ED Safety and Security

American College of Emergency Physicians

ADVANCING EMERGENCY CARE

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Emergency Department Security and Safety
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- Define the scope of the problem.
- Institute a process to review safety and security risks.
- Develop reporting methods for all safety and security breaches.
- List technology and personnel solutions.
- Describe staff training.

DETECT, DEFUSE, PROTECT

Violence is a public health problem of epidemic proportion. The danger to health care providers in professional settings escalates as violence moves off the streets and into the medical setting.

Violence is not an inescapable part of our lives. The reduction of violence in our offices, clinics, and hospitals requires that we make violence personally and culturally intolerable. Optimal patient care is achieved only when patients, visitors, and health-care workers are protected against violent acts occurring within the health-care setting. A safe working environment is conducive to improved staff morale, and enhanced productivity.

Medical personnel must develop strategies to prevent victimization. Preventive measures include the control of environmental factors that may provoke those with violent tendencies and graded management options including verbal or psychological intervention, show of force, and physical and/or chemical restraints. The key to violence reduction is the early recognition of potential violence by a calm and prepared health care provider. Occupational health and safety laws say employees must be provided with a safe working environment and safe systems of work. “General Duty Clause” of the Occupational Safety and Health Act requires employers to have a workplace that is “free from recognized hazards.” ENA (Emergency Nurses Association) Position Statement states, “Health care organizations have a responsibility to provide a safe and secure environment for their employees and the public. Emergency nurses have the right to take appropriate measures to protect themselves and their patients from injury due to violent individuals.” Employers should prepare a plan to identify, assess, and control potentially threatening or violent situations and incidents at work. The management plan should include procedures to cope with and defuse potentially violent situations, alert co-workers, call police and provide personal protection, personal alarms, or self-defense training.

JCAHO
EC.1.10 Hospitals must manage safety risks; EC 1.20 Hospitals must maintain safe environments
Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:
EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.
OSHA Guideline Preventing Workplace Violence in Healthcare and Social Service Settings, General
Duty Clause 5A-1- Employers must furnish a place of employment free from recognized hazards

Extent of the problem

Workplace violence
Leading cause of occupational death for women
Third leading cause of death for all workers

October 2006 survey conducted by Emergency Nurses Association found that 86% of respondents indicated that they were victims of workplace violence in the previous three years.

The results of an Emergency Nurses Association survey released in 2009 found that more than 50% of ED nurses had experienced violence by patients on the job and more than 25% had experienced 20 or more violent incidents in the past three years. Research showed long wait times, a shortage of nurses, drug and alcohol use by patients, and treatment of psychiatric patients all contributed to violence in the ED.

Per New Jersey press release for Senator Girgenit Bill upgrading penalties for assaulting healthcare workers
- According to the U.S. Department of Justice, more than 400,000 nurses and healthcare professionals are victims of violent crimes in the workplace each year.
- Twenty-five percent of nurses list physical assault as their top safety concern on the job, according to the American Nurses Association.
- Assaults on nurses are classified as a felony in the New York, and other healthcare workers were added to that existing statute in January.
- Similar laws also have been enacted in Alabama, Arizona, Illinois, Nevada and New Mexico.

Reprinted with permission from Massachusetts Nurses Association
- Workplace violence affects an estimated 1.7 million U.S. employees directly and millions more indirectly each year.
- Forty-eight percent of all non-fatal assaults in the U.S. workplace are committed by health care patients.
- Nurses and other personal care workers are at the highest risk. Health care workers suffer violent assaults at a rate 4 times higher than other industries; for nurses and other personal care workers, this rate jumps to 12 times higher than other industries.
- In a 2004 survey of Massachusetts nurses, 50 percent indicated they had been punched at least once in the last two years; 44% reported frequent threats of abuse (9 or more times in the last two years); and 25-30% were regularly or frequently pinched, scratched, spit on or had their hand or wrist twisted. The majority of acts were inflicted by patients; and furniture, pencils, pens, and medical equipment, and even hypodermic needles were most often used as weapons.
- Over half of those reporting said they later had difficulty concentrating on their job. Only 40% of the nurses had reported the incidents to management.
- Physicians are also at risk. In one study of Emergency physicians, 75% said they had been threatened in the last year, 28% had experienced at least one assault, and 18% had obtained a gun to protect themselves. Twelve percent were confronted outside of the
emergency room, and 4% had experienced a stalking event. Only 33% had security personnel permanently assigned to the department.

From OSHA.Gov

“Injury rates also reveal that health care and social service workers are at high risk of violent assault at work. BLS rates measure the number of events per 10,000 full-time workers—in this case, assaults resulting in injury. In 2000, health service workers overall had an incidence rate of 9.3 for injuries resulting from assaults and violent acts. The rate for social service workers was 15, and for nursing and personal care facility workers, 25. This compares to an overall private sector injury rate of 2.

- The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers
- The average annual rate for physicians is 16.2
- For nurses, 21.9
- For mental health professionals, 68.2
- For mental health custodial workers, 69
  (Note: These data do not compare directly to the BLS figures because DOJ presents violent incidents per 1,000 workers and BLS displays injuries involving days away from work per 10,000 workers. Both sources, however, reveal the same high risk for health care and social service workers.)

As significant as these numbers are, the actual number of incidents is probably much higher. Incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance.”

