REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-10)
Violence in the Emergency Department
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. To examine available data on the occurrence of violence in the emergency department (ED) and identify potential remedial actions to prepare for and respond to violence in the ED.

Methods. English-language reports were selected from a MEDLINE search of the literature from 1985 to August 2010 using the search terms "violence" or "assault" in combination with "emergency room or department," and "epidemiology," "prevention," "management," or "standards." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of The Joint Commission, American Hospital Association, International Association for Healthcare Safety and Security (IAHSS), Occupational Safety and Health Administration (OSHA), National Institute on Occupational Safety and Health, American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), and the American Psychiatric Association.

Results. A number of factors contribute to the emergency department (ED) emerging as a focal point for potential violence including 24 hour access, use as a medical clearance area for psychiatric patients, and factors related to the waiting room environment and triage system. Overall, studies indicate that between 35% and 80% of ED staff have been subjected to violence on the part of patients.

The Joint Commission Standards and Elements of Performance cover the way in which hospitals should address safety and security issues. Voluntary advisory guidelines from OSHA are intended to help employees establish effective workplace violence prevention programs. Guidance also is available from ACEP, ENA, and the IAHSS. Some states have adopted legislative remedies in an effort to mitigate violence directed against hospital employees. In addition, current American Medical Association policy provides sound guidance on some general approaches to hospital security

Conclusion. Assaults against ED personnel are problematic regardless of hospital size and location. Hospitals are required to identify safety and security risks and take action to minimize or eliminate such risks. Additionally, hospitals must have written procedures to follow in the event of a security incident, and if such an incident occurs, the hospital should follow its identified procedures. However, no universal strategy exists to prevent violence in the ED, and risk factors vary from hospital to hospital. Every hospital must assess its own specific vulnerabilities and apply the degree of security necessary, including the use and deployment of physical and electronic security safeguards. An institutional culture that encourages reporting, recordkeeping, and incident review also is important. In addition to having written plans and procedures, training should involve joint staff and security personnel exercises.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-10

Subject: Violence in the Emergency Department

Presented by: Albert J. Osbahr, III, MD, Chair

Referred to: Reference Committee K
(Michael M. Miller, MD, Chair)

Policy D-515.983, "Risk of Violence in the Emergency Department," (AMA Policy Database) asks that our American Medical Association (AMA) develop a report on the risk of violence in the emergency department (ED) considering information on the incidence and trends of violence in the ED. Furthermore, the policy urges that this report serve as a catalyst for the development of procedures to protect students, trainees, physicians, nurses, and other healthcare staff in the ED environment and to assure optimal care for patients with behavioral conditions in overcrowded acute emergency settings. A previous report on this topic was developed by the Young Physicians Section in 1995.[1]

Accordingly, this report examines available data on the occurrence of violence in the ED, explains the current standards that apply to workplace safety and security in hospital settings, and reviews current recommendations of various organizations on how to mitigate violence in the ER, with some attention to handling patients with psychiatric conditions or disorders. In reviewing the literature for this report, it became clear that substantial guidance is already available on many of these topics. Therefore, a menu of potential remedial actions to prepare for and respond to violence in the ED is offered in Appendix I.

METHODS

English-language reports were selected from a MEDLINE search of the literature from 1985 to August 2010 using the search terms "violence" or "assault" in combination with "emergency room or department," and "epidemiology," "prevention," "management," or "standards." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of The Joint Commission, American Hospital Association, International Association for Healthcare Safety and Security (IAHSS), Occupational Safety and Health Administration (OSHA), National Institute on Occupational Safety and Health (NIOSH), American College of Emergency Physicians (ACEP), Emergency Nurses Association ENA), and the American Psychiatric Association (APA).

AMA AND OTHER POLICY STATEMENTS

AMA Policy H-215.992 supports efforts by physicians and other hospital staff to encourage all hospitals to institute and/or maintain appropriate and adequate security measures, such as general identification, patrols, visual monitoring systems and metal detectors. Two policies address the issue of guns in hospitals (H-215.977 and H-215.978); the former also broadly addresses recommended security approaches to reduce violence in the ED. These policies recognize that

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Action of the AMA House of Delegates 2010 Interim Meeting: Council on Science and Public Health Report 2 Recommendations Adopted, and Remainder of Report Filed.

emergency departments are high risk environments for violence and support the efforts of the IAHSS, AHA and The Joint Commission to develop guidelines or standards on hospital security issues. Policy H-215.978 further notes that "physicians should work with their hospital safety committees to address security issues and be familiar with their own institution's policies and procedures. Hospitals should incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. Such policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials."

