Results of a survey on workplace violence, best practices, and safety tips

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In April 2017, ACEP asked members to respond to a survey on workplace violence and best practices for a safer workplace. Here's a compilation of the responses.

Members described violent incidents as failures of safety and security in their departments

- A behavioral health worker was punched in the face and had orbital bone fractures
- Assault of staff members by a patient
- Assaulted by cocaine-intoxicated schizophrenic as a resident with no intervention by staff before the escalation happened. No advanced education before the event to prepare to avoid or defuse the situation.
- Assaults on staff are unfortunately common.
- At least three incidents of physical violence against ED staff this year, including two physician injuries (one of which occurred with peace officers present in the exam room)
- Biggest failure is when doctors and nurses get punched or kicked or are victims.
- During my residency, five people were murdered on my hospital campus. Two were employees, but none in the ED. One EM resident's throat was slashed with a stolen scalpel, but not life threatening.
- Elderly patients who unexpectedly turn violent and have weapons
- GSW wounding of police officer surprised by prisoner who took away the officer's weapon
- Gun brandished in our ER
- I personally have been struck.
- I saw a provider threatened with death at the moment the provider declared a patient to be a drug seeker who was unworthy of receiving any controlled substances from the ED. Disrespectful language provokes anger and violent thoughts and should be avoided.
- Isolated occurrences of clinicians struck by patients
- Large fight between patient's friends and enemies
- Murderer walked in with complaints of chest pain on coughing, passed body on walking to xray, was discharged when all was normal.
- Nurses/techs running after eloping suicidal patients
- Recently had a large knife removed from a patient's purse shortly after the patient attacked staff.
- Someone was shot in the ED.
- Staff being physically assaulted
- Strangling of nurse

And they cited failures related to individual or institutional attitudes or approaches to workplace safety

- Administration could not care less. They pay only lip service. We deal with a significant number of menacing, belligerent, drug-demanding patients, and administration only cares about Press-Gainey numbers. I have been punched several times in ED recently, and I just had to take it. And I can give you worse personal stories.
- Allowing patients to assault staff without legal or personal consequences
- Awareness fatigue
- Complacency
- Departments that put patient experience above the safety of patients, their families, and their employees. Specifically, refusing to place metal detectors or security screening for guns/weapons in place despite incidents where patients or visitors have brought guns into the hospital or threatened that they have a gun in their possession and ended up getting tased several times by hospital security and police. How many times do we have to have a close call, or are we going to wait until someone actually gets killed before we see the signs and put safety first?
- Expecting staff to take abuse and be subjected to it all the time. No enforcement of any modicum of respect or proper behavior from patients and families.
- Failure to provide physician staff (who are independent contractors) with workers compensation coverage, health insurance coverage, or disability coverage (either company-paid or hospital-paid or physician-paid) for on-the-job injury
- Failure of local police to want to arrest patient who assaulted or attempted to assault a staff member -- they wanted an ongoing evaluation and discharge paper work.
- Failure to allow adequate rest periods for physicians (we work 24-hour shifts, plus hours of extra uncompensated time needed to complete charting, which is clearly unsafe without sleep)
- Failure to provide backup coverage (or even to plan for backup) for injured or ill physicians
- Failure to supply ED staff with adequate personal protective equipment (inadequate supplies, inadequate quality, or both); failure to provide sufficient staffing for ED personnel to have time to consistently use PPE
- Hospital cutbacks have all but eliminated a security presence in our ED, leaving the PCAs, nurses and doctors on the front line. We now have frequent assaults and injuries, and it has been nearly impossible to get the hospital to acknowledge this.
- Hospital is not interested in protecting employees because it eats into budget, feels as if it is cheaper to pay settlement if event takes place than to put preventative measures in place.
- Hospital leadership failing to recognize and support initiatives for workplace safety, especially how it uniquely pertains to specific areas of the hospital.
- Ignoring threatening behavior or violence by nurses or colleagues towards another colleague
- Kansas law will soon require our hospital (as the only state hospital on state owned property) to allow people to carry guns. Our efforts to prevent this have failed thus far.
- Not screening for weapons due to "we don't want to look like that kind of hospital"
- Our legislature is not friendly to health care providers. Patients can legally bring firearms into the ED or hospital. We cannot remove them. Further, an assault on a health care provider is treated like any other assault. Many of us have been threatened with weapons.
- Security was extremely reluctant to acknowledge the problems in our ED until there was a serious set of incidents and a major uproar from the staff. Now that we have more security, they are not backed up by their supervisors and administration as they should be.

