Australasian College for Emergency Medicine

Violence in emergency departments

P32 V5

August 2024

acem.org.au

Document Review

Timeframe for review:	Every three years, or earlier if required
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Standards and Endorsement Committee
Document maintenance:	Department of Policy, Research and Partnerships

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	March 2004	Revised document
V2	March 2011	Revised document
V3	Dec 2017	Entire document revised
V4	Nov 2021	Entire document revised
V5	August 2024	Member wide engagement for whole of document revisions

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1. Purpose

The safety of patients, visitors and staff in the Emergency Department (ED) is of primary concern to the Australasian College for Emergency Medicine (ACEM, the College). All members of the community and hospital staff have a right to an environment safe from violence while in the vicinity of the ED and wider hospital. The College condemns violence and aggression within the ED as unacceptable. The College's vision is that no staff, patients or accompanying persons suffer harm due to violent incidents in the ED and consequently supports the implementation of strategies for prevention.

This policy aims to identify both system and local-level opportunities to foster safer EDs in Australia and Aotearoa New Zealand, encourage a culture of incident reporting and evaluation, and improve the health, wellbeing and career sustainability of all hospital ED staff.

2. Scope

This policy applies to all staff of Australian and Aotearoa New Zealand EDs. This includes clinical and administrative staff external to the ED, hospital security personnel, and senior hospital executives and administrators.

External stakeholders include jurisdictional governments and funding bodies, health system managers, law enforcement personnel, paramedics and patient transport personnel, and other relevant health services. Patients and accompanying persons in the vicinity of the ED are also in scope.

Note that throughout this document, the terms violence and/or violent denote a range of actions and behaviours that include, but are not limited to, physical assault.

Bullying or occupational violence perpetrated by hospital employees against each other, and the clinical management of violent behaviour in patients are out of scope of the policy.

3. Definitions

Behavioural assessment room

A behavioural assessment room (BAR) is a designated area within or adjacent to the ED that provides a specifically designed space for the management of behaviourally disturbed, aggressive and/or violent patients that promotes the safety, privacy and dignity of patients, visitors and staff[1]. Ideally, BARs should provide an appropriately low stimulus environment. ACEM acknowledges that some Australian jurisdictions refer to BARs as safe assessment rooms (SARs), however, this document uses the term BAR throughout for ease of reference.

Hospital emergency codes

As part of the hospital system, many EDs in Australia and Aotearoa New Zealand utilise a recognised set of colour codes to organisationally prepare, plan, respond and recover from internal and external emergencies. While codes are based on standardised information to provide minimum standards for practice, they can differ across jurisdictions and health services. The Australian Standard 4083 (AS 4083—2010) deals specifically with emergencies usually attended by staff in health care facilities and specifies emergency response colour codes.[2] Generally, Code Black denotes a hospital-wide coordinated clinical and internal security response to a serious threat to personal safety. Some Australian jurisdictions use Code Grey to distinguish between a violent emergency and an armed threat (Code Black).

[1] Australasian College for Emergency Medicine (ACEM). Policy on Emergency Department Design. Melbourne: ACEM, 2025.

[2] Standards Australia. Planning for Emergencies — Health care facilities. Sydney: SAI Global Limited, 2010.

Trauma-informed practice

Trauma-informed practice considers trauma (broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness or horror) in all aspects of healthcare. It does not necessarily require health professionals to elicit disclosures of trauma; rather, it requires recognition of the lived experiences of individuals and awareness of triggers that can lead to re-traumatising and that efforts are made to minimise re-traumatisation.[3]

Violence

The World Health Organization defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in – or has a high likelihood of resulting in – injury, death, psychological harm, mal-development or deprivation.[4]

More specifically, physical violence is described as the use of physical force against another person or group that results in physical, sexual or psychological harm and includes (among others) beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching. Psychological violence is described as the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development and includes (among others) verbal abuse, bullying, harassment and threats.[5]

Workplace violence

Safe Work Australia and WorkSafe Aotearoa define workplace violence as any incident in which 'a person is abused, threatened or assaulted in circumstances arising out of or in the course of their work'.[6] [7]