**Impediments to quantifying the full extent and magnitude of workplace violence**

It is estimated that less than 25% of ED violence is reported.

Lack of a uniform definition of violence or the severity of the incident
- Aggressive
- Violent
- Abusive
- Dangerous
- Disruptive
- Destructive
- Threatening
- Rude

- We have a high threshold for reporting incident and a reluctance to notify police and file charges

*Our perceived professional responsibility to the patient overrides our feelings about the abusive incident*
- Denial:
"I try not to dwell on it. It won't happen again."
"It really wasn't that bad, I'm OK."

- Rationalization:
  "He was ill/upset/drunk...."

**Personal safety questions for your employer**

- Is there adequate security coverage?
- Does the ED treatment area and hospital have secured exterior doors?
- Are security assessments done to determine risks and vulnerabilities?
- Are there training opportunities for the staff?
- Is the staff educated and equipped to deal with violent or disruptive behavior?
- Does the administration support an aggressive stance against violence?

**Costs:**

- Police involvement
- Medical evaluations
- Physical and psychological therapy
- Temporary hires
- Employee assistance programs
- Loss of security
- Loss of personnel
- Loss of productivity
- Decrease in morale

From Emergency Nurses Association

**What are the specific factors that may promote violence in the emergency department?**

The emergency department has a number of additional risk factors due to the type of services provide and the overall stressful environment that describes these care settings.

Those factors include:

- 24-hour accessibility of the emergency department
- Lack of adequately trained, armed, or visible security guards
- Patient pain and discomfort
- Family member stress due to patient’s condition and fear of the unknown
- Family member anger related to hospital policies and the health care system in general
- Cramped space
- Long wait times

**Definitions:**

**Assaulted nurse:** (From Massachusetts Nurses Associations Workplace Violence)

One who is reasonably put in fear of being actually or potentially physically harmed while at work from a patient, co-worker, or visitor. This includes menacing gesture.

**Battered nurse:**

One who experiences actual physical contact from another (whether or not a physical injury occurred.)

**Physical Assaults:**
Violent acts of unwanted physical contact towards others. This includes slapping, pushing, kicking, punching, biting, scratching, deliberately throwing an object at a staff member, drawing a potential or actual weapon on a nurse.

**Sexual Assaults:**
- Unwanted sexual acts toward a nurse. This includes unwanted embraces, touching, exposures, or rape.

**Verbal or non-verbal Intimidation:**
- Verbal includes conversation, written, email, or voice mail communication that is meant to threaten, slur, harass or frighten. Non-verbal includes acts meant to frighten or threaten a nurse such as throwing an object at a wall, pounding walls or doors, stalking, tampering with data systems, stealing, etc.

Workplace violence falls into four broad categories.

**TYPE 1:**
Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.
- ~80 percent of workplace homicides
  - Motive is usually theft
    - In many cases the criminal is carrying a gun or other weapon, increasing the likelihood that the victim will be killed or seriously wounded
    - Preventive strategies include an emphasis on physical security measures, special employer policies, and employee training

**TYPE 2:**
Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services
- Violent acts occur as workers are performing their normal tasks.
  - Highest rate in healthcare occupations
  - Nurses in particular

**TYPE 3:**
Violence against coworkers, supervisors, or managers by a present or former employee

**TYPE 4:**
Violence committed in the workplace by someone who doesn’t work there, but has a personal relationship with an employee—an abusive spouse or domestic partner

- When the violence comes from an employee or someone close to an employee
  - Greater chance there was/ were warning sign(s)
    - That knowledge, along with the appropriate prevention programs, may help prevent or lessen violent episodes

An article by the American Bar Association Commission on Domestic Violence suggests the following to help monitor employees for signs of Intimate Partner Violence

**The Following Observable Behavior May Suggest Possible Victimization**
- Tardiness or unexplained absences
• Frequent-and often unplanned-use of leave time
• Anxiety
• Lack of concentration
• Change in job performance
• A tendency to remain isolated from coworkers or reluctance to participate in social events
• Discomfort when communicating with others
• Disruptive phone calls or e-mail
• Sudden or unexplained requests to be moved from public locations in the workplace, such as sales or reception areas
• Frequent financial problems indicating lack of access to money
• Unexplained bruises or injuries
• Noticeable change in use of makeup (to cover up injuries)
• Inappropriate clothes (e.g., sunglasses worn inside the building, turtleneck worn in the summer)
• Disruptive visits from current or former intimate partner
• Sudden changes of address or reluctance to divulge where she is staying
• Acting uncharacteristically moody, depressed, or distracted
• In the process of ending an intimate relationship; breakup seems to cause the employee undue anxiety
• Court appearances
• Being the victim of vandalism or threats

Intimate partner violence all too often follows the employee into work. Security measures must be taken to protect both the employee and fellow staff members.