- The recognition of this by legislators, law enforcement, and hospital admin as a significant issue. There is a reluctance to treat violence in the workplace as a significant concern, even to the point of what you would consider in the community.
- Too often these events are attributed to patient stress or patient illness and the providers/care team are blamed for the failures leading to violence
- Underestimating "old" or a "little" intoxicated. Anybody can cause harm to someone else.
- We are assessment, treatment, a place of kindness and charity, and a sanctuary from victimization. We are not a prison or an interrogation room or a courtroom. We are also not a drug rehab facility.
- We care more about Press-Ganey scores than staff safety. A family member or patient can yell and insult us, and we are afraid of doing something because we are going to get a complaint or bad review.
- When I worked at another shop, I was assaulted by a patient (not delirious or demented or elderly), and when I reported it to police, they told me to come down to the police station (west Baltimore) at 2 am (when I was off shift) to report it. That was the best they would do. They otherwise did not take it seriously at all. There was NO WAY I was going to the PD at 2 am in west Baltimore.

Failure to identify and deescalate a violent or potentially violent situation was mentioned

- Allowing verbal abuse to escalate to physical abuse, and allowing physical abuse to go without repercussion
- Not recognizing an escalation of the situation early on
- Not recognizing agitation and acting promptly and proactively to deescalate as indicated or get control of the patients
- Not securing an escalating situation before it gets out of hand

As were failures related to facility design and department practices or policies

- Automatic doors that stay open after letting a single person in
- Boarding and long waits increase tension and tempers, escalation by staff.
- Can't lock down the ED. Have no way to keep people out.
- Difficult patients allowed to leave without seeking help from security or informing staff of a brewing problem.
- During my residency, campus police initiated a policy that they could only intervene with aggressive patients in the ED if they initiated violence. So they could stand and watch until some staff member got hurt, and then they could jump in and intervene. Not helpful!
- ED crowding
- Electronic safety doors put in place to be activated in case of mob influx failed. No one had tried to close them since installation. Mob came into the ED.
- Failure to try nonviolent options first.
- Hospital allowing repeat offenders back. Not keeping them away.
- Lack of safety isolation spaces
- Lack of signage

- No lockdown from ambulatory triage when victim of gunshot wound of head brought in
- No zero-tolerance policies
- Not getting the team in time
- Overcrowding and boarding consistently leading to aggravated patients assaulting or verbally abusing ER staff
- Patients able to push through locked doors
- Patients are not screened for weapons.
- People making excuses for violent patients and just putting up with the behavior
- Police bringing intoxicated and aggressive patients to the ED instead of arresting them
- Required documentation is ridiculous and actually is a hindrance.
- Too many visitors
- We triage patients based on severity of illness or injury. Do we triage risk of injury to patients, medical/ancillary staff?
- Wide-open ED (no controlled ingress and egress)

Department safety and security were noted to fail in situations involving psychiatric, combative, or forensic patients

- Combative patients in triage with police but no chemical or physical restraints
- Dangerous psych patients boarding in over capacity EDs. We had a 61 yo staff member punched, KOed, and kicked on the ground by one of these patients.
- Inadequate show of force for unruly patients
- Intoxicated or belligerent patients are not treated as a priority or emergency.
- Need more psych beds. Need more psych beds. Did I mention we need more psych beds?
- Not enough staffing in ED, especially to closely monitor psych patients
- Process for restraining a violent or potentially violent patient who needs medical clearance or evaluation
- Psych patients boarding in hallways
- Psych unit escape or RN gets hurt by patients there or alarm goes off because psych patient pushes it for no reason or to act out.
- Too many psych patients allowed to
  roam

