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Definition

Workplace violence occurs when a person is physically or verbally abused, threatened, intimidated, harassed or assaulted in her or his employment. In Canada, employees have the right to a safe work environment, and it is the duty of the employer to provide it [1].

Nature and magnitude of the problem

The problem of workplace violence in the emergency department (ED) is grave. Healthcare providers have an estimated fourfold higher rate of workplace violence and fully half of such attacks occur in the ED [2–9]. Studies suggest that 43% of hospital nurses will be sexually harassed or assaulted

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this year [4] including over 50% of those working in the ED [10–15]. Over half of ED nurses are physically or verbally abused in any given week [10, 11]. The Canadian Federation of Nurses Unions (CFNU) reported in 2017 that "the number of violence-related lost-time claims for frontline health care workers has increased by almost 66% over the past decade, three times the rate of increase for police and correctional service officers combined" [8]. It is shocking that the risk of violence for a doctor or nurse working in a Canadian emergency department is increasing so dramatically and intolerable that it be left to rise unabated. The level of ED violence can reasonably be expected to continue to increase in the future due to the changing ED population, the prevalence of guns and paucity of services available to those prone to violence due to underlying medical, substance abuse or mental health disorders.

The increasing trend noted by the nursing profession is echoed by emergency physicians. Nearly 70% of emergency physicians say that ED violence has increased in the past five years, with 25% reporting it has increased greatly [16]. This high level of ED violence is undoubtedly a contributing factor in the already high ED physician burnout rate [17–19]. ED violence negatively affects both the quality of care which can be offered and the financial cost to the health care system [20]. In Ontario alone, ED violence costs $23.8 million annually [21].

The increasing pattern of violence against health care workers is disturbing not only because of its prevalence but also because of the culture of silence surrounding it and lack of effective mitigating action, despite its incredibly high human and financial cost. The CFNU's recent poll highlighted that, although violence in the ED is common, few people report the incidents and fewer still seek help from their unions. Many assume it is an occupational hazard they must accept and yet, not surprisingly, two thirds (66%) of nurses have thought of leaving their job in the past year [8]. The unhealthy work environment contributes

to nurse absenteeism, which is higher than all other occupations. In 2016, the annual cost of absenteeism due to illness or disability was at least $989 million" [8]. ED violence costs Canadians billions of dollars annually, money which could otherwise be spent constructively on necessary health and social services.

Changing the prevailing culture

The prevailing culture in the hospital system has implied that ED violence is part of the job, an inherent risk that it is futile to try to address [22]. The Canadian Association of Emergency Physicians (CAEP) seeks to change this perception and increase ED safety for physicians, hospital staff and patients. CAEP finds the level of ED violence unacceptable, the dearth of available mitigation techniques dangerous, the lack of effective recourse neglectful and callous, and the wasted human and financial resources unconscionable.

The most important component of any violence prevention program is a clear commitment by management. CAEP expects unequivocal support from hospitals and regional health authorities for workplace safety. Explicit, written policies and procedures to prevent ED violence must be implemented and adhered to, along with safe physical spaces and the provision of counselling and support of ED violence victims. Although physicians are not normally entitled to the benefits of regular hospital employees, in the event of workplace violence they should be fully supported.

Policies related to violence in the ED should: [1].

(1) Be developed by management and front-line representatives.
(2) Apply to management, employees and patients.
(3) Define workplace violence in precise, concrete language.
(4) Provide clear examples of unacceptable behaviour and working conditions.
(5) State in clear terms the organization's view toward workplace violence and its commitment to the prevention of workplace violence.
(6) Precisely state the consequences of making threats or committing a violent act, and outline concrete protocols and options that are available at the moment. This should include roles and notifications (i.e. security, police, management, etc.)
(7) Outline the process by which preventive measures will be developed.

(8) Mandate the reporting of all incidents of violence.
(9) Outline the confidential process by which employees can report incidents and to whom.
(10) Assure no reprisals will be made against reporting employees.
(11) Outline the procedures for investigating and resolving complaints including the right to recompense for time taken off work to deal with the physical, emotional or legal effects of the violence for all health-care professionals.
(12) Describe how information about potential risks of violence will be communicated to employees.
(13) Make a commitment to provide support services to victims of violence including all health-care professionals.
(14) Offer a confidential Employee Assistance Program (EAP) to allow all health care professionals to seek help.
(15) Make a commitment to fulfill the violence prevention training needs of different levels of personnel within the organization.
(16) Specifically address the measures which can be taken when an individual who has acted violently in the past presents to the ED for treatment.
(17) Commit to monitor and regularly review the policy.
(18) State applicable regulatory requirements.

In addition to the above policies, CAEP advocates for the following [23–32]:

(1) The development of a national safety standard to be developed in conjunction with security experts and other partners which outlines best practices, benchmarks and comprehensive plans for improved safety and security in EDs. Hospital administrators should be obligated to meet these standards within an urgent timeframe. The standards should include

(a) Providing for improved environmental design for Canadian EDs to prevent the dangers of isolation without limiting privacy. Restricting access to the ED has been shown to prevent violence.

(b) Providing for improved security measures for all Canadian emergency departments. Where feasible a visible security-presence is desirable. Alarm systems should also be explored.

(c) Developing guidelines and protocols for Code Silver: Active Shooter situations [33–40].

(d) Training for all staff to recognize aggressive and escalating behaviours and de-escalation training for all emergency staff.

(e) Equipping staff with appropriate medical protocols for the control, restraint and sedation of (potentially) violent patients as clinically appropriate.

(2) Better community access for mental health and substance use disorder patients.

(3) Support of initiatives to better understand and mitigate the barriers to reporting violence in the ED.

Multiple causes, zero tolerance

Violence in the ED has many antecedents, including poverty, racism, substance use, gang and personal violence. The violent patient may be exhibiting manifestations of delirium from a myriad of acute medical causes, or dementia. Inadequate community resources for those with mental health disorders and addictions have been a major contributor, as well. We believe the violent patient deserves the same optimal care expected by any patient and their individual medical and social circumstances must be considered in their ultimate care plan. Violence in the ED is more often than not a symptom rather than a personality trait; thus, we urge caution with respect to a 'zero tolerance' policy in which patients with a history of violence are denied access to care. We do believe, however, that maximal administrative efforts must be made to provide health care workers and our patients a safe and secure work environment.

It is incumbent upon hospital administrations to make full and complete efforts to help address the rising incidence and increasing toll of ED violence. They must provide a respectful and collaborative environment in which all cases of violence are reported without fear or intimidation. They must commit to staff engagement with violence prevention, including mandatory de-escalation training. Improving staffing ratios and patient flow will help provide a more secure facility for both patients and staff.

Physicians and nurses in our EDs struggle to contend with increased violence and burnout, with fewer and fewer supports and resources, in an era of increasing funding cuts. It is the position of CAEP that the escalating human and financial burden of these cuts is not only detrimental to society, but also violates the rights of healthcare workers to a safe work environment that will allow them to provide appropriate care to the public. In addition to the preservation of human dignity, skill and security, there is the potential for great financial savings in addressing ED violence nationally. It is thus imperative to meaningfully address the epidemic of violence in Canadian emergency departments and, for any delay in that regard, there should indeed be zero tolerance.

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