CAEP | ACMU
1978-2018

808-180 Elgin Street
Ottawa, ON K2P 2K3
(613) 523-3343
(800) 463-1158
(613) 523-0190
www.caep.ca

The Canadian Association of Emergency Physicians (CAEP) is the national specialty society for Emergency Medicine with over 2500 members.

The Problem:

With the birth of our specialty, our primary focus was on education and training to identify and treat life and limb threatening emergencies. Over the ensuing decades our role has changed. Emergency physicians now bear daily witness to failed social policies that result in increasing visits to our departments with substance abuse, alcoholism, poverty, marginalization and violence.

The latter is of grave and increasing concern to both our members and our nursing colleagues.

Health care providers have four-fold higher rate of workplace violence and 50% of all attacks on health care workers occur in the emergency department.

Emergency nurses bear the brunt of much of this violence.

Most assaults on emergency department personnel were by patients or visitors and the degree of physical violence has been increasing.

The Causes:

The root causes and contributing factors to violence in the emergency department have been well-described.

As with many problems that beset the emergency department, many contributors lie outside the department itself and are societal and cultural.

Chronic oppression, with racism, poverty, inequity and social exclusion lead to substance abuse, mental illness and violent behaviour.

As the population ages, complex presentations of the elderly in the emergency department, coupled with prolonged waits for care, leads to an increased risk of delirium and violent acts.

While violence in the community is certainly a driver for violence in the emergency department, it is not the sole driver.

There are factors intrinsic to current emergency service provision including overcrowding and increased wait times, insufficient nursing staffing levels and poor communication with patients, and poor environmental design all contribute to a risk of violence in the ER.

The Effects:

Multiple studies and reports have shown that exposure to violence in the emergency department has a deleterious and demoralizing effect on staff, most notably nursing staff. Occupational strain, impaired job performance, fear of patients and future assaults, decreased feelings of safety, reduced job satisfaction have commonly been identified.

Absenteeism, lost-time injuries and prematurely shortened careers have also been linked to violence in the department and leads to a large economic effect of workplace violence in the health care sector.

The solutions:

Violence in the emergency department can be prevented and certainly mitigated.

Violence in the emergency department is a symptom of a much bigger problem, broadly societal and reflective of societal oppression with racism and poverty leading to substance abuse, gang and personal violence, and inadequate upstream mental health resources for the mentally ill and those with substance abuse. This is a societal issue and beyond our immediate control.

Within the hospital and the department, however, we can consider the following.

While individual staff members can contribute to safety through their practice and behaviours, ultimately the responsibility legally and morally to provide a safe workplace falls to the employer and thus to a hospital's administration from Board to department leadership.
A few of the major considerations include:

- Appropriate facility design, with a limited number of controlled entry points to the ED and with the capability to rapidly lock down the department.

- Monitoring. There must be a visible security presence 24/7 with adequate back up available in response to an actual or potential incident.

- Skills and attitudes. Staff should receive training in non-violent de-escalation.

- Policies and Procedures. There should be clear policies and procedures in place, with regular staff training, to cover how staff respond to a high-risk situation.

- Care plans. Security as well as the clinical staff should have a system for tracking high risk patients and identifying them on return as well as ideally suggesting a safe approach individualized to the person's behaviors and known clinical issues.

- Incident reporting and review. There should be an incident reporting system as well as a process for incident review.

- Staff engagement. There should be clear lines of accountability for all aspects of ED safety.

Zero Tolerance:
We believe that violence in the emergency department is first a medical symptom which requires an assessment to diagnose the etiology. Intoxication, psychosis and mania, dementia and delirium, brain trauma and tumors are all potential causes of violent behaviour. Violence can also be a reflective of a much bigger socio-economic problem, with roots in oppression, racism and poverty, which can in turn lead to substance abuse, gang and personal violence and exacerbation of mental illness and addictions.

We support "zero tolerance" of violence in the ED – every incident requires an institutional response.

But the phrase "zero tolerance" cannot be used as an excuse to evict or ban patients who have not been properly assessed. This only makes us complicit in a culture of stigmatization and inequity. We believe that the violent patient deserves the best possible assessment and care from their ED providers, and their individual social and circumstances must be considered in their ultimate care plan.