeeping requirements.

On September 27, Pennsylvania introduced a separate HB 2593, the "Workplace Violence Prevention Act." That legislation addresses employee reporting of incidents of workplace violence and actions that a health facility must take regarding reporting, recordkeeping, and employees' rights. It mandates how health facilities should respond regarding employee concerns, suggestions, and communications regarding workplace violence. It further provides how criminal offenses involving workplace violence should be graded (i.e., one classification higher than the underlying criminal offense, with exceptions).

While the latest (and shorter) Pennsylvania bill does not call for a workplace violence committee or a prevention plan, it does refer to the general duty clause of the Occupational Safety and Health Act,

which requires employers to provide employees with a workplace free from recognized hazards that are causing or are likely to cause death or serious physical harm—even in the absence of a specific federal OSHA standard.

Takeaways

In the absence of OSHA rulemaking, states are continuing to take the lead in enacting laws to address workplace violence in health care facilities. Until recently, state initiatives focused on mandating workplace violence prevention programs and imposing enhanced criminal penalties for assaults on healthcare workers. More recently, we have seen different solutions such as those of California and North Carolina. We also are seeing innovation and efforts at the system and facility levels. Facilities would be wise to adopt a comprehensive plan incorporating not only compliance measures, but evidence-based measures to prevent and respond to incidents of violence.

For more on the legal landscape and implications for employers, listen to our recent podcast of *Diagnosing Health Care*, "Workplace Violence in Health Care".

Epstein Becker Green Attorney Ann W. Parks assisted with the preparation of this post.

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