Workplace violence is a broad term and covers a range of actions and behaviours that create a risk to the health and safety of all workers and includes:

- Biting, spitting, scratching, hitting, kicking
- Punching, pushing, shoving, tripping, grabbing
- Throwing objects
- Verbal threats and intimidation
- Psychological abuse
- Gender-based and racial abuse
- Sexual harassment, sexual abuse, and any form of unwanted/unwelcome physical contact
- Aggravated assault
- Threatening someone with a weapon or armed robbery.[7]

[3] Australasian College for Emergency Medicine. Access to care for patients with acute mental and behavioural conditions (P41). Melbourne: ACEM. 2022.

[4] Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R, editors. World report on violence and health. Geneva: World Health Organization, 2002.

[5] International Labour Office/International Council of Nurses/World Health Organization/Public Services International. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva: International Labour Office, 2002.

[6] Safe Work Australia. Workplace violence: a definition [Internet]. Canberra: Safe Work Australia; 2017

[7] WorkSafe New Zealand Mahi Haumaru Aotearoa, Managing workplace violence and threatening behaviour policy and procedure. WorkSafe New Zealand: Wellington

4. Background

Workplace violence has significant effects on a worker's psychological and physical health over the short and long term, and significant economic and social costs for workers and their families, workplaces and wider communities.[8]

While the ED is well-recognised as a setting in which workplace violence is more likely to occur, the true incidence remains unclear due to a culture of under-reporting.[8] [9] Despite this, reported data reveal high and increasing levels of violent incidents in EDs and other health care settings[10]. A recent meta-analysis[11] found that approximately 36 in every 10,000 ED presentations involve violence, with an estimated 45 in every 100 violent presentations associated with alcohol and/or other drugs.[8]

Studies examining violence in the ED consistently report a high prevalence of verbal aggression, followed by threats, then physical abuse.[12] Nine in 10 ACEM members reported feeling threatened by a patient[13], and four in 10 reported physical assault.[14] ED nurses also commonly experience patient-related violence.[15] [16] [17] Within the ED, violence is most prevalent in the triage area; excessively long waiting times, poorly understood triage systems, ED overcrowding and barriers to effective communication (including burnout and/or compassion fatigue) have been identified as contributing factors.[4] [12] [13] Studies on violence in UK EDs characterised patient perpetrator types as clinically confused, frustrated, intoxicated, antisocial, distressed/frightened, and socially isolated. [18]

Violence in EDs is under-reported due to perceptions among ED staff that it is an inherent part of the job.[8] ED staff who are exposed to workplace violence also under-report incidents due to barriers associated with complex and lengthy reporting systems, lack of time, unclear policies and procedures, confidentiality issues, peer pressure, the stigma of victimisation, and fear of retaliation by hospital administrators.[9] [13] [15] [19] This culture of under-reporting suggests that the quantitative evidence on violence in EDs is limited and of poor quality.[8] For instance, few studies have monitored trends in ED violence or evaluated the effectiveness of interventions over time. To understand the cumulative effects of violence on ED staff, as well as appropriate prevention and intervention strategies, instituting and supporting a culture of reporting is essential.

Regular monitoring and reporting of instances of violence in emergency departments is also essential. Recent ACEM data shows:

- 127 (86%) of the 147 ACEM accredited EDs reported there had been an incidence of violence in the previous month.

- Approx. one in every three FACEM trainees reported experiencing violence from a patient or carer, which often involved verbal and physical aggression.

[8] Nikathil S, Olaussen A, Gocentas R, Symons E, Mitra B. Workplace violence in the emergency department: A systematic review and meta-analysis. Emergency Medicine Australasia. 2017;29:265-75.

[9] Victoria Auditor-General. Occupational Violence Against Healthcare Workers. Melbourne: Victorian Government Printer, 2015.

[10] Te Whatu Ora Health New Zealand via OIA, Incidents relating to violence, aggression, or harassment against DHB staff from 2019–20 to 2021–22. 2023, NZ Herald

[11] Findings were limited by inaccurate data related to under-reporting and lack of objective evidence.