With respect to enhancing hospital security and safety, Policy H-215.977 notes that hospital policy development should begin with a careful needs assessment that examines past issues and addresses future needs. Policies should, at a minimum: (1) establish how all staff and visitors are identified; (2) address restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; (3) evaluate changes in the physical layout of the facility that would improve security; (4) consider the possible use of metal detectors; (5) consider the use of monitoring equipment such as closed circuit television; (6) have in place an internal emergency signaling system; (7) address signage for the facility regarding the possession of weapons and procedures to be followed when a weapon is discovered; and (8) establish the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

Policy H-215.977 also advises that once hospital policies are developed, training should be provided to all members of the staff, with the level and type of training based on the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included. Violence prevention policies should undergo periodic reassessment and evaluation and firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

Emergency room crowding is a recognized risk factor for precipitating violence. Policy H-130.940 supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding and the dissemination of best practices to reduce these occurrences.

American College of Emergency Physicians

The ACEP policy statement on ED violence states that ACEP "believes that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department are protected against violent acts occurring within the department."[2]

Furthermore, to ensure the security of the ED environment, ACEP policy notes that the hospital has the following responsibilities:

- Provide a best-practices security system including adequate security personnel, physical barriers, surveillance equipment, and other security components;
- Coordinate the security system with local law enforcement agencies;
- Develop written emergency department protocols for violent situations in the ED;
- Educate staff on preventing, recognizing, and dealing with potentially violent situations; and
- Conduct ongoing assessments of ED security system performance.

In addition, ACEP's Public Health and Injury Prevention Committee has developed an Information Paper on Workplace Violence, which has been submitted for publication, but at the time of this writing was not available for review.

Emergency Nurses Association

The Emergency Nurses Association has a well developed policy statement that more specifically addresses nursing issues, but that also endorses several general approaches for reducing emergency department violence that are consistent with the features found in Appendix I.[3]

EPIDEMIOLOGY OF EMERGENCY DEPARTMENT VIOLENCE

A recent study of acute care hospitals in New Jersey confirmed that significant variations exist in security programs based on the size of the hospital and local community crime rates.[4] Larger hospitals and hospitals in higher crime areas institute more extensive security measures. Based on OSHA work-related reportable injuries, small hospitals in high crime areas had the highest rate of assaults against ED personnel over a 10-year period. Larger hospitals had lower rates of assault regardless of location. Thus, assaults against ED personnel are problematic regardless of hospital size and location.

Risk Factors

A number of factors contribute to the ED emerging as a focal point for potential violence including 24-hour access, use as a medical clearance area for psychiatric patients, and an unpleasant waiting room environment. The latter may involve overcrowding or cramped space, long wait times, noise and commotion, lack of access to food and refreshments, a slow pace of updates for friends and family, and lack of understanding of the triage system. These can all trigger additional stress and anger in family members, friends, and visitors.

Individual patient and visitor factors also are important, especially the involvement of drugs and alcohol or domestic violence. Based on data obtained from the Drug Abuse Warning Network, visits to the emergency department for drug- and alcohol-related incidents rose from 1.6 million in 2005 to nearly 2 million in 2008.[5] From 2006 to 2008, the number of those visits resulting in violence jumped from 16,000 to more than 21,000.

The location of the ED, patient volume, and nature of the clientele are related to the likelihood that local crime, gang activity, or weapons may be a significant problem. Adequately trained, armed, and visible security guards can serve as a deterrent, but if this presence is lacking, violence is more likely. The mix of patients, caregivers, medical staff, and other service providers (e.g., police, fire, ambulance, coroner) can further contribute to volatility. Finally, the increasing use of the ED as a medical clearance area for psychiatric patients is an additional risk factor for violence.

Incidence of Violence Against ED Workers

The reliability of data on ED violence is complicated somewhat by the tendency for underreporting of incidents. The ENA has noted that underreporting may be due to a lack of institutional reporting policies, the perception that assaults are part of the job, employee beliefs that reporting will not benefit them, and employee concerns that assaults might be viewed as a result of poor job performance or negligence.[3] As many as 50% of incidents may go unreported to employers.[6] In addition, violent incidents in the ER often are not reported to law enforcement authorities because of a belief that such reports will not be taken seriously, and that workers will be stigmatized.