**OSHA.Gov** lists the following risk factors for Health care and social service workers for work related assaults.

These include:
• The prevalence of handguns and other weapons among patients, their families or friends
• The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals
• The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others)
• The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets
• Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly
• The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members
• Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients
• Isolated work with clients during examinations or treatment
• Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings);
• Lack of staff training in recognizing and managing escalating hostile and assaultive behavior
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- Poorly lit parking areas

http://www.osha.gov/Publications/OSHA3148/osha3148.html

Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers

Violence Prevention Programs

At a minimum, workplace violence prevention programs should:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensure that managers, supervisors, coworkers, clients, patients and visitors know about this policy
- Ensure that no employee who reports or experiences workplace violence faces reprisals
- Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress
- Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client
- Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery

OSHA and Massachusetts Nurses Association identifies the following key components of a Workplace Violence Prevention Program:

1) Management commitment and employee involvement
2) Worksite hazard analysis
3) Hazard prevention and control
4) Safety and health training for workers, managers and supervisors including where and how to report injuries
5) Post incident debriefing activities including appropriate evaluation and treatment of all workers affected by an incident of violence
6) Accurate recordkeeping
7) Policies that address harassment and bullying
8) Methods for detection, confiscation and control of firearms and weapons from anyone (other than law enforcement officers) who enter the facility
9) Security guards trained according to national standards

The five main components of any effective safety and health program also apply to the prevention of workplace violence:

* Management commitment and employee involvement
* Worksite analysis
* Hazard prevention and control
* Safety and health training
* Recordkeeping and program evaluation

Management Commitment and Employee Involvement

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence. This commitment should include:

- Demonstrating organizational concern for employee emotional and physical safety and health
- Exhibiting equal commitment to the safety and health of workers and patients/clients
- Assigning responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors and employees understand their obligations
- Allocating appropriate authority and resources to all responsible parties
- Maintaining a system of accountability for involved managers, supervisors and employees
- Establishing a comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents
- Supporting and implementing appropriate recommendations from safety and health committees

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement and evaluate the program. Employee involvement should include:

- Understanding and complying with the workplace violence prevention program and other safety and security measures
- Participating in employee complaint or suggestion procedures covering safety and security concerns
- Reporting violent incidents promptly and accurately
- Participating in safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections and respond with recommendations for corrective strategies
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior or criminal intent and discusses appropriate responses

Worksite Analysis

A worksite analysis involves a step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific areas where hazards may develop. A team evaluates the vulnerability to workplace violence and determines the appropriate preventive actions to be taken. The team or coordinator can review injury and illness records and workers’ compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes or employee training. As the team or coordinator identifies appropriate controls, they should be instituted.

The recommended program for worksite analysis includes, but is not limited to:

- Analyzing and tracking records
Screening surveys
Analyzing workplace security

One important screening tool is an employee questionnaire or survey to get employees' ideas on the potential for violent incidents and to identify or confirm the need for improved security measures.

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations and situations that could lead to violence. To find areas requiring further evaluation, the team or coordinator should:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.
- Note high-risk factors such as types of clients or patients (for example, those with psychiatric conditions or who are disoriented by drugs, alcohol or stress); physical risk factors related to building layout or design; isolated locations and job activities; lighting problems; lack of phones and other communication devices; areas of easy, unsecured access; and areas with previous security problems.
- Evaluate the effectiveness of existing security measures, including engineering controls. Determine if risk factors have been reduced or eliminated and take appropriate action.

Hazard Prevention and Control

After hazards are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

Engineering controls and workplace adaptations to minimize risk

Engineering controls remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those described in the following paragraphs. The selection of any measure, of course, should be based on the hazards identified in the workplace security analysis of each facility.

Among other options, employers may choose to:

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones and private channel radios where risk is apparent or may be anticipated. Arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors—installed or hand-held, where appropriate—to detect guns, knives or other weapons, according to the recommendations of security consultants.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations and install deep service counters or bullet-resistant, shatter-proof glass in reception, triage and admitting areas or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings without grids for patients who "act out" and establish separate rooms for criminal patients.
- Provide comfortable client or patient waiting rooms designed to minimize stress.
- Ensure that counseling or patient care rooms have two exits.
- Lock doors to staff counseling rooms and treatment rooms to limit access.
- Arrange furniture to prevent entrapment of staff.
- Use minimal furniture in interview rooms or crisis treatment areas and ensure that it is lightweight, without sharp corners or edges and affixed to the floor, if possible. Limit the number of pictures, vases, ashtrays or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient/client and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting, both indoors and outdoors.
- Replace burned-out lights and broken windows and locks.
- Keep automobiles well maintained if they are used in the field.
- Lock automobiles at all times.

Administrative and work practice controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. Some options for employers are to:

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Give police physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep log books and reports of such incidents to help determine any necessary actions to prevent recurrences.
- Advise employees of company procedures for requesting police assistance or filing charges when assaulted and help them do so, if necessary.
- Provide management support during emergencies. Respond promptly to all complaints.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers to deal with aggressive behavior. Follow written security procedures.
- Ensure that adequate and properly trained staff are available to restrain patients or clients, if necessary.
- Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure that adequate and qualified staff are available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
Establish a list of "restricted visitors" for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses' stations and visitor sign-in areas.

Review and revise visitor check systems, when necessary. Limit information given to outsiders about hospitalized victims of violence.

Supervise the movement of psychiatric clients and patients throughout the facility.

Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.

Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Do not allow employees to enter seclusion rooms alone.

Establish policies and procedures for secured areas and emergency evacuations.

Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.

Establish a system—such as chart tags, log books or verbal census reports—to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed.

Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions).

Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.

Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals or in-house social service or occupational health service staff to help diffuse patient or client anger.

Transfer assaultive clients to acute care units, criminal units or other more restrictive settings.

Ensure that nurses and physicians are not alone when performing intimate physical examinations of patients.

Discourage employees from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. Urge community workers to carry only required identification and money.

Survey the facility periodically to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.

Provide staff with identification badges, preferably without last names, to readily verify employment.

Discourage employees from carrying keys, pens or other items that could be used as weapons.

Provide staff members with security escorts to parking areas in evening or late hours. Ensure that parking areas are highly visible, well lit and safely accessible to the building.

Use the "buddy system," especially when personal safety may be threatened. Encourage home health care providers, social service workers and others to avoid threatening situations.

Advise staff to exercise extra care in elevators, stairwells and unfamiliar residences; leave the premises immediately if there is a hazardous situation; or request police escort if needed.

Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits and the refusal to provide services in a clearly hazardous situation.
Establish a daily work plan for field staff to keep a designated contact person informed about their whereabouts throughout the workday. Have the contact person follow up if an employee does not report in as expected.

Employer responses to incidents of violence

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for employees who are victimized personally or may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of its severity. Provide the injured transportation to medical care if it is not available onsite.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These may include:

* Short- and long-term psychological trauma;
* Fear of returning to work;
* Changes in relationships with coworkers and family;
* Feelings of incompetence, guilt, powerlessness; and
* Fear of criticism by supervisors or managers.

Consequently, a strong follow-up program for these employees will not only help them to deal with these problems but also help prepare them to confront or prevent future incidents of violence.

Safety and Health Training

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their coworkers through established policies and procedures.

Training for all employees

Every employee should understand the concept of "universal precautions for violence"—that is, that violence should be expected but can be avoided or mitigated through preparation. Frequent training also can reduce the likelihood of being assaulted.

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It also includes instructions on how to limit physical interventions in workplace altercations whenever possible, unless enough staff or emergency response teams and security personnel are available. In addition, all employees should be trained to behave compassionately toward coworkers when an incident occurs.

The training program should involve all employees, including supervisors and managers.

New and reassigned employees should receive an initial orientation before being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff.
Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations and drills.

Topics may include management of assaultive behavior, professional assault-response training, police assault-avoidance programs or personal safety training such as how to prevent and avoid assaults. A combination of training programs may be used, depending on the severity of the risk.

Employees should receive required training annually. In large institutions, refresher programs may be needed more frequently, perhaps monthly or quarterly, to effectively reach and inform all employees.

What training should cover

The training should cover topics such as:
- The workplace violence prevention policy
- Risk factors that cause or contribute to assaults
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults
- Ways to prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications as chemical restraints
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors
- Progressive behavior control methods and safe methods to apply restraints
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures
- Ways to protect oneself and coworkers, including use of the "buddy system"
- Policies and procedures for reporting and recordkeeping
- Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences
- Policies and procedures for obtaining medical care, counseling, workers' compensation or legal assistance after a violent episode or injury

Training for supervisors and managers

Supervisors and managers need to learn to recognize high-risk situations, so they can ensure that employees are not placed in assignments that compromise their safety. They also need training to ensure that they encourage employees to report incidents.

Supervisors and managers should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program and staffing policy and procedures to reduce or eliminate the hazards.

Training for security personnel
Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing and observing and reviewing reports of behavior of individuals in threatening situations.

Recordkeeping and Program Evaluation How employers can determine program effectiveness

Recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made.

Important Records:

- OSHA Log of Work-Related Injury and Illness (OSHA Form 300)
  Any new work-related injury that results in:
  - Death
  - Days away from work
  - Days of restriction or job transfer
  - Medical treatment beyond first aid
  - Loss of consciousness or a significant injury diagnosed by a licensed health care professional

- Medical reports of work injury and supervisors' reports for each recorded assault. These records should describe the type of assault, such as an unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost work time that resulted and the nature of injuries sustained. These medical records are confidential documents and should be kept in a locked location under the direct responsibility of a health care professional

- Records of incidents of abuse, verbal attacks or aggressive behavior that may be threatening, such as pushing or shouting and acts of aggression toward other clients. This may be kept as part of an assaultive incident report. Ensure that the affected department evaluates these records routinely

- Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient’s chart. All staff who care for a potentially aggressive, abusive or violent client should be aware of the person’s background and history. Log the admission of violent patients to help determine potential risks

- Documentation of minutes of safety meetings, records of hazard analyses and corrective actions recommended and taken

- Records of all training programs, attendees and qualifications of trainers

Violence Prevention Strategies:
Patient interaction

- Allow a family member to stay with the patient and calm them
- Limit the visitors (traffic) in the treatment area
- Screen visitors for trauma patients (avoids the potential for restitution)
- Institute liaisons between patients and families (improves communication)

Interviewing techniques:

- Honest, straightforward and frank; but not overly friendly
- Avoid excessive eye contact
- Avoid entering the patient's personal space
- Trust your "gut" feelings; if you feel uncomfortable, reassess the situation

Observe the patient for:

- Tense posture
- Provocative behavior, staring
- Angry demeanor or threatening and/or loud speech
- Tough, intimidating stance
- Hypervigilance
- Signs of agitation:
  - Tremors
  - Pacing
  - Pounding walls
  - Sweating
  - Clenching of fists, teeth and hands
  - Throwing furniture

