Australasian College
for Emergency Medicine

Violence in emergency departments

Policy P32

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
01	Mar 2004	Revised document
02	Mar 2011	Revised document
03	Dec 2017	Entire document revised
04	Nov 2021	Entire document revised

Related documents

This Policy should be read in conjunction with the following ACEM documents, which can be found in the ACEM Standards and Advocacy Library.:

- 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
- 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

1. Purpose and scope

The safety of patients, visitors and staff in the Emergency Department (ED) is of primary concern to Australasian College for Emergency Medicine (ACEM). It is recognised that staff in the ED who perform public services that are essential to the community have an increased vulnerability to experience violence due to their occupation and working environment. It is also recognised that while in the vicinity of the ED and wider hospital, all members of the community 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 and consequently supports the implementation of strategies for prevention.

This document is a policy of ACEM. This policy applies to all ED staff in Australia and Aotearoa New Zealand when preventing, responding to, and managing incidents of violence in the ED. Overall, the policy aims 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.

In scope for this policy are all staff of Australian and Aotearoa 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.

2. Definitions

2.1 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.

2.2 Emergency department design

ED 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] Crime prevention through environmental design (CPETED) provides the opportunity through the planning and design phase to maximise natural surveillance and incorporate features that minimise the reliance on overt security measures.[4]

2.3 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.[5] 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).

2.4 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.

2.5 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.[6]

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.[7]

2.6 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'.[8] 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
- Aggravated assault
- Any form of indecent physical contac.
- Threatening someone with a weapon or armed robbery[7]

3. 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.[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.[9,10] A recent meta-analysis[i] 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]

Studies examining violence in the ED consistently report a high prevalence of verbal aggression, followed by threats, then physical abuse.[11] Nine in 10 ACEM members[ii] report feeling threatened by a patient, and four in 10 report physical assault.[12] ED nurses also commonly experience patient-related violence.[13,14,15] 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.[3,10,11,12,13] Work to address violence in UK EDs characterised patient perpetrator types as clinically confused, frustrated, intoxicated, antisocial, distressed/frightened, and socially isolated.[12,16]

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.[8,12,14,17] 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.

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]

4. 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, 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.

In the context of the ED, violence is often perpetrated by those people that do not have rational control of their behaviour. Factors that influence this may include pain, grief, psychoses, dementia, intoxication via alcohol or other drugs, anaesthesia. The causative factors associated with violence in the ED are important because they impact on the strategies used to manage the behaviour.

The principle of least restrictive practice should be employed for every patient. ED staff should have training in de-escalation strategies, which should be employed in the first instance, together with utilisation of appropriately trained hospital security personnel. Additional strategies to manage risk, as detailed below, should be utilised where appropriate. Restraint in its various forms 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, all other less restrictive means of management must have been explored and found unsuitable.

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

ii 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.

Clinicians should acquaint themselves with S817 Statement on the Use of Restrictive Practices in Emergency Departments, the legal requirements of their jurisdiction with respect to restrictive practices, and the policies and procedures within their workplaces.

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.[18]

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 multifaceted approach is needed in both 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 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 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 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.[11, 19]
- Staff Training should be 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, which also promotes a healing environment that is safe and free of psychosocial aggravating factors created through poor design.[1,3]

All funded 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.

5. Procedures and actions

5.1 Governance

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 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.

5.2 Prevention

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, conductive to mutual respect and cooperation. This is especially important for staff in triage and front-of-house roles.

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, culturally safe, and culturally competent communication.
- Workplace violence prevention measures.
- Workplace policies and procedures.
- Appropriate use of sedation and restraint (where permitted).
- Emergency and post-incident responses.
- Their right to withdraw to safety at any time.
- 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). Consideration should be given to all staff members carrying personal duress alarms. Implementation of patient alert systems that generate a signal that warn staff of any potential risk to themselves and others should also be encouraged.[20]

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.[21] 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.[22] 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 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.

ED design

The ED entrance should be well lit and designed in such a way that prevents hiding spaces. CCTV cameras may be installed both outside and inside the waiting room, noting that governance around the security of this footage is paramount. 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, patients, and visitors, 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] Triage areas provide ED staff with a clear line of sight into the waiting room while still preserving patient privacy and confidentiality. Functional minimum requirements include security measures for ED staff and patients by way of duress alarms and closed-circuit television (CCTV).

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. Comfortable 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.

5.3 Early identification

Risk alerts

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

Risk screening

ACEM highly recommends the use of risk screening tools to improve objectivity to the assessment of risk of violence and promote proactivity in its management. There are currently no validated tools specifically designed for ED. 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.[23]

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.

5.4 Management

Least-restrictive methods

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. Addressing concerns, attending to needs, and keeping patients and visitors informed should be routine responsibilities of all 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.

Behavioural crises

All 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 considering if a patient should be discharged from care. The starting point for these assessments is that capacity is assumed, and staff should not place themselves at risk of harm to prove otherwise.

A consistent and uniform approach to emergency management, including behavioural crises within hospitals and health care facilities in Australia and Aotearoa New Zealand is recommended by ACEM.

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.

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 forthcoming ACEM statement on restrictive practices, appropriate sedation should be employed.[20] Physical restraint in the ED should always occur as a last resort under medical supervision and for the shortest time possible, and should always be 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 and adhered to in local policies for the management of violence.

5.5 Post-incident management

Post-incident debriefs and support

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.

Standardised reporting

ED staff should be encouraged and supported to report violence to hospital administration and all incidents should be appropriately recorded and fully 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 empower clinicians to report.

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

system in accordance with jurisdictional practices:

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

Legal action and support

ED staff should be actively 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.

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