



# EMERGENCY DEPARTMENT VIOLENCE

Resources for a Safer Workplace: *Your Experiences*

## Abstract

James J. Sullivan, Jr., MD, is Chief of Emergency Medicine at Harrington HealthCare System in Southbridge, Massachusetts. He recently shared his thoughts on the June 14 attack in his emergency care center, in which a nurse was stabbed 11 times by a former patient. We've compiled the following from his posts on the ACEP listserv for Emergency Department Directors Academy and the Facebook group EMDocs, with his permission.

August 15, 2017

***I wanted to say thanks again to all of you for your thoughts, individually and collectively, and let you all know that the nurse attacked in my department on June 14 is out of the hospital and doing rehab at home.***

*I am trying to figure out how to continue to focus on this issue going forward, and it is my hope/intent to raise awareness, both with the public and government/advocacy groups, about the increasing threat of violence directed against health care workers, and, in the ED.*

*Up front, I would mention that we now want every patient/visitor, limit visitors/family to 1/patient, and have metal detectors at the entrance to both EDs (we staff a satellite ED as well as the main one), AND our excellent (ie, young, fit, mostly male, mostly affiliated w/ local police forces) public safety officers are always at the triage area (so no nurse is alone during that particularly vulnerable period of time), and they will (now) be armed with some kind of pepper spray and handcuffs.*

*Many ED directors have commented on the resistance, often by senior administrators, to many of these safety implementations, predicated on the notion(s) that 1) it gives a sense that the hospital is inhospitable in some way; 2) interferes with operational throughput; and/or 3) "No one else is doing it. We shouldn't be the first."*

*Perhaps the fact that we are (among the) first renders at least the third contention moot.*

*We are, in Massachusetts, advocating for a law increasing legal penalties for violence directed against health care workers, to include EMS personnel.*

*At the bottom, I include overall safety changes at our facilities since the attack.*

*Best to all,  
Jim*

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***I wrote this recently, by way of attempting to suss out my thoughts about next steps.***

While I support the notion of a bill identifying medical caregivers (like police, fire, EMS) as being specifically protected under the law from assault (as is appropriate for anyone who voluntarily chooses a profession which necessarily places the welfare of others ahead of one's own), I do believe that it is not sufficient. The assailant in Southbridge is (presumably) psychotic, and I believe would not have been dissuaded from any attack by the awareness of increased penalties. I think it is critical to engage all of us, advocacy organizations, and leaders of government to re-establish an understanding of the function of the ED, not as a 24/7 extension of every possible permutation of outpatient/specialty care, but as a facility to manage acute illness/injury, and whose function is as much to establish the absence of serious/life-health threatening conditions than it is to establish a definitive diagnosis in all cases.

(I often tell patients, "We are not as good as we'd like to be at telling you what 'it' is, but we're very good at telling you what 'it' is not, and the intent is to determine the actuality/likelihood of something serious.")

Staff safety must be considered no less our obligation than patient care, and both need to precede any issue/concern with patient satisfaction. Not sure how that fits into a bill..

So much of this is stuff you, and everyone in the wider EM community know, of course...

I fully support the notion of passing laws expressing identifying assault on health care workers as being similar to assault on law enforcement officers, but I am unconvinced, ultimately, of the likely value/efficacy of that. Elise's assaulter, if what I have heard/read is true, was someone in the throes of a psychotic break and unlikely to have known/cared about any such law. As such, I am unconvinced about the value of such a law as a preventative for future assaults.

My larger question/concern/desire then, is to use our position as an advocacy group, in concert with other such groups regionally and nationally, to more forcefully engage the conversation about the factors which have led to the increasing acceptance of workplace violence, in particular, against health care workers, in particular in what is often the most uncontrolled, chaotic, and potentially dangerous environment, the ED.

We are all aware of the many forces over the years which have unintentionally conspired to create the current toxic "brew" of anger and resentment that is often commonplace in the ED.

The deregulation and release of long-term, institutionalized psychiatric patients, beginning under the Reagan administration (and the failure of that and all subsequent administrations to make good on the promise of funding to provide comprehensive outpatient services for these individuals), means that the only place to "reliably" receive evaluation and (short-term) stabilization of acute psychiatric issues is the ED. The absence of IOP/inpatient beds means that these patients linger for days in our EDs, with little to no ongoing care.

The initiation of the false premise of "pain as the fifth vital sign" in the 1990s, and the lie put to us by pharmaceutical companies that it is/was appropriate to treat non cancer chronic pain with opiate/opioids (they do not cause addiction in that circumstance, or so we were told), and the more recent massive effort to curtail the liberal use of such addicting medications, means that many addicted/habituated pts, with no one else willing to fill their need, come to the ED either for refills of controlled medications or as overdoses due to using illicit substitutes, or for exacerbations of chronic pain, and are often instructed to come to us by the outpatient physician(s).

The continuing chronic shortage of primary care physicians, the increasingly overwhelming regulatory burden under which they practice, has meant that many patients with complex and competing medical issues can only seek care for stabilization of

these conditions during times of decompensation via the ED.

Similarly, the inability of medicine at large to provide lower cost, timely evaluation of low acuity, rapid onset conditions (infection/abscess care, sprains/fractures/lacerations), means that many of these patients of necessity seek care in the ED. They often wait, and become angry and frustrated.

The increasing focus on "patient/customer service", timely evaluation and throughput, in addition to an increasing responsibility to manage acute, severe, illness/injury, means that our work is atomized and isolated, rendering all health care workers to be at greater risk of assault.