Other incidents were related to failures of the security devices, measures, personnel, and practices intended to prevent them

- 911 response of greater than 10 minutes from local police
- Everyone has a safety badge except for the physicians (because of an oversight in the fact that physicians are not employees and are part of med staff instead).
- Failure of security to expel violent or abusive individuals from the premises once MSE has been completed
- Guards can't touch patients.
- Inadequate resources for workplace safety
- Lack of effective security

- Lack of immediate response from security in potentially violent situations
- No armed security personnel
- No metal detector in the ED due to admin's concern of public perception
- No metal detectors
- Not involving security early on
- One security guard for the whole campus who is unarmed and can't be reached on hospital phone if she is patrolling another building
- Our security guards are not trained to restrain patients (ie, they are not sheriffs, who were the security guards at the county hospital where I trained). This makes me feel less safe.
- Our security is not allowed to have guns. Our safety is actually provided by EMTs who concealed carry, but this depends on whether or not they are working.
- Our security is terrible. We need a total overhaul.
- Rely on security
- Response time of security
- Security guard cutbacks and cut too thin
- Slow, weak response from security
- Violation of the locked unit

Here are "best practices" noted by survey respondents related to …

Individual or institutional attitudes or approaches to workplace safety

- Awareness
- Enhanced situational awareness
- Identification and deescalation of a violent or potentially violent situation

Deescalation

- Deescalation of conflict
- Deescalation, avoid triggering events
- Preparation and knowledge of de-escalation techniques

Education and training of clinicians, providers, and staff

- Best training for staff
- CPI training for deescalation
- Deescalation training
- Deescalation training
- Deescalation training for nurses (I don't recommend as has never been effective)
- Education of staff
- Resident education to prepare them before being in the situation
- Train staff in how to quickly call for help and recognize the potential for violence before it happens

- Train staff in self-defense.
- We have trained all of our residents in an abbreviated SAMA (Satori Alternatives to Managing Aggression) course. We also have some lectures and plan on doing some sim training with them. We have taken the BETA guidelines (WJEM 2012) and created an EPIC order set by a multidisciplinary team (psych, EM, nursing, pharm, techs, police) at Parkland Hospital. The meds include atypical antipsychotics, and we divided them into pharmacotherapy for psychosis and then the "undifferentiated" patient with further stratification by mild, moderate, and severe agitation to give providers guidance on what to use for their patients. We hope this will decrease dwell times and reduce the number of physical assaults on staff by patients.

Legal or regulatory consequences or solutions

- Adequate protections and prosecutions after an event

Physical plant or design solutions

- Glass doors so staff are never out of sight of other staff.
- Locked unit
- Locked unit, one entrance point
- Physical space to safely isolate violent patients
- Plexiglass surround around the nursing station to make it more difficult for patients to get at the nursing staff, and a security staff person stationed in that area at all times
- Prior to my becoming the director of a small ED, I observed that registration was completely vulnerable to the public. I discussed it with the administrator, and he said nothing would happen. It did, fortunately no injuries. The reception area is now secured, and the ED desk clerk has a CCTV of the reception area, and silent panic buttons have been installed for the nurse's desk, the physician's desk, and reception.
- Signage

Department and hospital policies

- Having policies in place instead of creating the environment
- Zero tolerance policies

Practices, procedures, and processes

- Code for violence, guard response, sometimes with a dog
- Incident reporting
- Lots of hands for when we need to put patients in restraints for their own and/or our staff's safety
- Overhead paging to crisis intervention unit (psych) if assistance is needed
- Press a button for crisis team help

- Safe entry and exit strategies related to patient engagement
- Safety huddle during board rounds to assess potential concerns in the department
- Team rather than individual approaches. We have a "Code White" for violent patients.
- Team tie down
- We call "TEAM" to room #x. That way we get all hands on deck to help safely restrain a patient.
- We have CODE GREEN, which is an emergency security call for combative patients, and we have two or three security guards, charge RN, and MD respond immediately.