[12] Pompeii L, Dement J, Schoenfisch A, Lavery A, Souder M, Smith C, et al. Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence (Type II) on hospital workers: A review of the literature and existing occupational injury data. Journal of Safety Research. 2013;44:57-64.

[13] Australasian College for Emergency Medicine. ACEM Workforce Sustainability Survey Report, November 2016. Melbourne: ACEM. 2016

[14] Australasian College for Emergency Medicine. ACEM Workforce Sustainability Survey Report, November 2019. Melbourne: ACEM, 2019.

[15] Morphet J, Griffiths D, Plummer V, Innes K, Fairhall R, Beattie J. At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses. Australian Health Review. 2014;38:194-201.

[16] Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence at triage: A qualitative descriptive study. International Emergency Nursing. 2011;19:12-9.

[17] Pich JV, Kable A, Hazelton M. Antecedents and precipitants of patient-related violence in the emergency department: results from the Australian VENT Study (Violence in Emergency Medicine and Triage). Australasian Emergency Nursing Journal. 2017;20:107-113

[18] Design Council. Perpetrator characteristics: Profiling traits of violent and aggressive behaviour in A&E [Internet]. London: Design Council; 2011.

[19] Kowalenko T, Gates D, Gillespie G, Succop P, Mentzal T. Prospective study of violence against ED workers. American Journal of Emergency Medicine. 2013;31:197-205.

- A majority of ACEM members report that they had felt unsafe due to the behaviour of an alcohol-affected patient while working in ED [20].

Patients and accompanying persons in the ED are often fearful, anxious, stressed and/or in pain.[3] Where possible, the design of the ED should play a role in mitigating negative psychosocial states. A positive patient journey through the ED from arrival to discharge can improve patient satisfaction, reduce the perception of long waiting times, and reduce instances of frustration and aggression.[16]

5. Policy

5.1 Health system responsibility

Jurisdictional health system managers and hospitals have a legal responsibility to ensure that the ED is a safe workplace for all employees, while at the same time providing community access to safe, high quality, equitable emergency medical care. Hospital administrators must ensure that policies, procedures, staffing models, preventative training and education, verbal de-escalation and safe restraint training and education, ED design and incident reporting systems contribute to the prevention, minimisation and effective management of violence in the ED.

There are no excuses for violent behaviour in the ED, however it is important to understand the causative factors associated with violence as they impact the strategies used to manage the behaviour. Causative factors that may be associated with violent behaviour include pain, grief, psychoses, dementia, intoxication via alcohol or other drugs, and anaesthesia.

ED overcrowding and access block can create environments that contribute to violence. Jurisdictional health system managers and hospital administrators should address these issues by employing a whole-of-hospital approach to managing patient flow through the hospital.[21]

A whole-of-hospital workplace health and safety culture, including relevant policies and procedures, must be promoted and embedded so that staff feel confident and supported to report all incidents of violence in the hospital risk management system. Policies and procedures relating to violence should be well-communicated to staff.

Where incidents occur, staff should be supported to report the incident through established processes (for example, an incident reporting process). A report made by any member of the ED staff must be followed-up and actioned as a priority.

5.2 Service-level responsibility

Hospital administration must have measures in place to prevent violence and policies and procedures on how to address it if it happens.[22] A multifaceted approach is needed in hospitals in Australia and Aotearoa New Zealand to effectively prevent, minimise and respond to incidents of violence in the ED. Such an approach should address the following:

- A standardised system of risk management and violent incident reporting with built-in measures for regular evaluation that also provides:
    - Reliable estimates of ED violence incidence, prevalence and trends
    - Identification of relevant individual, service and system level correlates
    - Evidence to inform the design, development and implementation of ED violence prevention and intervention strategies and initiatives.

[20] Australasian College for Emergency Medicine. 2022 Annual Site Census; 2022 Trainee Placement Survey; 2022 Alcohol-related ED presentations, Survey Findings

[21] Australasian College for Emergency Medicine. Statement on emergency department overcrowding (S57). Melbourne: ACEM, 2021.