In the end, this toxic brew consists of the psychotic, the addicted/withdrawing/in pain, the complex patients who require much evaluation, the low acuity patients who wait, all of whom have become increasingly entitled, and who, under duress, turn their anger and frustration toward the care workers who 1) MEAN them no harm (in fact, quite the opposite) and 2) DID them no harm.

It seems to me that the public is increasingly of the opinion that they have a right to their entitlement, their unreasonable expectations, and have a right, when they choose, to direct their anger at us, to include feeling justified with verbal and physical assault.

It is this which we must combat; we MUST lead a conversation that reminds ALL stakeholders, including presumptive patients (ie, the public) that health care worker safety is absolutely equal to patient care in terms of our focus and our goal, and inconveniences which improve safety and do not impede timely care for those who need it most is in EVERYONE's interest.

At Harrington, we HAVE placed metal detectors at our ED entrances, we HAVE decided that we will never again allow a nurse to do triage alone, we HAVE increased our public safety officer staffing, and we HAVE begun to investigate how to provide them with better tools (Taser, baton, handcuffs, spray), we HAVE begun to reduce

the number of open entrances into the building, so as to reduce unintended "guests," and we HAVE set strict policies on the number of visitors allowed/patient, so as to reduce the crowding (Brownian motion leading, as we know, to energy transference).

I think it is critical that the public know that we will not tolerate threats of ANY kind and ANY time, to include no excuses for the intoxicated person/patient whose assault occurs under the influence, since it is almost always true that the use of such intoxicating substances was volitional in the first place.

At Harrington, we DO and HAVE sent "No Trespass" letters to patients/visitors who have been verbally/physically assaultive.

If every ED follows suit, it will become increasingly clear to those who do not think it unreasonable to seek to meet their demands via the use or threat of violence that that behavior will not be tolerated, and that it may lead to expulsion from the ED and arrest and prosecution.

### **Summary of Safety Changes at Our Two Campuses**

I have, below, listed the latest safety updates at Harrington, so as to give y'all a sense of what we have done to further minimize risk, and I must commend our senior leaders for being so responsive.

The most important (and for those who, like us, have struggled with the prior unwillingness of senior staff to use metal detectors since they worry that it creates some kind of inhospitable environment):

1. We now have metal detectors at both facilities. By report, two firearms have been temporarily locked in our safe via our public safety officers, and everyone seems to carry a knife!
2. Everyone entering by EMS gets wanded.
3. One visitor per patient.
4. Upstaffed our public safety officers to three per shift. One is at the triage area 24/7, so our triage nurse is never alone.
5. Broke a hole in a wall to allow a second exit path from the triage room.

6. Since the attack, the hospital has been paying OT for Southbridge and Webster police officers to be present in each ED 24/7. That will end at some indeterminate (but likely soon) date.
7. We will likely arm our public safety officers with either baton, spray, or Taser, still to be determined.
8. Panic buttons throughout the EDs.

This missive is from our CIO, who oversees security, about global safety changes throughout the Harrington system.

### **Good Afternoon. Below are further updates on security projects and initiatives:**

#### **System-wide Activities**

- Reverse 911 System – The system is currently live with the contact information housed in your HR record. HR has sent out a survey to update your personnel info. Please make sure to complete this survey to ensure you receive communications. We are preparing to send out test messages in the near future.
- Security Assessments – We have commenced the project with the vendor which will take approximately 4-6 weeks. We had completed an assessment of the SB ER immediately after the incident and will be reviewing with the ER security workgroup.
- M.O.A.B Training – We will be sending 4 staff members to Management of Aggressive Behavior (MOAB) instructor training. Once instructors, they will provide training to employees on an ongoing basis. MOAB will augment Dr. Armstrong training and focus more on defensive tactics rather than de-escalation.

- Card Access/Building Security – We have awarded the card access installation to a vendor. Work will commence in the next 1-2 weeks. As part of the project, all employees will receive new badges which will be used to “swipe” into secured doors which will include most exterior doors across both campuses. Further communications will be provided once the project is underway.
- Meditech Violence History Indicator – IT has created an indicator that flags patients who may have had a security incident in the past. It is our intent to enhance this functionality and use it more comprehensively throughout the system. IT will contact you on a departmental basis as we add this functionality to your status boards, trackers etc.

#### **Southbridge Campus**

- We continue to search/wand patients and visitors entering through the ECC. A walk-through metal detector has been installed. The ECC vestibule area is being re-designed to house both security and registration.
- The current registration area is being re-designed/re-constructed with the intent of moving triage back to that area.
- Patients continue to be limited to 1 visitor and re-entry is discouraged. There may be exceptions, but this is at the discretion of the charge nurse.
- We have designed a plan to secure the back ER hallway and radiology hallways. This will involve the installation and re-configuration of hallway doors and addition of card access. You will see activity in these areas in the upcoming weeks once materials are received.

- Panic Buttons – Panic buttons have been installed in the SB ECC. Further installations will occur throughout the facility on a floor-by-floor basis, starting with the 1st floor.
- We continue to have a police detail which is based in the ER.

#### **Webster Campus**

- We continue to search/wand patients and visitors entering the ECC. A walk-through detector has been ordered and is due to arrive today. We will install once a location is identified.
- Patients continue to be limited to 1 visitor and re-entry is discouraged. There may be exceptions, but this is at the discretion of the charge nurse.
- Campus perimeter security – We have assessed the exterior perimeter and will include certain doors in the card-access project.
- Panic Buttons – We will be installing panic buttons throughout the campus.
- Police detail is still in place