Overall, studies have shown that between 35% and 80% of hospital staff have been subjected to violence on the part of patients or visitors at least once during their careers.[7]

Data on the prevalence of workplace violence involving health care workers is derived from government statistics, surveys of individual hospitals, and national surveys of emergency departments, physicians, and nurses. The problem of ED violence has been formally recognized for more than a quarter of a century. Based on information obtained from the U.S. Department of Justice, approximately 1.7 million episodes of workplace violence occurred annually between 1993 and 1999, with 12% involving a medical (i.e., physician, nurse, technician) or mental health (i.e., professional or custodial) worker.[8] Nurses experienced the highest rate of work-related violence among medical workers (22 per 1000). A similar combined annual rate of violence against nurses was detected in the Minnesota Nurses' Study (13.2/1000 for physical assault and 38.8/1000 for non-physical assault).[9] Nurses working in emergency departments were at greatest risk.[10] Forty-eight percent of all nonfatal assaults in the workplace are committed by healthcare patients.

More than 20 years ago, a survey of U.S. teaching hospital ED medical directors found that one-third experienced verbal threats daily, and approximately 20% experienced at least one threat with a weapon each month. Thirteen percent had injured patients by using restraint measures. Fewer than half of the institutions provided ED nurses with formal training in the recognition and management of aggression and violence, and only 60% had security personnel present in the ED 24 hours a day.[11] During the same time period, a one-year retrospective review of university police log records and ED staff incident reports at the University of California Irvine Medical Center (a university teaching hospital and Level I trauma center) found that police responded to the ED nearly twice daily, most commonly during the night shift. Police custody and psychiatric patients awaiting medical clearance accounted for 40% of the cases. More than 20% of incidents occurred in the waiting room and 4% of the incidents were a significant threat to ED staff.[12] Another study conducted at 50 New Jersey hospital EDs over a ten-year period from 1992-2001 found that 90% of ED nurses were verbally abused and one-third were assaulted.[13] A retrospective survey of emergency department employees at an urban inner city tertiary care center in 1996 found that 57% of respondents had been physically assaulted during the year.[14]

More recently, a survey of ED workers across five hospitals over a six-month period found that most workers had been verbally harassed by patients or visitors, and that 67% of nurses, 63% of patient aides and 51% of physicians had been assaulted by patients at least once.[15] Approximately two-thirds of these subjects did not report the incident to hospital authorities. A cross sectional survey of more than 3,000 members of the ENA revealed that 25% of respondents reported more than 20 incidents of physical violence over a three-year period; the rate of verbal abuse was 10-fold higher during the same time period.[16] Nurses who work in EDs are at higher risk of violence and physical assaults than other nurses.[6]

With respect to physicians, a mail survey of self-reported, work-related violence involving emergency physicians in Michigan over a 12-month period revealed that 28% experienced at least one physical assault and 74% experienced at least 1 verbal threat.[17] In a prospective, cross-sectional, online survey of emergency medicine residents and attending physicians at emergency medicine residency programs in the U.S., 78% reported at least one act of workplace violence in the previous 12 months, most commonly in EDs with >60,000 patient visits annually.[18] As in other studies, the most common threat was verbal (74%) compared with physical assaults (21%). This study also found that ~60% of facilities did not screen for weapons or utilize metal detectors.

The National Emergency Department Safety Study (NEDSS) also recently examined the prevalence of physical attacks on ED personnel over a five-year period; nearly 3,500 physical

attacks were reported.[19] One in five EDs reported that attempts to bring weapons (knives or guns) into the ED were common. Most of the EDs were in academic settings.

REQUIREMENTS, GUIDANCE AND STANDARDS

The Joint Commission

The Joint Commission Standards and Elements of Performance (EP) cover the ways hospitals should address safety and security issues. The security standards and EP are located in the chapter on Management of the Environment of Care in the *Comprehensive Accreditation Manual for Hospitals*.[20]

Standard EC.02.01.01 states that "the hospital manages safety and security risks." The various elements of performance demand that the hospital identify safety and security risks and take action to minimize or eliminate such risks in the physical environment. Additionally, hospitals should identify (as necessary) individuals entering the facility and have a means to control access to security sensitive areas. The hospital must have written procedures to follow in the event of a security incident, and if such an incident occurs, the hospital should follow its identified procedures.