Interview setting - "Privacy but not isolation"

- Give yourself unrestricted access to the door and emergency buttons/exits
- Store or remove supplies/equipment, which could be used as weapons

Staff protection

- Professional training
- First names only on nametags
- Increase staff assertiveness and unity
- Limit access to staff information (phone number, address, schedule)
- Stop the attitude - "it (violence) comes with the territory"

Personal measures:

- Obtain training and education
- Dress for work: comfortable clothes, low shoes, and safe jewelry
- Tuck ties in shirt; avoid stethoscopes hanging around your neck
- Set realistic deadlines for the patient and visitors
- Don't divulge personal information
- Summon security as soon as danger is appreciated
- Review your institution's policies regarding filing charges against a perpetrator

**Position yourself carefully**

- Stand about 1.5 meters (4 to 5 feet) in front of the patient but off to the side
- Do not face him or her directly
- Close enough to allow you to develop a rapport
- But far enough away to not threaten personal space and out of reach
- This is a less provocative and intimidating stance, and
- Provides a narrower target reducing exposure
Don’t turn your back
Always approach from the front

Learn defusing techniques
- Maintain personal space
- Allow some degree of venting
- Ignore personal affronts
- Avoid arguing or defending
- Avoid threatening body language
- Calmly and firmly set limits
- Impose your own peace:
  - Tame your emotions by training yourself to stay cool
- Recognize your own physical cues and remind yourself to stay calm

In a situation:
- Calmly state, without issuing hostile commands, that violence will not be tolerated
- Avoid asking “why” questions: can seem accusatory or challenging
- Play the fixer: Ask: “What can I do to help?”
- “What would make things easier for you?”
- Do not ignore threats:
  - No threat of violence is harmless
- Failure to respond may make an angry patient or make him feel that he is not being taken seriously
- Set limits
- Violent patients may become even more agitated when they sense that others are not in control
- Don’t look directly into the patient’s eyes: this is threatening
  - Focus your eyes on the chin:
    - Perceived as less threatening
    - You can easily see the hands
  - Check your body language
  - Adopt a submissive pose
    - Arms relaxed and hanging down at the side
    - Palms open below your waist and facing the person
    - Shoulders drooping,
    - Legs relaxed

- Remain calm; ensure help is on the way
- Back out of the room quickly. Run if you have to!
  - If there are two of you, run in opposite directions
- If necessary lock yourself into a room or run out of the building:
  - A violent patient is unlikely to hurt other patients; the staff is more at risk
  - Carry a portable phone

If attacked:
- Maintain your own airway
- Tuck your chin: protect your carotids and trachea
- Find and use shields
- Move quickly
- If the situation warrants, use chemical and/or physical restraints
- If you have the potential to get hurt, let the patient leave
  - No Heroics
- If the patient has a weapon
  - Ask the patient to place it on the floor, and then both leave the room
  - Do not try and retrieve the weapon
  - Let police disarm patients

Most violent and aggressive behavior is criminal in nature

**Call the police immediately if the patient:**
* Makes any threats, verbal or physical
* Acts destructively (hits the walls, destroys equipment, hits someone)
* Is noisy, hyperactive and won't quiet down after one or two requests
* Is armed (e.g., gun, knife, broken bottle)

**Once the situation is under control, differentiate between an organic or functional cause of the violence**

Departmental policies:
- Separate patients with minor illnesses from those with major illnesses
- Institute security, restraints, and strategies - before
  * Injecting Narcan
  * Attempting any intervention in an escalating patient
  * Separating a child from an angry, intoxicated, or psychotic parent
  * Telling an angry psychiatric patient of a hospital transfer

- Train staff in the proper use of restraints
- Use a minimum of five people to restrain a patient
- Undress all psychiatric patients - examine clothing and personal items for weapons
- Give immediate attention to any agitated patient or visitor
- Realize that restraining a patient intent on leaving is not a job for medical staff
- Warn all hospital staff, referral physicians, and authorities of a patient’s violence
- Notify authorities if a violent patient leaves the hospital
- Obtain a psychiatric evaluation on violent patients
- Assign the "right" personnel

**Staff may unknowingly escalate a patient’s agitation**

Unacceptable:
- Snappy retorts
- Intolerance of complaints
- Ignoring requests for information
- Failure to recognize physical or verbal signals
- Overreaction to people or situations

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**Verbal and Physical Interventions:**
Training programs should stress verbal strategies and non-abusive physical strategies:

- **Verbal techniques**
  - Show concern and respect
  - Speak in a calm, slow voice empathizing with the patient’s concerns
  - Talking softly is particularly effective when a patient is loud and belligerent
  - Acknowledge their anger and direct it toward an appropriate cause
  - Behave politely, and listen uncritically and actively
  - Remain nonjudgmental
  - Do not attempt to “correct” the patient’s perception
  - Do not take the person’s anger personally, even when directed at you
  - Tell the patient what you want of him, not what you don’t want
  - Give the patient options (preferably three options), not ultimatums
    - Ex. you may either sit in the chair, lie on the stretcher, or be restrained

  An offer of food, drink, or medication
  - Reduces the patient’s anxiety
  - Demonstrates concern, sharing food is a natural bond between people
  - People aren’t as likely to argue if they’re eating
    - Avoid hot drinks or potential weapons (eating utensils, plates)
    - Avoid “why” questions They may be perceived as an attack
    - Avoid emotional or judgmental comments
    - Do not make promises you cannot keep

- **Verbal techniques are rarely effective in an intoxicated, psychotic, delirious or extremely agitated patient**

- **Physical techniques (training in the following)**
  - Team restraints
  - Moving, walking and carrying a person
  - Escapes from simple holds: wrist grips, hair pulls, bites. clothes pulls
  - Escapes from life-threatening attacks: ex. front and back chokes

**Restraints:**
Restraints are any physical or pharmacological means used to restrict a patient’s movement, activity or access to their body.