Psychiatric, combative, or forensic patients

- All patients with psychiatric complaint dressed in paper scrubs on presentation
- Concentrate the psych and intoxicated patients in one area (we have seven areas or pods).
- Rapid response for agitated mental health patients
- Reduce behavioral health patient boarding in the ED
- Undress psych patients.

Patient restraint, either chemical or physical, sedation

- Appropriate use of medications to restrain patients early when a situation is escalating
- Loosen up on the ketamine
- Sedate early

Security devices, measures, personnel, and practices

- 24/7 security personnel to 1:1 with at-risk patients
- Allow protection for ED staff by security guards and concealed carry.

- Armed law enforcement/security in the ED around the clock
- Armed off-duty sheriff's officers
- Call 911 to summon police for violent patients (we do not have hospital security personnel).
- Call the police department
- Easy ways to call security to the bedside 24/7
- Ever-present security guards
- Good relationship with and response from local law enforcement.

- Guards who are part of the security officers at the doors
- Have PD in the ED with backup
- Have security guards

- Having a security office right outside the ED
- Heavy security
- Locking and alarm systems for ED
- Multiple alert levels for security
- No metal detectors (false sense of security)
- Off-duty police officer in uniform present 4P-4A
- On-call security close to the ER
- Police officer in the ED all the time
- Police presence at night and armed security 24/7
- Security guards
- Security in ED 24 hours a day
- Security in the ED (still not enough)
- Security with "Code Gray" alert
- Wand patients for weapons.
- We have no on-site security in our rural ED, so we call in peace officers for back-up in any questionable situation.
- Individual or institutional attitudes or approaches to workplace safety

Here are respondents' safety tips and other suggestions for a safer workplace related to …

Individual or institutional attitudes or approaches to workplace safety

- Always watch yourself, be aware of your surroundings, learn to defend yourself if a situation arises. Don't accept that this is a part of our job...it isn't!
- More respect for all physicians; administration treats doctors as anther disposable hired tech.
- Put safety of staff first.
- Situational awareness
- That ED directors be responsive to reports or complaints of threatening behavior or violence by patients, family members, or staff.
- Vigilance

Identification and deescalation of a violent or potentially violent situation

- Early deescalation
- Learn deescalation techniques. There is a video with Scott Zeller, MD, that really helps with safety tips.
- Recognizing that we will face difficult situations with our patients and family, deescalation training is key. Next, there must be a practice of involving hospital security and law enforcement in consistent practices related to this.

Education and training of clinicians, providers, and staff

- All staff needs yearly training.
- All staff should be trained in basic self-defense, such as grab escapes and joint locks.
- Educate staff on what the level of training of security guards is and when to call 911.

- Highly recommend ALICE training.
- I think that we should make yearly training a best practice.
- TACT training, awareness of escalating potential for violence (levels of patient agitation) and how to intervene
- Training, ongoing education, and debriefing have been successful for us.

Legal or regulatory consequences or solutions

- Allow ED staff to press charges for assault by patients.
- Deregulate medical/pharm restraint
- Enforce laws that make it a felony to assault a HCW in the ED
- In Colorado we have some excellent laws that make assault against a HCW a felony, and that explicitly defines spitting on a HCW as a felonious assault. These are good laws, they work well. I would also like to see legislation prohibiting hospitals/health care employers from retaliating against a HCW who chooses to press charges. It's controversial, but I have concerns about laws that define PTSD as a compensable injury. This seems to me well-intended but ripe for abuse.
- Law enforcement needs to prosecute these cases to the fullest. Often because patients are intoxicated or ill, they are treated with leniency.
- Legislative actions to support medical personnel who are assaulted, giving it some kind of consequence.
- Make hospitals responsible!
- Make sure that law enforcement penalties are set high. This probably does not deter offenders but makes health care workers feel safer.
- No institutional resistance to reporting threats or pressing charges.
- Vigorously prosecute patients that harm staff.
- We need a federal law that indemnifies hospitals against prosecution for removing dangerous patients. This would include no EMTALA screening exam, which seems to be the biggest problem between police and hospital administrators. This law should also require a minimum of 30 days of jail time for injuring any hospital worker in the emergency department.
- When patients go to jail, send them with few-day supply of all their medications so they don't bounce back to the ED.