Another relevant Joint Commission standard for emergency room safety and security (EC.04.01.010) requires that the hospital establish a process(es) for "continually monitoring, internally reporting, and investigating security incidents involving patients, staff or others within its facilities," and that the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness every 12 months.

National Institute for Occupational Safety and Health (NIOSH)

NIOSH defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." Physical assaults include being hit, slapped, kicked, pushed, choked, grabbed, sexually assaulted, or otherwise subjected to physical contact intended to injure or harm. Non-physical violence includes threats, sexual harassment, and verbal abuse. Female workers are more prone to sexual assaults (e.g., groping) and sexual harassment.

NIOSH published a primer on violence and occupational hazards in hospitals in 2002.[21] The primer notes that "to prevent violence in hospitals, employers should develop a safety and health program that includes management commitment, employee participation, hazard identification, safety and health training, and hazard prevention, control, and reporting. Employers should evaluate this program periodically." Selected elements of this primer are contained in Appendix II.

Occupational Safety and Health Administration (OSHA)

The Occupational Safety and Health Act of 1970 mandates that all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm (General Duty Clause).[22] In 2004, OSHA released guidelines for preventing workplace violence for health care and social service workers.[23] These guidelines are advisory in nature and are "intended to help employees establish effective workplace violence prevention programs adapted to their specific worksites." The OSHA Guidelines identify five main components for violence prevention, including management commitment and employee involvement, worksite analysis, hazard prevention and control, safety and health training, and

recordkeeping and program evaluation. Each of these components contains numerous specific options, recommended actions, and approaches.

International Association for Healthcare Security and Safety (IAHSS)

The IAHSS is a professional organization comprising security, law enforcement, and safety professionals who are involved in managing and directing security and safety programs in healthcare institutions. IAHSS provides numerous resources to help in the design and scope of healthcare security practices, including basic security guidelines for the healthcare industry and also provides training programs for security officers and credentialing of management-level personnel (www.IAHSS.org). Many of the IAHSS guidelines are noted in the 5th edition of *Hospital and Healthcare Security*, an encyclopedic discussion of the security needs of hospitals and other health care settings and how to address them.[24]

Legislative Remedies

In 1993 California passed the Hospital Safety and Security Act in an effort to mitigate violence directed against hospital employees.[25] The Act requires all acute care hospitals in California to conduct a security and safety assessment and develop a security plan containing specific performance measures intended to reduce aggressive or violent behavior. Specific components that are required include: (1) suitable physical layout and design and use of alarms and other physical security safeguards; (2) appropriate staff-to-patient ratios; (3) trained security personnel to identify and manage aggression and violence; (4) specific policies for both violence prevention and response linked to staff training; and (5) establishment of individual or committee responsibility to develop the security plan, including reporting requirements.

Other states, such as IL, NJ, OR, and WA, have adopted similar statutes requiring health care facilities to establish a violence prevention program for the purpose of protecting health care workers, to
conduct violence prevention training, and to train personnel to identify risk factors for violence, as well as to have the ability to appropriately respond and manage violent disturbances.[26]

EFFECTIVENESS OF INTERVENTIONS

Among hospital violence prevention policies, zero tolerance toward workplace violence and having clear descriptions of the types of specific behaviors that are prohibited may protect against work-related assaults of nurses.[27] Implementation of a "security system" (i.e., metal detectors, cameras, limited access controls, and manned security booth at the ED entrance) increases the number of weapons recovered from patients thereby limiting the potential for catastrophic events, but may not reduce the overall assault rate by such patients.[28]

Focused educational efforts aimed at preventing and managing aggressive behavior reduce violent events in the short term but need to be reinforced periodically.[29] However, studies generally have found a lack of obvious protection from individual training.[30] Additional research is needed to establish the best training methods for reducing ED violence.