[22] Safe Work Australia. Workplace violence and aggression – advice for workers. 2011

- Hospital policies and procedures for the effective identification and management of violence in EDs and other hospital-based emergency care centres tailored to meet specific local requirements, while conforming to national standards. Processes for identifying and assessing behaviours of concern should also be available.

- Adequate staffing models – including hospital security personnel – appropriate to ED size, functionality and demand, which also consider ED staff health, wellbeing and longevity, with due regard to workforce sustainability.[23]

- Staff Training provided in evidence-informed models of care to support the prevention, identification, and management of workplace violence.

- Quality ED design that meets the dual needs of ED staff and patients/accompanying persons, and which also promotes a healing environment that is safe and free of psychosocial aggravating factors created through poor design.[14]

All initiatives with the aim of reducing, preventing or responding to violence in the ED should be robustly evaluated to determine their effectiveness. Successful initiatives should be adopted as core hospital policy, while ineffective initiatives should not be allowed to become ED business as usual.

6. Procedures and Actions

6.1 Governance

6.1.1 Service policies and procedures

The Hospital Executive must ensure that established policies, procedures and processes are in place to support all staff across the hospital to report all incidents, including where these incidents occur against ED staff. These elements include:

- Effective implementation of policies and workplace violence prevention programmes.

- Resourcing to enable policy requirements to be met.

- Ongoing monitoring of the policies, procedures and processes to ensure they are contemporary and reflective of lessons learned.

- Undertaking risk assessments in accordance with local procedures, with completed assessments (and control measures) communicated to staff.

6.1.2 ED policies and procedures

EDs must have specific, contemporary policies and procedures for the prevention, early identification, and proactive management of violence within a patient-care focused framework. All EDs should be provided with the resources and capability to mount a timely and appropriate response to any violent incident as it occurs, including prompt access to appropriately trained hospital security and/or police at all times.

6.2 Prevention

6.2.1 Staff training

ED staff must be aware of hospital policies and procedures for the management and reporting of violent incidents and have appropriate training in the recognition of early predictors of violence and its immediate management. Professionalism, cultural safety, cultural competency, and communication skills should be emphasised as key elements in fostering a safer environment for all parties, conducive to mutual respect and cooperation. This is especially important for staff in triage and front-of-house roles.

[23] Australasian College for Emergency Medicine. Guidelines on constructing a sustainable emergency department medical workforce (G23). Melbourne: ACEM, 2023.

The hospital administration is responsible for ensuring that ED staff understand their legal responsibilities and medico-legal protections with respect to the circumstances under which treatment can be refused or withdrawn or violent people removed from the ED if they do not have an illness or injury requiring time critical care or they are accompanying a patient.

All ED staff, including ED security personnel and external stakeholder liaison contacts (for example, police and ambulance staff), should receive regular and ongoing violence prevention training that includes verbal de-escalation strategies to safely manage behavioural disturbances and/or aggression.

Training should help staff adopt best practice and understand:

- Risk factors for aggression and violence, including clinical and non-clinical characteristics
- Signs of escalation and imminent violence
- Effective ED communication strategies, including mediation, culturally safe, and culturally competent communication
- De-escalation strategies
- Trauma-informed practice
- Workplace violence prevention measures
- Workplace policies and procedures on violence prevention and management
- Appropriate use of sedation and restraint (where permitted)
- Emergency and post-incident responses
- Their right to withdraw to safety at any time (including security staff) [24]
- Incident reporting procedures.

ED staff must receive adequate training in the hospital's emergency and risk management systems, including initiating and responding to internal emergencies (for example Code Black responses or other hospital-wide standardised emergency management system). All staff members should have access to personal and/or fixed duress alarms at high-risk areas such as triage. Implementation of patient alert systems that generate a signal to warn staff of any potential risk to themselves and others, should also be encouraged.[25]

6.2.2 Resourcing of ED security personnel

Dedicated, specifically trained hospital security personnel are an important ED resource that should be adequately funded by jurisdictional health system managers, and employed and trained by hospital EDs as an integrated part of the ED clinical team.[26] Well-trained, experienced hospital security personnel with strong, reassuring, and supportive physical presence, excellent communication skills, an aptitude for learning, a solid understanding of cultural safety and competency, and a positive 'customer service' attitude can be successfully utilised in the ED to problem solve and eliminate unnecessary conflict.[27] All ED security personnel must clearly understand the 'rules of engagement' within their individual workplaces and be ready at all times to protect staff, patients and accompanying others from physical assault.

