



Violence in the Emergency Department: Strategies for Prevention and Response

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Violence in healthcare facilities presents a growing and significant challenge to patients, providers, support staff, and visitors. Hospital emergency departments (EDs)—where doors are always “open”—are frequently the site of violence, which is either carried over from external conflict or perpetrated by patients (and/or their loved ones) against healthcare workers. This article highlights variables that contribute to challenging situations and strategies hospitals can use to prevent them, keeping patients and staff as safe as possible.

When it comes to the safety of an ED, we divide levels of protection into two categories: **active and passive**. Active security can include the presence of officers, bullet-resistant glass, and clear escape paths staff can take to evade violent interactions. Passive protection can include visibility across the ED (e.g., being able to see colleagues as they interact with patients), knowing where safe zones are, and ensuring there are no “dead-end” corridors (even if they are short and meet local codes). Between active and passive security is technology—panic buttons, call systems, cameras—things that keep staff, patients, and the public safe.

It is a complex relationship, and challenges abound: how do hospitals control automobile and ambulance access to the ED? What about security during a disaster or other incident that could potentially bring hundreds of people to a site? How easy is it for people to walk by a hospital corridor and access the interior of the facility? Does your facility ensure all new and existing employees are regularly trained in how to recognize and manage a violent situation? Addressing these and other security-related questions is key to ED crime prevention.

First, it is important to have **visibility across the department**. In “old fashioned” spaces, there may be a nurse’s station on one or two ends of the bay, and the bathrooms, staff breakrooms, and physician workrooms are in the middle. While that layout seems practical, staff at the nurse’s stations do not have a clear visual across the department. To address this, you may consider **moving the support areas to the perimeter**. Enclose the workrooms and medication rooms in glass—bullet-resistant if possible—to provide a safe space for staff in the event of gun violence or law enforcement activity. This is not to say that it is a healthcare worker’s responsibility to have security visual control; making these adjustments also allows for clearer and more comprehensive security angles.

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Another factor that mitigates violence is having some sort of **visible security**. In the 1980's, an officer in the ED waiting area may have implied you were in an unsafe facility. Today, it is the opposite—people want to see security to feel safe. In one facility we worked in, there was a huge sign with the word “police” on it, close to a pane of mirrored one-way glass. Staff told us the entire set up was fake, but it deterred negative behavior because it simply implied the presence of security.

In the early 2000's, **metal detectors** were likely in just 1 out of 25 hospitals. Today, it is safe to say they are being considered by nearly every hospital and implemented in about half of new remodels. Determining where to place them is a significant consideration; planning for queuing, sorting, bag holding, and search areas means setting aside a decent amount of space in an already congested area. There are currently more passive systems in development that would alert security if someone had a large amount of metal on them. Again, just the perception of this type of system may deter criminal behavior and make staff, patients, and visitors feel safer.

There also needs to be a **visual connectedness between areas** like triage, the reception area, the public area, the walk-in vestibule, and the parking lot. Can security see into all these areas and the interactions at the reception desk and in the triage area? Do staff have a clear line of visibility from the triage area to the waiting area? Can security or staff see the front door, or see who is pulling up to the ED at any time? Do cameras capture images of each car as it drops patients off at the ED?

Updating the triage method is another step hospitals can take to help reduce the chance of violence in the ED. Make triage a rapid sorting progress, as it was initially designed to be, so that providers get a better sense not only of the illness or injury that brought the patient to the ED, but reasons behind an injury and any immediate threats to safety (e.g., the perpetrator drove the patient to the ED).

Controlling access points to the reception and treatment areas can help keep patients and providers safe. Ensuring that triage/assessment rooms have both front and back doors controlled by locks is also important. In most hospital EDs, a nurse opens a door to the waiting area, calling out a name or bringing a wheelchair to a patient. How many times have we seen people hang out by those doors and then try to slip into the clinical space? They might have good intentions, simply trying to get in to see a family member. They might instead be a gang member looking for another gang member or someone who wanting to finish assaulting the person who got away and is now in your ED.

Some hospitals have added a “man-trap” or “sally port” just inside the main entry doors to the clinical area. To get through a sally port, a staff member, patient, or visitor must step through the first set of doors, wait a few seconds until those doors close, then open the second set of doors using a card swipe or keyed access. This inner vestibule should be equipped with security cameras and monitored.