Legislative remedies, such as those introduced in California in 1993 requiring acute care and psychiatric facilities to implement comprehensive security plans, result in an improvement in hospital security programs.[31] Limited analysis suggest that such remedies also reduce assault rates among emergency department employees in both for-profit hospitals and in smaller community-based hospitals.[32]

DEVELOPING A PLAN FOR PREVENTING AND RESPONDING TO VIOLENCE

The ECRI Institute maintains a Health Risk Control System.[33] Membership includes unbiased in-depth risk analyses, sample policies, and procedures that can be adapted to local needs to develop written plans, ready-to-use education and training tools, consultation services, and newsletter updates. With respect to security management plans, the IAHSS basic guideline states "Healthcare facilities must develop a security management plan. The plan should include preventive, protective, and response measures designed to provide a safe environment." These and every other contemporary guidance on preventing and responding to violence in healthcare settings emphasize the absolute necessity of developing a multidisciplinary, comprehensive plan that considers various security issues. Therefore, every hospital must assess its own specific vulnerabilities and apply the degree of security necessary to ensure the safety of the staff and optimal treatment for the patient. Among the chief assessment considerations are:[10]

- history of actual events;
- annual volume of ED patient admissions;
- trauma level designation;
- primary service area and types of patients and visitors typically seen;
- specialized services offered such as psychiatric or forensic patient agreements;
- history with aggressive patients in treatment areas;
- expectations of security staff for patient assistance;
- average amount of time spent by security staff on patient assistance;
- area's crime rate (or propensity for crime); and
- layout and design of the ED.

Patients with Psychiatric and Behavioral Disorders

Hospital EDs are treating an increasing number of patients with mental and substance use disorders in association with the relative decline in federal, state, and community services and support for such patients. The APA's "Practice Guidelines for the Psychiatric Evaluation of Adults" includes specific approaches for the emergency evaluation of psychiatric patients.[34] In addition, a monograph available on the APA Web site, entitled *Safe MD,* discusses practical applications and approaches to safe practice including those recommended for managing aggressive patients.[35] Several patient characteristics that may increase the risk of aggression are noted as well as several tips for working safely with potentially dangerous patients.

Use of a predetermined emergency department triage system or scale to ensure timely and appropriate treatment of patients who are very distressed, acutely psychotic, violent, or aggressive can be helpful.[36,37] Where possible, EDs should have dedicated treatment (quiet) rooms for psychiatric patients that avoid exacerbation of the patient's illness. Facilities with significant psychiatric presentations should consider hiring dedicated psychiatrically trained staff.

DISCUSSION

Hospitals are required to identify safety and security risks and take action to minimize or eliminate such risks. Additionally, hospitals must have written procedures to follow in the event of a security incident, and if such an incident occurs, the hospital should follow its identified procedures. However, no universal strategy exists to prevent violence in the ED, and risk factors vary from hospital to hospital.

The provision of a proper level of security and safety for the healthcare environment is a subset of overall hospital risk management. The identification of specific risks begins with a facility security review process. Every hospital must assess its specific vulnerabilities and apply the degree of security necessary, including the use and deployment of physical and electronic security safeguards. Security sensitive areas such as the emergency department require special staff orientation and training.

In a general way, *psychological safeguards* (command signage; visitor badging and sign in; visitor management systems; greetings/staff acknowledgement), *physical security safeguards* (security officers; closed-circuit television monitors, barriers, lighting,), and *electronic security components* (electronic access control systems, video surveillance, alarms, audio duress codes, restricted access or lockdown; metal screening) are important elements to a successful plan. An institutional culture that encourages reporting, recordkeeping, and incident review also is important. In addition to having written plans and procedures, training should involve joint staff and security personnel exercises.

Many excellent guidance documents exist, including the OSHA Guidelines, the ECRI Healthcare Risk Control System, and the programs and policies of the IAHSS to assist management in putting effective workplace violence prevention programs in place. In addition, current AMA policy provides sound guidance on some general approaches to hospital security. Finally, state legislation that mandates and regulates safety standards and controls for hospital violence prevention or that addresses criminal penalties for assaulting healthcare workers should be encouraged.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and the remainder of this report be filed:

1. That Policy H-215.977, "Guns in Hospitals," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association (AMA) make this report available to hospitals, emergency medicine departments, emergency physicians, mental health physicians, patient advocates, and law enforcement organizations as a resource designed to assist in the implementation of procedures to protect students, trainees, physicians, nurses, and other healthcare staff in the Emergency Department environment and to assure optimal care for patients, including those with psychiatric or behavioral conditions. (Directive to Take Action)

3. That Policy D-515.983 be rescinded, having been accomplished by preparation and dissemination of this report. (Directive to Take Action)

Fiscal Note: Less than $500

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APPENDIX I

NIOSH General Prevention Strategies for Employers to Reduce the Risk of Workplace Violence

Environmental Designs

1. Develop emergency signaling, alarms, and monitoring systems.
2. Install security devices such as metal detectors to prevent armed persons from entering the hospital.
3. Install other security devices such as cameras and good lighting in hallways.
4. Provide security escorts to the parking lots at night.
5. Design waiting areas to accommodate and assist visitors and patients who may have a delay in service.
6. Design the triage area and other public areas to minimize the risk of assault:
   - Provide staff restrooms and emergency exits.
   - Install enclosed nurses' stations.
   - Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas.
   - Arrange furniture and other objects to minimize their use as weapons.

