



VIOLENCE IN EMERGENCY DEPARTMENTS

1. PURPOSE

The safety of patients, visitors and staff in the ED is of primary concern to Australasian College for Emergency Medicine (ACEM). While in the vicinity of the ED and the wider hospital, all people have a right to an environment safe from violence. The College's vision is that no staff, patients or accompanying persons suffer harm due to violent incidents in the ED.

This document is a policy of ACEM. This policy applies to all emergency department (ED) staff in Australia and New Zealand when responding to and managing incidents of violence in the ED. Overall, the policy aims to foster safer EDs in Australia and 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

In scope for this policy are all clinical and administrative staff of Australian and New Zealand EDs, as well as clinical and administrative staff external to the ED, hospital security personnel, and senior hospital executives and administrators. External stakeholders are 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.

This document does not address bullying or occupational violence perpetrated by hospital employees against each other, nor the clinical management of violent behaviour in patients.

3. DEFINITIONS

3.1 Behavioural assessment room

Behavioural assessment room (BAR) is a designated area within or adjacent to the ED that provides for the safe management of behaviourally disturbed, aggressive and/or violent patients. (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.

3.2 Emergency department design

Emergency department design can influence and reduce levels of violence through building and interior design solutions. (2) Good ED design – incorporating environment, information, service, lighting, sound, and digital design – provides opportunities for creating ambient environments for patients and accompanying persons that prompt positive behaviours and guide expectations. For instance, clear, accurate information with supportive wayfinding can help reduce frustration at the beginning of the ED experience. (1, 3)

3.3 Hospital emergency codes

As part of the hospital system, many EDs in Australia and 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. (4) 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). A consistent approach to emergency management within hospitals and health care facilities in Australia and New Zealand is recommended by ACEM.

3.4 Triage area

The first point of contact for all ED presentations, a triage area is designed for the initial clinical assessment of patients and allocation of an urgency score according to the Australasian Triage Scale. Triage areas provide ED staff with a clear line of sight into the waiting room while still preserving patient privacy and confidentiality. Functional requirements include security measures for ED staff and patients by way of duress alarms and closed-circuit television (CCTV). (1)

3.5 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. (5)

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. (6)

3.6 Workplace violence

Safe Work Australia defines *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’. (7) This definition is broad 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
- Aggravated assault
- Any form of indecent physical contact
- Threatening someone with a weapon or armed robbery. (7)

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, their families, workplaces and wider community. (7) 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) A recent meta-analysis¹ found that approximately 36 in every 10,000 ED presentations involve violence, with about 45 in every 100 violent presentations estimated to be associated with alcohol and/or other drugs. (8)

¹ Findings were limited by inaccurate data related to under-reporting and lack of objective evidence.

Studies examining violence in the ED consistently report a high prevalence of verbal aggression, followed by threats, then physical abuse. (10) Nine in 10 ACEM members² report feeling threatened by a patient, and four in 10 report physical assault. (11) Emergency department nurses also commonly experience patient-related violence. (12-14) 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. (3, 10-13) Work to address violence in UK EDs characterised patient perpetrator types as clinically confused, frustrated, intoxicated, antisocial, distressed/frightened and socially isolated. (12, 15)

Violence in EDs is under-reported due to perceptions among ED staff that it is an inherent part of the job. (8) Emergency department 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. (8, 12, 14, 16) 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 a culture of reporting is essential.

5. POLICY

Jurisdictional health system managers and hospitals have a responsibility to guarantee that the ED is a safe workplace for all employees, while at the same time ensuring community access to safe, high quality, equitable emergency medical care.

Hospital administrators must ensure that policies, procedures, staffing models, ED design and incident reporting systems contribute to the prevention, minimisation and effective management of violence in the ED.

Emergency department staff should never be expected to put their own safety at risk to provide patient care including when assisting with the management of violent patients and/or accompanying persons. In the first instance, de-escalation strategies should be employed together with utilisation of appropriately trained hospital security personnel.

Emergency department 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. (17)

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.

A holistic approach is needed in both Australia and New Zealand to effectively prevent, minimise and respond to incidents of violence in the ED. Such an approach should address the following domains:

- 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.
- Hospital policies and procedures for the effective management of violence in EDs and other hospital-based emergency care centres tailored to meet specific local requirements, while at the same time conforming to national standards.