The face-to-face encounter with the patient

- Always have a backup plan when physically with a patient.
- Always talk in a quiet voice when diffusing situations. The louder a patient gets, the quieter the caregiver needs to get. At the same time, the rest of the staff needs to collect in a show of force to prevent any action by the involved patient.
- Always work as a team.
- Don't get backed in to a corner or not have access to a door.
- Don't get physical yourself with the patient: then they lose the captain of the ship.
- Don't get sick, don't get hurt, don't get old, don't let a potentially violent patient get between you and your nearest exit, and pray that they are not armed.
- Don't take it personally. The patient is upset with the system or their circumstance.
- Don't take unnecessary risks.
- Feet "down and crossed" so they can’t kick you
- Keep a safe physical distance from yourself and potentially violent patients. Stay between the patient and the door.

- Keep your cool, do not escalate the situation, and call for help early.
- Pay attention. Listen to that little voice or feeling that something isn't right.
- Run, hide, fight.

Physical plant or design solutions

- Always have panic buttons available for additional help and know where they are.
- Boat cleat tie downs exist, but nobody has them (quick release for emesis and imaging).
- Design and planning are key as a multidisciplinary team.
- Design for changes.
- Have signs around the ED that any sign of misconduct or possible aggression to an ED staff member will be reported to the police.
- If possible, an area of the ED with rooms with doors or more cameras may be helpful.
- Locked access to unit
- Signage

Department and hospital policies

- Do not accept verbal abuse in any form. This is an open door to physical assault and harm. I have a zero-tolerance policy for patients verbally abusing staff.
- Have policies that support provider autonomy, with supportive, realistic, and practical training.
- Have written guidelines and recommendations.
- Limitation of visitors
- Need a no tolerance rule. Attack in the ED, go to jail.
- Zero tolerance and felony infractions for verbal and physical assault on health care workers. If assaulting a taxicab driver in NYC is punishable with a potential 25-year conviction (posted on all cabs), then the same should apply to health care providers

Practices, procedures, and processes

- A really flat leader threshold.
- Allow for "lockdown" periods of heightened security during gang violence outbreaks.
- Avoid mission creep into legal or tactical areas unless there is no other option for the provider. If there are histrionics from patients or companions regarding prescription amounts, having an administrative cap on amounts per prescription can deescalate or at least redirect the emotions away from the providers. Robust ketamine dosing in the violently psychotic should be promoted at a national level to decrease the duration of these very dangerous patient encounters. Addicts need a plan for action, not disrespect and rejection. Demand that Psychiatry and Addiction Medicine step up efforts to take the burden of addict management away from us and send it to the office setting where it belongs.
- Awareness, positioning, de-escalation when possible
- Clear, previously defined exit strategy
- Communication and teaming behavior
- Create a safe environment. Decrease the staff and patient stress. Have security located nearby. Prevent overcrowding. Get staffed trained and empower them to recognize the potential for violence and protect themselves when it happens. Support those after they have experienced a workplace safety event. Have hospital leadership publicly support prevention of workplace violence.
- Develop a committee to address the staff concerns.

- Develop a team strategy.
- For our own safety, it's better to over-react.
- Have large, strong staff on every shift.
- Hospital needs to make a big incident report for each attack and not shrug if off. If each incident -- the verbal assault, spitting, kicking, etc -- gets documented, we can get data that identifies how big the problem is and how dangerous our profession is. Perhaps we do not want to know that data as it will scare docs and nurses away from the profession.
- If violence is anticipated, have a large number of people go in together to confront the potentially violent offender. Almost always works.
- Maintain a consistent approach.
- Stay by the door, have an exit, and take a chaperone if at all concerned.
- Take another staff into the room.
- Teamwork is essential.
- Yearly if not more often, a walkthrough to look for gaps in safety measures.