An important note about the location of card readers: violent attacks can happen anywhere, and it is important to take into consideration the distance between a card reader and a door. Hospitals should consider placing a card reader 10-12 feet from a door, and another one adjacent to the door to provide a second access point for staff in the event an attack takes place right up against the locked door. It is also critical for staff to know which card reader goes with which door when there are several in a small area. Card readers for door access must be tied to emergency power to prevent deactivation when power is lost.

COVID-19 and ED Updates

Some hospitals have created different ED entrances for assumed/ symptomatic COVID-positive patients and trauma patients. Others are repurposing decontamination areas as entrances for patients who should be isolated for assessment. Many facilities are exploring segmenting the ED into care zones, with rooms in one zone equipped with negative air pressure capabilities. Five years ago, the costs associated with these changes were considered excessive; now that we are experiencing a pandemic, some leaders are reconsidering.

One lesson hospital staff have learned is that when some patients wait a long time to seek treatment, they can be extremely sick—and often extremely frustrated—by the time they arrive to the ED. The same can be said for their loved ones, who may also have high levels of frustration and/or anxiety. These tensions can quickly elevate security situations; training staff to deescalate them is critical to everyone's safety.

Technology plays an important role in staff safety. Some systems provide healthcare staff with badges fitted with buttons configured to send an alert message that includes the staff member's name and location in case of distress. A component of real-time location systems (RTLS), these advances in technology can help hospitals track staff and supplies (and patients as necessary). RTLS may also eventually negate the need for multiple cards and card readers; integrated platforms can facilitate communication and collaboration, especially in the event of a lockdown or violent incident.

Building better stations begins with making sure there are two ways out of every space. We are moving away from building large U-shaped stations and towards creating multiple 6 to 8-foot wide “high-low” stations. In that setup, one section has seats, and the other section has taller stools. The chance of being trapped behind this type of station are much lower than with a U-shape station. Partially glassing in these stations can help keep sound from leaving but ensures staff can still hear a cry for help or noises related to a scuffle. Sometimes it is as simple (and relatively affordable) as removing a storage closet that has been in the middle of an ED for 20 years.

Training in de-escalation can help staff understand how to recognize potential threats, how and when to intervene, when to retreat, and when to evacuate. Also, as patients with mental health issues continue being brought or sent to the ED for treatment, this type of training can ensure that those patients are more quickly screened and, in a perfect world, transported to a floor or other location that is more suited to treat them. These types of training should be part of a facility's comprehensive workplace violence prevention training, which should include regular drills and tabletop exercises to promote partnerships, and ensure staff are comfortable and confident in their options should a situation arise.

Developing spaces for patients experiencing behavioral health challenges can protect patients and providers. Some hospitals are retrofitting rooms to ensure patients can not use any equipment or supplies to harm themselves. Others are creating flexible units for patients that can hold adolescents on side, adults on the other, with a few rooms in between, to allow for flexibility during surge. Similar changes are being made to **create rooms used to treat forensic patients**—some hospitals have created an exam room on the perimeter of the ED with one door accessible from outside the hospital and the other from inside, allowing for easier treatment and transport while minimizing the opportunity for negative interactions.

Communication challenges need to be addressed before any physical improvements are made to the ED, particularly when dealing with an older facility. It is vital to ensure that wireless technology and public safety radios will work through existing and planned architecture. Walls are not the only challenges you need to plan for—other technologies and tools in the ED (e.g., wireless monitoring of cardiac patients and patients' oxygen levels) may scramble signals. It is also important to work with local law enforcement to determine how and where signals need to be boosted or alternate radios need to be stored.

As violence against healthcare workers increases and gains more media attention, it is critical for healthcare executives to act now to protect staff and patients. The goal of this article was to demonstrate that no matter the size of your ED, or the location of your healthcare facility, there are a variety of changes you can make now to protect everyone who accesses your facility. As the field continues to endure a pandemic and shortages in staff, providing healthcare workers with tools they need to manage challenging situations and a safe space in which to work can increase their sense of security and contribute to staff retention.