² ACEM members for this purpose were specialist emergency physicians and emergency medicine advanced and provisional trainees. Data sourced from the 2016 Workforce Sustainability Survey Report. Respondents were asked about experiences of patient-initiated aggression in the past year.

- 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. (11, 18)
- Quality ED design that meets the dual needs of ED staff and patients/accompanying persons, which also promotes a healing environment that is safe and free of psychosocial elements created through poor design. (1, 3)

All funded initiatives with the aim of reducing or responding to violence in the ED should be robustly evaluated to determine their effectiveness and whether they should be adopted as core hospital and/or ED business as usual.

6. PROCEDURES AND ACTIONS

6.1 ED policies and procedures

Emergency departments must have specific, contemporary policies and procedures for the prevention, rapid assessment and containment of violence within a patient-care focused framework. All EDs should have capability to mount a timely and appropriate response to any violent incident as it occurs, including prompt access at all times to appropriately trained hospital security and/or police.

6.2 Staff training

Emergency department 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. Importantly, ED triage area staffing models should also consider individual interpersonal attributes such as friendliness, professionalism and cultural competence to foster a safer environment for all parties conducive to mutual respect and cooperation.

All ED staff, including ED security personnel, 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 and culturally competent communication
- Workplace violence prevention measures
- Workplace policies and procedures
- Appropriate use of sedation and restraint
- Emergency and post-incident responses
- Their right to withdraw to safety at any time.

Emergency department staff must receive adequate training in the hospital's emergency and risk management systems, including initiating and responding to internal emergencies (e.g. Code Black responses or other hospital-wide standardised emergency management system). Consideration should be given to all staff members carrying personal duress alarms. Implementation of patient alert systems that generate a signal which warn staff of any potential risk to themselves and others should also be encouraged. (19)

6.3 Restraint

Hospitals and EDs will have legal frameworks in place regarding the use of sedation and restraint for the management of violence. 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, appropriate sedation should be employed. (20) Physical restraint in the ED should always occur under medical supervision and for the shortest time possible to allow safe administration of sedation. Physical restraint is a measure of last resort and prolonged physical restraint in the ED is inhumane. Prone restraint carries increased risks of musculoskeletal injury and respiratory compromise and is actively discouraged by ACEM. (21)

Wherever possible, ACEM supports a reduction in the use of restraint in the ED to manage patients exhibiting disturbed and/or aggressive behaviour. Prevention strategies, such as engagement, rapport development and communication, situational awareness and appropriate case management should be employed wherever possible.

6.4 Resourcing of ED security personnel

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. (22) Well-trained, experienced hospital security personnel with strong physical presence, excellent communication skills, an aptitude for learning, and a positive 'customer service' attitude can be successfully utilised in the ED to problem solve and eliminate unnecessary conflict. (23) 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.

It is important to note inconsistencies in resourcing of security personnel in Australian and New Zealand rural and remote EDs. Often, rural and remote EDs are not resourced to contract after-hours security personnel and instead rely on the on-call use of 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.

6.5 ED design

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. (15)

The ED entrance should be well lit and designed in such a way that prevents hiding spaces. CCTV cameras should be installed both outside and inside the waiting room. Security personnel should be visible and accessible to the ED entrance and waiting room. (1)

The waiting room should provide security and protection for ED staff, while still enabling clear communication with patients and visitors. Waiting rooms should be designed to prevent unauthorised entry into the clinical area of the ED, and also provide staff with appropriate visibility of patients and accompanying persons in the waiting room. (1, 3)

The triage area should be easily identifiable, accessible and properly staffed. Clear signs and wayfinding should be utilised to indicate where patients report. (1)

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.

A waiting time that feels long due to crowded, noisy surroundings or a lack of positive distractions can contribute to anxiety and irritability. ACEM recommends the adoption of electronic signage that digitally displays expected waiting times for patients. (3)

Consideration should be given to appropriate lighting, noise levels and distractions like art works, public television, magazines, and video entertainment for children. Seating arranged in conversational groupings, tables for food and drink, and charging stations for mobile devices should be considered.

Consideration should also be given to providing an appropriately secure environment, including discrete physical barriers, secure locks, surveillance systems, personal duress alarm systems and separate purpose-designed patient assessment areas.

6.6 Assessment rooms

Separate rooms for the assessment and management of patients suffering from a behavioural disturbance should be provided. 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 BAR for the management of acutely disturbed or

violent patients. These rooms should be designed in such a way that they minimise risk of injury to the patient and ED staff.