Psychiatric, combative, or forensic patients

- A lot more $ for psych services as opposed to just warehousing them sometimes for days before they get placed, and sobering centers to get the drunks out of our ED.
- Behavioral health patients need to be completely stripped and belongings removed.
- Have more than one staff member at a time in psychiatric area.
- Have separate psych area.
- Patient restraint, either chemical or physical, sedation
- Don't be afraid to restrain both chemically and physically if needed.
- Have an agreed-upon chemical sedation practice so providers do not have to make it up on the fly.
- Sedate and restrain before the patient escalates.
- Use effective chemical restraints early when a situation is escalating.

Security devices, measures, personnel, and practices

- 24 hour/day security presence
- Active and adequate security coverage 24/7, appropriate staffing.
- Allow protection for ED staff by security guards and concealed carry.
- Armed off-duty law enforcement
- Armed security guards in every ED to start
- Boots to the ground, more security in the ED; real security, not retired workers
- Don't hesitate to call the police for backup.
- Good relations with police
- Good relationships with local law enforcement are also very important.
- Have locking and alarm systems for ED.
- Have security in the ED at all times.
- I would like our more dangerous ED to get a security dog.
- It's amazing how often patients walk up, see the medical detector, turn around, go to their car, then come back. I don't know if it has changed the number of incidents, but I do feel it shows that violence will not be tolerated.
- Metal detectors
- Metal detectors and security screen for anyone entering the ED from the waiting room.

- No guns because guards usually aren't military and can be disarmed easily and have fatalities from use of guard's service revolver.
- Panic button
- Proactive and adequate security personnel
- Screen for weapons on all patients.
- Security presence 24 hours/day
- Security presence in the ED is very helpful. Perhaps not always possible in smaller EDs but very important.
- Uniformed security rounding in the ED regularly
- Visible and present security
- What about hiring security experts/team from civilian to military to do surveys of facilities and put together guidelines.

Finally, here are respondents' suggestions on what ACEP can do to help

- A formalized survey with choices, working with key stakeholders like TJC, AHA, and group leaders (chairs and directors and groups) to implement solutions. Use PR to bring attention to the issue.
- A position paper with very specific, itemized recommendation, plus an enforcement protocol would be a good start. I am glad to see that this questionnaire shows an interest in the subject.
- Advocacy, best practice guidelines, spread the word
- Advocate for stricter laws for assaulting or battering a medical worker.
- Awareness and possibly best practices that can be brought to hospitals
- Awareness! Help us convince administrations of the need for safety measures.
- Be the spokesperson for this issue, continue to do studies more detailed in terms of experience of EC physicians (contact Brad Walters or Terry Kowlenko from Michigan for additional information as to that).
- Build a template of features that are advised to be addressed in every ED.
- Circulate best practices.
- Create and educate on feasible best practices.
- Demand OSHA strictly hold administrators and employers responsible for violent injuries to staff in ERs, compensate staff for all injuries.
- Educate everyone that guidelines do exist and the "restrain and medicate" approach is where most people get hurt. I have spent 2 years working on this at my program, and it has been effective. We actually just finished the order set, but many of us have been practicing this way for the past year and have seen a profound affect.
- Encourage hospitals to invest in security, metal detectors.
- Encourage hospitals to pursue legal action against patients who, in their right minds, decide to threaten or hurt staff.
- Engage the hospital security industry prepare for the next social media video of patient assault in the ED.
- Gather the best information and evidence on comprehensive approaches.
- Guidelines for basic security recommendations for all EDs.
- Guidelines for deescalation of agitated patients and when use of physical or chemical restraints is recommended vs calling security or law enforcement because patients are verbally or physically abusing staff.