All ED security personnel should operate as part of a multidisciplinary team that includes clinicians, with clearly defined roles. There must be opportunities for ED security staff to regularly train with ED clinical staff to build the skills of all those involved in responding to an incident.

[24] WorkSafe Mahi Haumaru Aotearoa. Your rights and obligations. New Zealand. 2017

[25] Hogarth K, Beattie J, Morphet J. Nurses' attitudes towards the reporting of violence in the emergency department. Australasian Emergency Nursing Journal. 2016;19:75-81.

[26] Safe Work Australia. Workplace violence and aggression – advice for workers. Australia

[27] York T, MacAlister D. Hospital and healthcare security. Sixth ed. Oxford: Elsevier Inc; 2015.

It is important to note inconsistencies in resourcing of security personnel in Australian and Aotearoa New Zealand rural and remote EDs. Often, regional, rural, and remote EDs are not resourced to contract after-hours security personnel and instead rely on internal hospital staff contracted primarily in another role, such as wardsmen, or external agents such as on-call private security firms and/or local police. Security personnel and police are therefore unlikely to be able to respond to a violent ED incident in an appropriately short timeframe. In these contexts, specific local arrangements must be in place, including memoranda of understanding.

6.2.3 ED design

The ED entrance should be well lit and designed in such a way that optimises visibility. CCTV cameras may be installed both outside and inside the waiting room, noting that governance around the security of this footage is paramount.

The reception and registration desk serving the main entrance should allow for surveillance of all persons entering the hospital. A high and wide reception desk provides a level of protection for staff. Duress alarms should be installed at reception and triage.

The triage area should be easily identifiable, accessible and properly staffed. Clear signs and wayfinding should be utilised to indicate where patients report.[1] Triage areas should provide ED staff with a clear line of sight into the waiting room while still preserving patient privacy and confidentiality.

Waiting rooms should be designed to prevent unauthorised entry into the clinical area of the ED and provide staff with appropriate visibility of patients and accompanying persons in the waiting room.[13] Consideration should be given to appropriate lighting, noise levels and distractions like art works, public television, magazines, and video entertainment for children in the waiting room. Comfortable seating arranged in conversational groupings, tables for food and drink, and charging stations for mobile devices should also be considered. These considerations can assist in reducing stress and agitation levels.

The ED environment must be adapted so that it is culturally safe. Providing private areas away from crowded waiting areas to discuss health information and take vital signs, may assist some patients, including Māori patients, feel less vulnerable and exposed. ED design can result in a culturally unsafe environment when there is limited space for family or community support.

Hospitals should provide separate rooms for the assessment and management of patients suffering from a behavioural disturbance. ACEM recommends an appropriately low stimulus area for patients suffering from an acute psychological or psychiatric crisis (such as a mental health short stay unit) and a behavioural assessment room (BAR) for the management of acutely disturbed or violent patients. These rooms should be designed to minimise the risk of injury to the patient and ED staff.

6.2. 4 Liaison with other emergency services

It is essential that regular meetings occur with internal and external stakeholders to improve awareness of ED pressures and to ensure communication across impacted parties and the coordination of efforts for all involved in the care of emergency department patients. This includes broader hospital staff, ED staff, local police, ambulance service, mental health first responders and other community-based healthcare workers.

These meetings should regularly discuss systems and processes to prevent or manage violent incidents. A multi-disciplinary approach is essential as it acknowledges the respective strengths and limitations of each impacted service and the broader journey of the patient through the healthcare system.

Regular meetings will also provide scope to discuss known violent patients/offenders and put in place proactive alert systems to minimise the likelihood of an incident.