**Physical Restraints**

Patients have a right to be free from restraints unless the restraint is necessary to:

- Prevent imminent harm to the patient or other persons when other means of control are ineffective or inappropriate
- Prevent serious disruption of the medical evaluation and treatment
- Prevent significant damage to the physical environment
- To treat the patient’s medical symptoms
The FDA estimates that at least 100 deaths from improper use of restraints may occur annually.

- Reports of burns, broken bones, and other injuries related to patient restraints
- Many problems with restraint devices are never reported to the FDA

Prior to using restraints, consider the following:

**Risks:**
- Aspiration
- Skin breakdown or injury
- Suffocation
- Rhabdomyolysis
- Neurovascular compromise and its sequelae

- Carefully weigh the benefits against the risks
- Consider other alternatives
- Use the least restrictive method of restraint
- Restraints may never be used for discipline or staff convenience
- Obtain a written order which includes:
  - Time limitation
  - Type of restraint
  - Clinical justification of the necessity for restraint
  - Monitoring tool for reassessment, attention to patient needs, neurovascular checks

ED personnel may initiate restraints in an emergency situation prior to obtaining the written order, but it must then be obtained within one hour.

Effective 2 Aug. 1999: HCFA regulations on patient rights set new guidelines limiting the use and duration for chemical and physical restraints as well as seclusion.

Under this regulation, as Federal law, the standards are that the order for restraint or seclusion cannot be written for more than:

- **4 hours for an adult**
- **2 hours for children ages 9 to 17**
- **1 hour for patients under 9**

The original order can be renewed up to a maximum of 24 hours, before requiring that the practitioner see and reevaluate the patient.

The regulation states that “a restraint can only be used if needed to improve the patient’s well-being and less restrictive interventions have been determined to be ineffective”

**General recommendations:**
- Find alternatives to using restraints whenever possible.
- Use with patient or family consent.
- Discontinue use as soon as feasible.
- Observe patients in restraints frequently.
- Remove restraints as often as possible to allow for normal body functioning and daily activities.
- Apply and adjust the restraint so that it is comfortable for the patient.
Follow the manufacturer's directions to:
- Select the type of restraint recommended for the patient's condition
- Use the correct size for the patient's weight and height
- Note the front and back of the restraint and apply correctly
- Tie knots that can be released quickly
- Secure bed restraints to the bedsprings or frame, never to the mattress or bed rails.
- With an adjustable bed, secure the restraints to the parts of the bed that move with the patient

Documentation:
- Document: assessment, intervention and outcome including:
  - Patient behaviors requiring the restraints to prevent or manage the behavior
  - Less restrictive interventions used, which were unsuccessful in re-establishing patient self-control.
  - Patient cooperation sought in implementing safety interventions.
  - Specific interventions employed and patient response.
  - Management of the patient:

If verbal interventions have failed move to the next level of intervention
- **Show of Force**
  5 people as a minimum
  One person to control the head and one person for each extremity
  One person to serve as the leader and four followers
  Initially gather around the leader with an image of confidence.
  The leader states, "come calmly or you will go in restraints"
  The leader states the reason restraints are needed
  Give the patient a few seconds to back down

If the show of force fails then move to
- **The Take Down**
  At signal of the leader each extremity is controlled and one staff member holds the head.
  Control is most easily obtained by immobilizing the major joints.
  The patient is brought to the floor in a backward motion and then rolled over.
  - Most should be restrained in the supine position
  - Consider the side position for the elderly or ill to prevent aspiration
  Restraints are then applied
  Debrief:
  Discuss the events with the staff and later the patient to aid in prevention of further incidents.

All staff that have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques

[http://www.hcfa.gov/quality/4b2.htm](http://www.hcfa.gov/quality/4b2.htm)

**Chemical Restraints**
Agitated patients are a danger to themselves and others. The immediate goal of treatment of the acutely agitated individual is to reduce the agitation, irritability, and/or hostility to a level where the patient is not a physical danger to himself or others and to a level where they can be medically managed. This may involve the use of antipsychotics and benzodiazepines either alone or in combination. The rationale behind the combination approach is to take advantage of the anxiolytic/sedative effects of the benzodiazepine and allow for a lower dose of the antipsychotic.

OSHA’s on-line Hospital e-tool on Workplace Violence -
This e-tool is a comprehensive approach to violence prevention for hospitals and health care employers

Public Employees Federation on-line Resource List for Workplace Violence.
www.pef.org/healthandsafety/resource_list_workplace_violence_prevention.htm

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, Appendix A: Workplace Violence Program Check lists
www.osha.gov/SLTC/workplaceviolence

www.nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/occupationalhealth/workplaceviolence/ANAResources/PreventingWorkplaceViolence.aspx


www.massnurses.org/health/docs/Research04


Massachusetts Nurses Association slogan:
In Healthcare or Anywhere: Violence is NOT part of the job.