- Have an education document with specific action steps that are evidence based.
- How to be more safe in the department with improved situational awareness.
- I think ACEP should run a national hotline for several months to gather and log calls for threats in the workplace or unsafe workplaces. The logs can then be examined and data gathered regarding what the most common threats actually are.
- Investigate what works. What is best practice. Share this knowledge. Provide resources to those trying to fix this problem in their ED. Provide resources/support for those who suffered from workplace violence (maybe wellness committee). Provide resources listing executive summaries for healthcare worker violence protection/prosecution initiatives, laws, for each state. help state chapters in states with weak laws improve their laws.
- Legislate more psych beds.
- Lobby for no-tolerance laws.
- Make the recommendation that whenever possible have security based in ED. Perhaps there is a level of visit volume where that should always be the case. Recommend best practice protocols for local law enforcement engagement, and physical and chemical restraints.
- Maybe a survey on workplace violence and best practices against # of risk claims.
- Please, please, please find and advocate best practices! I am a retiring ACEP member, my daughter is just now starting her EM residency, please help keep her safe!
- Promote practices that decrease paranoia. Giving full vent to paranoid practices permits the creation of virtual safety while ignoring real issues. What good are cameras to someone who is dead? What good are stickers saying "No knives" when "customer service" says we have to permit cell phone videos. (They say no videos except when there are complaints.)
- Promote state and local laws to extend protections for EMS/police/utility workers to emergency department staff. Such changes would better empower hospitals to pursue legal action against appropriate patients who should know better. (One does not get away with striking police while intoxicated and it should not be allowed in the ED either.)
- Promoting data collection of what works. Mission statements to share with workplace.
- Promotional/examples of signs
- Publicize the survey sharing what others are doing
- Quite a few years ago, I did a survey study of the experience with violence in the ED of emergency medicine attending physicians here in the state of Michigan. It was a chapter grant study and supported by the Michigan Chapter. I am currently repeating the survey to see if there have been changes in the patterns and frequency of violence in the ED towards physicians with a medical student group from the Oakland University William Beaumont School of Medicine. Just thought you might be interested.
- Raise awareness with the AHA and TJC about the inherent dangers in the ED workplace for staff. work with regulatory agencies to have zero tolerance for violent behavior in the ED (and in the hospital in general).
- Reach out to hospital administrators and stress importance of a safe work environment.
- Recommend security in EDs where feasible.
- Share best practice with all.
- Share the results of this survey with CMS, the AMA, the FSMB, hospital CEOs and risk managers, law enforcement, and the general public.
- Standardized response techniques
- State legislation. Arizona was the first state to pass legislation elevating assault on a healthcare worker to a Class VI Felony. See: AZ Revised Statute §13-1204 https://www.ena.org/government/State/Documents/StateLawsWorkplaceViolenceSheet.pdf

- Suggested protocols based on evidence of successful preventive and reaction measures
- Support a gun-free ED. Perhaps some education on violence, deescalation, etc.
- Support resolutions that anyone who is a victim may press charges.
- Talk about it and get everyone involved. We don't work in silos.
- Techniques for safety, deescalation, and facility design for safety
- Toolkit, presentations. Step up and advocate for legislation that supports reporting in the ED. The police seem bored to take a report or down-right refuse due to "medical issues."
- Truthfully, we need to support legislation supporting aggressive policing and indemnifying hospitals. I was in the Army and at some facilities we were escalated quickly with security presence and aggressive drunks or psych patients who would not control themselves were Tazed. It was virtually 100 % effective. Yes, we still gave Haldol to appropriate patients but a schizophrenic who attacked was Tazed and it works. In these facilities there were not staff injuries or fear.
- Videos of deescalation. Let TJC know that boarding and long waits contribute to workplace violence.
- Vigilance
- While it would be hard to develop, it would be nice to see some minimum recommendations from ACEP (hospital should provide x security officers per y patient census, visitors must have visitor badges, etc).
- White paper on minimum standards
- Workshops on deescalation techniques, self-defense
- Yes, make a national policy/guideline regarding best practices/what NEEDS to be in place for physician safety and work with the hospital association and TJC to ensure that hospitals are held to such. Work with contract groups to care about the safety of their staff. Work with hospitals to care about staff safety as much as they care about their reputation => not standing behind staff members who want to press charges. Ensure that it is a FELONY in EVERY STATE to assault a licensed health care professional and unable to be dropped without hearing by magistrate/judge.