6.3 Risk assessment and planning

6.3.1 Risk alerts

Past behaviour is the best predictor of future behaviour. All EDs should have systems that alert staff of previous violent behaviour at future presentations. All staff should be trained to check alerts on arrival and before interaction and enter alerts after incidents of violence.

6.3.2 Risk screening

ACEM highly recommends the use of risk screening tools to improve objectivity in the assessment of violence risk and promote proactivity in its management. There are currently no validated tools specifically designed for EDs. The only validated tool in healthcare settings, the Bröset Violence Checklist, while not designed for or validated in EDs, is proving simple and effective within the ED environment.[28]

Experienced ED staff rapidly pick up on subtle cues about a patient's behaviour that suggests a potential for violence. This ability is powerful for early identification of potential problems but a screening tool should also be used to ensure that any response is objective.

6.3.3. Risk mitigation

Any alerts or screening tool should be aligned with a selection of multi-dimensional strategies to mitigate the risk, covering environment and location, as well as the responsibilities of security, nursing, and medical staff.

6.4 Incident management

6.4.1 Behavioural crises

All ED staff should be empowered to call for assistance when feeling their safety is being threatened. If least-restrictive methods fail, a rapid assessment is required to determine the clinical priorities and legal considerations under which a decision is made. Escalation to a senior medical or nursing staff member is essential when assessing and managing a behavioural emergency where there is an identified risk of violence or escalating aggression. The starting point for these assessments is that capacity is assumed, and staff should not place themselves at risk of harm to prove otherwise.

If a violent person is putting others at risk due to violent behaviour and is determined not to have a clinical problem requiring time critical emergency care, it may be appropriate for them to be removed from the ED with security and/or police assistance where required.

ACEM recommends a consistent and uniform approach to emergency management, including behavioural crises within hospitals and health care facilities in Australia and Aotearoa New Zealand.

6.4.2 Least-restrictive methods

The principle of least restrictive practice should be employed for every patient. ED staff should have training in de-escalation strategies, that should be employed in the first instance, together with utilisation of appropriately trained hospital security personnel. Mechanical, physical, or chemical restraint is a last resort measure that should only be used to facilitate assessment and/or treatment that will prevent imminent harm to the patient or others, and all other less restrictive means of management have been explored and found unsuitable.

Clinicians should acquaint themselves with the ACEM Statement on the use of restrictive practices in emergency departments S817 [29], the legal requirements of their jurisdiction with respect to restrictive practices, and their workplace policies and procedures.

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[28] Senz A, Ilarda E, Klim S, Kelly AM. Development, implementation and evaluation of a process to recognise and reduce aggression and violence in an Australian emergency department. Emergency Medicine Australasia. 2020 Dec 17.

[29] Australasian College for Emergency Medicine. Statement on the use of restrictive practice in emergency departments (S817). Melbourne: ACEM. 2022

All NZ health service providers should meet Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 that requires the allocation of resources to address actions that minimise restrictive practices. [30] The Australian Commission on Safety and Quality in Healthcare Action 5.35 outlines the use of restraint where clinically necessary and strategies to improve health services to reduce the use of restrictive practices.[31] Internal policies should include the aim of eliminating seclusion and restraint wherever possible.

ACEM supports a reduction in the use of restraint in the ED to manage patients exhibiting disturbed and/or aggressive behaviour wherever possible. Prevention strategies, such as engagement, rapport development and communication, situational awareness, and appropriate case management should be employed wherever possible. Addressing concerns, attending to needs, and keeping patients and visitors informed should be routine responsibilities of all ED staff. De-escalation strategies should be employed early. For certain patient groups, e.g., for acute mental health or withdrawal presentations, proactive use of pharmacotherapy to manage symptoms may be appropriate and prevent escalation.

6.4.3 Seclusion and restraint

When responding to violence, a team-based approach is best by staff who are trained and practised in verbal de-escalation, therapeutic sedation and physical restraint. If restraint is required, and meets all criteria set out in the ACEM Statement on the use of restrictive practices in emergency departments S817, appropriate sedation should be employed.[29] Physical restraint in the ED should occur as a last resort under medical supervision and for the shortest time possible and always documented. ED staff should be aware of the relevant legal frameworks governing the use of sedation and restraint in their jurisdiction, and these should be articulated clearly in local policies for the management of violence and followed.

