Ensuring ED Excellence through Violence Prevention

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On June 3, 2010, The Joint Commission issued a Sentinel Event Alert – one of only forty-five (45) such alerts announced since 1998 – urging hospitals to take heed of the Joint Commission's concern about the growth and underreporting of *hospital violence*. Those of us connected with and practicing in the emergency department are all too familiar with the reality of violence and laud the Joint Commission for their diligence in warning hospitals. And it's about time… (www.jointcommission.org/SentinelEvents/SentinelEvent

Violence in the Emergency Department has been a growing concern for many years. People are coming to the ED in record numbers and the trend continues upward as a massive volume of individuals who require primary or emergency medical services continue to seek care that (often) only the ED can provide. Each situation is exaggerated by the unintended consequences of an outdated EMTALA law.

(http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf)

A dramatic loss of inpatient psychiatric treatment facilities and limited treatment options for this cohort plus the overuse and misuse of ED resources due in part to scarce primary care in the community yields the very unpleasant fact that dangerous situations can and do crop up in Emergency Departments. Growing charity debt, unreimbursed care and the reallocation of hospital state subsidies that have been propping up a large number of ED's for many years has led to the shuttering of increasing numbers of ED's. This sustained lack of financial resources has created over-crowding in the enduring EDs. The risk of violence is enhanced by hospitals – and not only by the ED – when they fail to adequately plan & implement surge capacity strategies and to efficiently manage inpatient beds/discharges; these failures alone create a backlog in the ED/ lobby. The sheer volume of individuals waiting to see a provider or waiting to be admitted can become a recipe for disaster.

www.aha.org/aha/trendwatch/chartbook/2010/chapter3.pdf,
http://www.aha.org/aha/trendwatch/chartbook/2010/chart3-9.pdf

In general, individuals who need the ED come when they are in pain. When they are confronted with the situation in which they must wait in an unpleasant, overcrowded

environment that is devoid of calm, comfort and communication even the most tolerant individual can become agitated and unreasonable. The EDAPC – or ED as Primary Care – creates a new model for care and one that the ED has not been prompt in adapting to or changing.

Preventing violence in the Emergency Department is not a difficult paradigm; it is simple formula of common sense and does not necessarily have to cost the equivalent of the national debt to employ. The mandate for change must come from ED leadership as it is necessary for those familiar with operations to identify the gaps and to recommend changes & improvements. The emergency department medical and nursing directors must take the lead in developing the business case to educate hospital administration using the language that CEO's understand: numbers. Use or create your own dashboard, collecting critical and influential ED metrics such as the number of LWOBS (lost revenue), near-miss violence incidents (risk), or the potential outcome from an open access ED that allows anyone to wander into the ED and into the hospital.

The Joint Commission issued Sentinel Event Alert # 45 in response to the upward trend of violent crimes reported through the Joint Commission database in the past three years. The violent crimes that have consistently been reported are assaults, rapes and homicides and involve entire hospitals – not just emergency departments. The numbers that have been reported are exceptionally low leading the Joint Commission to conclude that there has been a "significant under-reporting" of this type of violent offense. Nonetheless, the numbers are on the rise and are noteworthy enough for the Joint Commission to take preliminary action with the issuance of the alert.

The Joint Commission already has a four-prong requirement in the Environment of Care standard upon which hospitals (not just ED's) will be assessed when re-accreditation time rolls around:

1) A written security plan.

2) Risk assessments to determine the potential for violence.

3) Written strategies for preventing violence.

4) A violence response plan.

The Joint Commission follows the reminder of this requisite with thirteen (13) recommendations to which they refer as "suggested actions" to quell potential violence.

There is no way to know precisely how many incidents of violence – serious and minor – have not been reported. Nurses, physicians and other ED healthcare workers have been told

routinely that patient and/or family and visitor aggression or outright violence are "part of the job" and our healthcare colleague victims have been discouraged from reporting any patient, family or visitor hostility (verbal or physical) against them. If the hospital does not define aggression & violent behavior and if they do not have and insist upon policy, protocol *and* a simple & quick method for reporting violence, incidents will not be reported. Likewise, if the hospital does not pro-actively communicate to patients that there is a zero tolerance for aggressive and violent behavior and insist that ED professionals report every episode of aggression and violence, the numbers will continue to be low.

Consider the following five *Quickstart* solution steps to initiate a violence prevention framework:

1) Violence awareness. Conduct violence awareness for the entire hospital.
2) Gap analysis. Assess your gaps and solutions for gap fillers (such as ED access & visitor management)
3) Violence prevention plan. Write a violence prevention plan for your ED and solicit support from hospital administration (select an ED Violence Prevention champion from top management)
4) Policies and procedures. Define violence & aggression and write and implement relevant policies and procedures-especially for reporting violence and aggression. Communicate to staff. Communicate zero tolerance to patients, families & visitors.
5) Training. Provide de-escalation training for staff.

Ensure that your emergency department continues its pursuit of excellence by putting a robust security plan into action – driven by the needs of your ED.

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