Administrative Controls

1. Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
2. Restrict the movement of the public in hospitals by card-controlled access.
3. Develop a system for alerting security personnel when violence is threatened.

Behavior Modifications

Provide all workers with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness.

Safety Tips for Hospital Workers

Watch for signals that may be associated with impending violence:

1. Verbally expressed anger and frustration
2. Body language such as threatening gestures
3. Signs of drug or alcohol use
4. Presence of a weapon

Maintain behavior that helps diffuse anger:

1. Present calm, caring attitude.
2. Don't match the threats.
3. Don't give orders.
4. Acknowledge the person's feelings (for example, "I know you are frustrated").
5. Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly).

Be alert:

1. Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
2. Be vigilant throughout the encounter.
3. Don't isolate yourself with a potentially violent person.
4. Always keep an open path for exiting—don't let the potentially violent person stand between you and the door.

Take these steps if you can't defuse the situation quickly:

1. Remove yourself from the situation.
2. Call security for help.
3. Report any violent incidents to your management.

APPENDIX II

Essential Steps to Dealing with ED Violence[1,2,19,21,22]

Worksite Analysis

- The identification of specific risks generally begins with a facility worksite security analysis and risk assessment. Analysis should include a review of medical, safety, worker's compensation, insurance records, and results of a focused employee survey.
- Specific analyses include past incidents, jobs or locations with the greatest risk, current clientele, and effectiveness of existing security measures.

Management Commitment, Employee Involvement, and Employer Response

- Demonstrating organizational concern for employee emotional and physical safety and health, assigning responsibility, maintaining accountability, and allocating appropriate authority and resources.
- Implement an interdisciplinary approach for a workplace violence prevention program.
- Develop written emergency department protocols for violent situations occurring in the ED and state clearly that violence is not permitted or tolerated.
- Staff should play an integral role in risk assessment, development of workplace safety policies and procedures, violence prevention planning and monitoring, implementation of security procedures, and safety education and training.
- Staff has a right (and must be encouraged) to report incidents of violence and abuse to their employer without fear of reprisal, as well as to local police authorities.
- Establish a program for counseling and debriefing for employees experiencing or witnessing assaults and conduct ongoing assessments of ED security system performance.

Planning for Violence Prevention and Control

- The ED must have a plan and procedure to control or regulate access, including how nonemployees are screened, identified, and directed to service points; in some cases, a list of restricted visitors is helpful.
- A best-practices security system should be available including adequate and trained security personnel, physical barriers, closed-circuit video and surveillance equipment, and other security components; this system should be coordinated with local law enforcement agencies.
- Security personnel should be trained in psychological approaches to handling aggressive patients, types of disorders, and ways to defuse hostile situations. A 24-hour security presence is advisable.
- The ED must have a specific written critical incident response plan for violence occurring in the ED.
- Procedures should reduce the likelihood of contraband entering the ED.
- The ED should have a system of alerting other staff members of an emergency or escalating situation that requires immediate help. Alarm systems, panic/wall buttons, pull chains, hand-held/foot or other activation devices should be available, with particular attention given to isolated areas.
- Establish separate rooms for psychiatric (or criminal) patients that have two exits; supervise the movement of psychiatric patients.
- Provide lockable and secure bathrooms for staff members and employee "safe rooms" for use during emergencies.

Safety and Health Training

- ED staff should undergo security orientation and education including an understanding of the workplace violence prevention policy. Staff should receive training on their role in protecting the area, identifying potential security compromises, minimizing security risks, and for preventing, recognizing, de-escalating aggressive behavior, including the appropriate use of physical restraints.
- Hospitals should periodically conduct drills to test responses to critical incidents. Training should include joint collaborative exercises between security personnel and ED staff.

Recordkeeping and Program Evaluation

- Important records include the OSHA log of work-related injury, medical reports of work injury, other reports of abuse, verbal attacks or aggressive behavior, and information on patients with a history of past violence, drug abuse or criminal activity.
- Safety and security measures should be evaluated annually.