Under NZ mental health guidelines, seclusion is still permitted as a last resort to prevent harm in emergency situations, and when providers have tried other less restrictive practices. All uses of locked seclusion rooms and areas that the patient/service user cannot freely exit must be recorded as seclusion events.[32] Legislation varies between Australian states and territories, but all states and territories have legislation and associated regulations that includes criteria for when and where seclusion and restraint may be used.[33]

6.5 Post-incident management

6.5.1 Responding to violent incidents

The hospital and the health system have a responsibility to act in response to violent incidents. Actions taken by the hospital and/or system resulting from violent incidents should be promptly and transparently reported to staff (including, importantly, those directly affected by the incident).

In instances where violent incidents need to be reported to police, the hospital administration should make the initial report. Hospital administration should provide support to ED staff in any police investigations that may arise as a result of violent incidents in the ED.

Hospital management are responsible for reporting all ‘reportable incidents’ to the relevant work safety authority.

6.5.2 Post-incident debriefs and support

ED staff are encouraged to routinely hold structured debrief sessions after all significant security events. All hospitals should provide appropriate psychosocial and legal support systems for ED staff during any investigation and/or legal proceedings. Support systems should be in place for ED staff who are returning to work after experiencing workplace violence.

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[30] Ministry of Health Manutū Hauora. Sector Guidance for Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021). Wellington Ministry of Health; 2021.

[31] Australian Commission on Safety and Quality in Healthcare. NSQHS Standards. Action 5.53. Australia, 2024

[32] Ministry of Health Manutū Hauora. Guidelines for reducing and eliminating seclusion and restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health; 2023

[33] Australian Institute of Health and Welfare. Seclusion and restraint in mental health care. Australian Government, 2024

6.5.3 Standardised reporting

Violent incidents should be reported to hospital administration and all incidents (including near misses) should be appropriately recorded and fully investigated. Each incident of violence should be reported through the hospital risk management system so that the true extent of violence in EDs can be understood and monitored over time.

Administrative and clinical leadership is necessary for a change in culture to empower clinicians to report violence incidents. Both the literature and anecdotal reports from ACEM members suggest that one of the barriers to violent incident reporting is the time required to enter data into the hospital risk management system. Hospital management should ensure that reporting processes are streamline so that reports can be made quickly and easily. Standardised systemwide reporting processes should be established to support improved reporting and to facilitate stronger responses.

ACEM recommends the following broad categories for inclusion in a whole-of-hospital violence surveillance system in accordance with jurisdictional practices:

1. Worker demographics (for example job title, department).
2. Workplace violence subtype (for example verbal abuse, threat of assault, physical assault).
3. Perpetrator characteristics (for example patient, visitor, gender).
4. Event setting (for example in person, telephone).
5. Hospital location (for example ED, intensive care unit).
6. Physical location (for example hallway, waiting room).
7. Hospital factors (for example emergency/acuity, long wait time, short staffing).
8. Perpetrator factors (for example receipt of bad news, mental and behavioural condition, alcohol intoxication).
9. Warning signs (for example frustration, anxiety, mumbling).
10. Weapon type (where relevant).
11. Involvement of others (for example co-workers, security personnel).
12. Intervention used (for example de-escalation, security, sedation).
13. Immediate consequences for worker (for example distress, injury).
14. Text description of the event (completed by worker).
15. Recommendations for future prevention efforts.

7. Related documents

- Quality Standards for Emergency Departments & Other Hospital-based Emergency Care Services
- G15 Emergency Department Design Guidelines
- S57 Statement on Emergency Department Overcrowding
- S43 Statement on Alcohol Harm
- S817 Statement on the use of restrictive practices in emergency departments

- P41 Access to care for patients with acute mental and behavioural conditions
- Relevant jurisdictional workplace health and safety legislation
- Relevant hospital and/or health care facility workplace health and safety policies/procedures
- Relevant jurisdictional medical indemnity legislation

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