6.7 Standardised reporting

Emergency department staff should be encouraged and supported to report violence to hospital administration and all incidents should be investigated. However, it is also incumbent on ED staff to report each incident of violence through the hospital risk management system so that the true extent of violence in EDs can be understood and monitored over time.

Both the literature and anecdotal reports from ACEM members suggest that one of the barriers to violent incident reporting is the time to enter data into the hospital risk management system. Administrative and clinical leadership is necessary for a change in culture to occur.

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

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

6.8 Legal action and support

ED staff should be encouraged and supported by hospital administration to report violent incidents to the police. In the event that a violent patient is determined upon assessment not to have an acute medical problem, hospital security personnel and/or the police should be contacted for assistance.

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.

7. RELATED DOCUMENTS

- [Quality Standards for emergency departments and other hospital-based emergency care services](#)
- [G15 – Emergency department design guidelines](#)
- [S57 – Statement on emergency department overcrowding](#)
- [S43 – Statement on alcohol harm](#)
- Relevant jurisdictional workplace health and safety legislation
- Relevant hospital and/or health care facility workplace health and safety policies and procedures
- Relevant jurisdictional medical indemnity legislation

8. REFERENCES

1. Australasian College for Emergency Medicine. Emergency Department Design Guidelines (G15). 3rd ed. Melbourne: ACEM; 2014.
2. Vincent M. Including occupational violence prevention in the design process. Melbourne: Vincent Chrisp & Partners 2011.
3. Design Council. Improving patient experience in A&E. London: Design Council, 2012.
4. Standards Australia. Planning for emergencies—Health care facilities. Sydney: SAI Global Limited, 2010.
5. Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002.
6. 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.
7. Safe Work Australia. Workplace violence: a definition [Internet]. Canberra: Safe Work Australia; 2017 [updated 2017 Mar 27]. Available from: <https://www.safeworkaustralia.gov.au/workplace-violence>.
8. Nikathil S, Olausson 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. 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.
11. Australasian College for Emergency Medicine. Workforce Sustainability Survey Report, November 2016. Melbourne: ACEM, 2016.
12. 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.
13. Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence at triage: A qualitative descriptive study. *International Emergency Nursing*. 2011;19:12-9.
14. Kennedy M. Violence in emergency departments: under-reported, unconstrained, and unconscionable. *Medical Journal of Australia*. 2005;183(7):362-5.
15. Design Council. Perpetrator characteristics: Profiling traits of violent and aggressive behaviour in A&E [Internet]. London: Design Council; 2011. Available from: <http://www.designcouncil.org.uk/resources/report/perpetrator-characteristics>.
16. 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.
17. Australasian College for Emergency Medicine. Statement on emergency department overcrowding (S57). Melbourne: ACEM, 2016.
18. Australasian College for Emergency Medicine. Guidelines on constructing and retaining a senior emergency medicine workforce (G23). Melbourne: ACEM, 2015.
19. 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.
20. NSW Ministry of Health. Principles for Safe Management of Disturbed and/or Aggressive Behaviour and Use of Restraint. North Sydney: Ministry of Health, NSW, 2015.
21. Australasian College for Emergency Medicine. Policy on access to care for patients with an acute mental health-related behavioural disturbance (P41). Melbourne: ACEM, 2017.

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22. Safe Work Australia. Workplace violence is not ok - keeping emergency departments safe [Internet]. Canberra: Safe Work Australia; 2017 [updated 2017 May 22017 Jun 29]. Available from: <https://www.safeworkaustralia.gov.au/media/workplace-violence-not-ok-keeping-emergency-departments-safe>.
23. York T, MacAlister D. Hospital and healthcare security. Sixth ed. Oxford: Elsevier Inc; 2015.

9. DOCUMENT REVIEW

Timeframe for review: In 12 months.
[Provide your feedback](#) for the next review.

9.1 Responsibilities

Authoring group: Public Health Committee
Document authorisation: Council of Advocacy, Practice and Partnership
Document implementation: Standards Committee
Document maintenance: Department of Policy and Research

9.2 Revision history

Version	Date of Version	Pages Revised / Brief Explanation of Revision
01	Mar 2004	Revised document
02	Mar 2011	Revised document
03	Dec 2017	Entire document revised

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