Workplace violence is the leading cause of occupational death for women and third leading cause of death for all workers.

Death is a high price to pay to practice one's profession.
Workplace Violence Checklist*

The following items serve merely as an example of what might be used or modified by employers to help identify potential workplace violence problems.

This checklist helps identify present or potential workplace violence problems. Employers also may be aware of other serious hazards not listed here.

Designated competent and responsible observers can readily make periodic inspections to identify and evaluate workplace security hazards and threats of workplace violence. These inspections should be scheduled on a regular basis; when new, previously unidentified security hazards are recognized; when occupational deaths, injuries, or threats of injury occur; when a safety, health and security program is established; and whenever workplace security conditions warrant an inspection.

Periodic inspections for security hazards include identifying and evaluating potential workplace security hazards and changes in employee work practices, which may lead to compromising security. Please use the following checklist to identify and evaluate workplace security hazards. TRUE notations indicate a potential risk for serious security hazards:

- __T__ F This industry frequently confronts violent behavior and assaults of staff.
- __T__ F Violence has occurred on the premises or in conducting business.
- __T__ F Customers, clients, or coworkers assault, threaten, yell, push, or verbally abuse employees or use racial or sexual remarks.
- __T__ F Employees are NOT required to report incidents or threats of violence, regardless of injury or severity, to employer.
- __T__ F Employees have NOT been trained by the employer to recognize and handle threatening, aggressive, or violent behavior.
- __T__ F Violence is accepted as "part of the job" by some managers, supervisors, and/or employees.
- __T__ F Access and freedom of movement within the workplace are NOT restricted to those persons who have a legitimate reason for being there.
- __T__ F The workplace security system is inadequate—i.e., door locks malfunction, windows are not secure, and there are no physical barriers or containment systems.
- __T__ F Employees or staff members have been assaulted, threatened, or verbally abused by clients and patients.
- __T__ F Medical and counseling services have NOT been offered to employees who have been assaulted.
- __T__ F Alarm systems such as panic alarm buttons, silent alarms, or personal electronic alarm systems are NOT being used for prompt security assistance.
- __T__ F There is no regular training provided on correct response to alarm sounding.
- __T__ F Alarm systems are NOT tested on a monthly basis to assure correct function.
- __T__ F Security guards are NOT employed at the workplace.
- __T__ F Closed circuit cameras and mirrors are NOT used to monitor dangerous areas.
- __T__ F Metal detectors are NOT available or NOT used in the facility.
- __T__ F Employees have NOT been trained to recognize and control hostile and escalating aggressive behaviors, and to manage assaultive behavior.
- __T__ F Employees CANNOT adjust work schedules to use the "Buddy system" for visits to clients in areas where they feel threatened.
- __T__ F Cellular phones or other communication devices are NOT made available to field staff to enable them to request aid.
- __T__ F Vehicles are NOT maintained on a regular basis to ensure reliability and safety.
- __T__ F Employees work where assistance is NOT quickly available.

*This form was taken from: Guideline for Preventing Workplace Violence for Health Care and Social Service Workers. OSHA 3148 1996.
Preventing Violence in the Emergency Department

A 260-pound psychiatric patient charges his nurse and strikes her in the face as she prepares to take his blood pressure in the emergency department (ED). A subdued female patient suddenly draws a knife from her purse and stabs an emergency physician 13 times, allegedly because the physician would not prescribe the antibiotic she had requested. A combative patient wrestles a handgun from an armed security guard, shooting and killing a radiology technician and another patient.

Events like these are devastating to caregivers, hospitals, and patients. The effects of such violence can include on-the-job fear for physicians and nurses and setbacks in caregiver recruitment and retention for the hospital. In addition, negative community perception of the hospital can lead to fewer patients and poor financial performance. Unfortunately, violence in EDs is a nationwide trend.

An Industry-wide Issue

According to the Bureau of Labor Statistics (n.d.), healthcare workers experience violent assaults at a rate four times higher than average. Nurses experience violence at 12 times the national average, and it is even worse for emergency nurses.

The Emergency Nurses Association (ENA) initiated a study of workplace violence in 2007. Distributed to nearly 3,500 emergency nurses, the survey results revealed that workplace violence is shockingly prevalent and has caused great fear among the nursing community. Preliminary search results revealed that 86% of emergency nurses had experienced physical violence during the last 3 years, and 27% had experienced violence on more than 20 occasions during that time period. Physical violence ranged from pushing and scratching to assault with deadly weapons and sexual assault.

Naturally, these violent events caused fear and concern among nurses. Seventy-two percent reported they did not feel safe on the job, and 19% indicated they were leaving the emergency nursing profession because of violence. In addition, nurses said that many incidences of violence are unreported due to fear of retaliation, inconvenience of reporting, a lack of physical injury sustained, or concern that doing so may affect customer service scores.

ED physicians have had similar experiences. A 6-year (1993-1999) National Crime Victimization Study conducted by the Department of Justice concluded physicians are injured 28% more often than workers in other industries (Dunhard, n.d.).

According to a study conducted in Michigan, 75% of ED physicians reported having been threatened in the past year and 28% had been physically assaulted (Kowalenko, 2005). As a result, 16% considered leaving their hospital or job and 18% had obtained a gun for protection.

Unfortunately, some violent events result in healthcare providers losing their lives. Between 1996 and 2000, there were 69 homicides reported in health services, and 23% of the homicides took place in the ED (U. S. Dept. of Labor, n.d.).

The emotional, social and financial cost of ED violence is incalculable. Reducing the number of violent incidents that take place and minimizing the long-term effects of the ones that occur is a top priority. However, before efforts can be taken to curb violence against ED caregivers, healthcare leaders must understand the causes.

Cause for Concern

Many factors contribute to violence against ED caregivers, so no single solution will eliminate the problem. EDs are publicly accessible facilities that are open 24 hours a day. They stock narcotics and often have cash on hand, making them vulnerable to potential robbery. Many EDs have aging physical structures with poor design and lighting that can place providers at risk.

EDs care for an often-underserved population, including patients with psychiatric, social, criminal, or substance-abuse problems. Individuals who have been arrested for alcohol- and drug-related violations are often brought to the ED for medical clearance before being taken to jail. Gang activity and the prevalence of concealed firearms also contribute to the problem.

During a 1-month period, a hospital in Los Angeles identified and confiscated 300 weapons from patients, including shotguns, .357-magnum handguns, and automatic military weapons (Lavoie, et al., 1988). Still, relatively few EDs are staffed with qualified, armed security personnel.

Addressing the Problem

Hospital administrators have a responsibility to make their facilities as safe as possible, but many do not know where to start. Various studies have supported hospitals’ ability to reduce assaults through organized approaches such as employee training. However, little evidence exists that a specific set of measures can eliminate violence in the hospital.

Despite the myriad causes and challenges associated with violence against ED caregivers, certain measures can be taken to curb the likelihood of violent events and improve staff responses in order to minimize the harmful results. A multifaceted approach must be considered to craft the optimal solution that mitigates risk of violent incidents. The solutions must be tailored to the
hospital risk analysis and trend experiences. This approach includes human, policy, process, equipment, and technology dimensions.

While all cases are unique and no actions are guaranteed to eliminate violence, the following five steps may provide an initial framework for administrators to assess their hospital’s vulnerability for violence and take measures to prevent it.

1. Become familiar with your facility’s unique violence risks.
   
   Review the findings of your most recent Joint Commission hazard vulnerability analysis (2009 standard: EM.01.01.01) as well as incident reports, Occupational Safety and Health Administration (OSHA) logs, and security logs. Your local crime index report can add additional insight to your facility’s unique risks. Involve a multidisciplinary team that includes staff, supervisors, risk management professionals, hospital security and the local police in order to help promote an institutional understanding of the importance of the project. Consider utilizing trained experts when reviewing equipment and technology-based security measures.

2. Assess and update your facility’s workplace violence prevention program.
   
   OSHA offers a comprehensive set of fundamental guidelines that can assist in this assessment. Available at the OSHA web site (www.osha.gov), these guidelines clearly identify five key elements for an effective program:
   - management commitment and employee involvement; worksite analysis;
   - hazard prevention and control;
   - safety and health training; and
   - recordkeeping and program evaluation.

   Use the above risk analysis and this program assessment to take specific action to improve onsite security. Evaluate security personnel and select additional security equipment based upon the potential for violence in the specific facility. Taking action on the information from the initial analysis will not only make the facility safer but also help staff members feel more secure.

3. Revise and improve your workplace violence prevention training program.
   
   Staff training and awareness is a critical component of workplace safety, and programs can vary widely from hospital to hospital. Many facilities offer programs that do not include hands-on training or real-life scenarios. Make sure your training program involves all hospital staff members and addresses the specific potential events identified in the risk analysis and program assessment. Provide non-violent crisis intervention designed to develop skills such as diffusion of escalating situations. Also, consider including role-playing to teach basic physical defensive maneuvers and correct take-down and restraint application techniques. Remember to include physicians, volunteers, contract employees, and clerical staff in this training.

4. Enact a “zero-tolerance” policy for violence and encourage reporting of violent incidents.
   
   Make sure hospital workers understand that violence against them is never appropriate. Demonstrate that hospital administrators support violence prevention efforts by regularly communicating about these issues. Safety should be a topic at every staff meeting. Encourage reporting of every incident of workplace violence, however small it may seem.

5. Provide opportunity for crisis debriefing and staff support following a violent incident.
   
   If a violent event takes place in the facility, proactively arrange opportunities to debrief. Providing an opportunity for staff members to review and process an incident in a timely manner can be emotionally beneficial, ultimately allowing them to resume patient care duties and reduce time away from work. Depending on the nature of the event, consider utilizing experts trained in post-crisis management to ensure the positive benefits of these efforts are realized. Of course, not every staff member will feel comfortable participating in debriefing. Allow individuals to deal with the event as they choose.

   While sometimes complicated and time-consuming, taking steps to prevent violence against ED caregivers is always worthwhile. EDs are the medical safety net of our country, and, in order to recruit and retain qualified caregivers for the long haul, their safety must be a priority.

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REFERENCES


