

Virginia State Crime Commission

Hospital Violence

2009

HOSPITAL VIOLENCE

Senate Joint Resolution 358, introduced by Senator Kenneth W. Stolle during the 2009 Regular Session of the General Assembly, directed the Crime Commission to study issues of public safety in hospital emergency rooms. Specifically, it was resolved that the Crime Commission be directed to:

- Research public safety issues that exist in hospital emergency rooms, including the occurrence of violent incidents in hospital emergency rooms across the Commonwealth;
- Compile strategies that can be used by hospitals to prevent or deal with violent incidents; and,
- Identify the most effective methods of preventing emergency room violence and of dealing with violent incidents when they occur.

Also incorporated into this study was House Bill 2436, referred to the Crime Commission by the House Courts of Justice Committee. This bill was introduced during the 2009 Regular Session of the General Assembly by Delegate Christopher K. Peace to address violence occurring in hospital emergency departments across the Commonwealth. Specifically, this bill sought to amend and reenact section C of § 18.2-57, the so called “protected class” in the assault and battery statute, by adding emergency room personnel defined as physicians, physicians’ assistants, nurses, or nurse practitioners while engaged in the performance of his duties as an emergency health care provider in an emergency room of a hospital or clinic or on the premises of any other facility rendering emergency medical care.

The Crime Commission utilized several methodologies to address the directives of the mandate regarding emergency department (ED) violence, including: completing a literature and legislative review; creating a workgroup of medical and academic practitioners; attending emergency department security awareness training; identifying available data; and, conducting field observations.

There was very little literature available concerning ED violence and the studies that were

available typically suffered from limitation that prevented the application of their findings to EDs in general. For example, a very recent, nationwide study was published, which surveyed ED nurses. The study was based on 3,518 responses, representing 65 EDs. One of the findings noted that there was a median of eleven violent attacks per year (for the five year reporting period) per site. The authors caution that most of the survey respondents worked in large “academic settings.” Likewise, a later article also cautioned that most of the survey respondents came from EDs located in the northeastern United States and in “urban settings, which may be associated with higher incidence of violence,” so the findings may not be generalizable to all EDs.

Finally, to compound the aforementioned issues is the limited scope of available data. One study noted that “(t)he true incidence of violence in U.S. EDs is not known because there are no reporting requirements, much of the research involves retrospective surveys, and there are no standards or definitions of workplace violence.”

While there is no way to concretely ascertain the level or amount of violence directed at ED staff, some studies suggest reasons for violent behavior in EDs. It is thought that ED employees are subject to an increased risk for violent behavior due to exposure to:

- Patients under the influence of drugs and/or alcohol;
- Patients with psychiatric disorders;
- Prolonged waiting periods and overcrowding;
- Open, 24-7 access to EDs;
- Stress on patients’ families; and,
- Criminal and street gang activity, victims, and affiliates.

In order to cope with violence in EDs, there are some steps that hospitals can make that may minimize violent behavior. Increased police and/or security presence, environmental barriers and metal detectors are cited by ED employees as a way to reduce violence. A recent article outlined “five starting points toward a safer ED;” based on recommendations from hospital security directors and other experts:

- Access Control
- Staff ID badges

- Metal Detectors
- Surveillance
- Emergency Alerts

There has been some legislative activity addressing hospital violence in the last few years by a few states: California, Washington, Oregon, and New Jersey. Unfortunately, as with the literature review, there are practically no known published comprehensive reviews available that detail the results of any of the legislation in reducing violent behavior directed at ED staff. Another way in which states may address ED violence is to increase the penalty of assault, much like the proposal in HB 2436, introduced during the 2009 Regular Session of the Virginia General Assembly. Recently, Oklahoma passed a bill that increased the penalty from a misdemeanor to a felony for an assault upon “doctors, residents, interns, nurses, nurses' aides, ambulance attendants and operators, paramedics, emergency medical technicians, and members of a hospital security force.” This measure passed by the Oklahoma legislature with an emergency clause, making it effective immediately after “passage and approval.”

Staff also did a 50 state survey of assault and battery statutes and determined that a little over half (26) of the states provide an enhanced or increased punishment for assaults directed at ED staff.

In order for the Crime Commission to better understand ED violence, staff invited medical and academic practitioners who were familiar with ED violence to participate in our ED violence workgroup. The following is a summary of the important issues discussed at the workgroup meeting:

- Many assaults go unreported.
- Local law enforcement data will not be specific enough to determine if the assaults occurred in the ED.
- Security varies from hospital to hospital, from full time, deputized officers to a few private security officers.
- A significant percentage of the violent or assaultive behavior is caused by patients with mental disorders or patients with drug or alcohol addictions.
- There is a reluctance to press charges against patients with mental disorders, as well as difficulties prosecuting them.

- Security training available to ED staff varies from hospital to hospital.
- Strategies to prevent or deal with violent incidents vary by hospital.

Additionally, staff conducted field visits to two local hospitals. During ED visits, staff formally met with police and security personnel to discuss their roles, activities, and difficulties as well as proactive measures undertaken to promote ED safety. These visits helped to provide an understanding of ED operations, allowed staff to observe the environment in EDs and the attached waiting rooms, identify potential data sources and their limitations, and to confirm information gathered from the workgroup and the literature review.

CONCLUSION

The most significant problem encountered with the study is the lack of reliable data concerning the prevalence of violent incidents in EDs in the Commonwealth, as well as nationally. Likewise, there are very few reports that address preventative measures that EDs can take to reduce violence. While there is some data available from U.S. Department of Labor, Virginia State Police, and local law enforcement departments, this data does not possess the requisite precision to determine if the violent acts occurred in hospital EDs, doctor's offices, or outpatient clinics or if the incidents were even related to violent acts against ED personnel. Subsequently, there is no way to determine how much of a problem violent incidents are in EDs throughout in the Commonwealth. Given the lack of available data, it is difficult to make informed legislative or policy decisions regarding ED violence in the Commonwealth.

Unless there is some change in the way violent acts are reported, internally and externally, there is no way to get an accurate picture of the pervasiveness or infrequency of violent acts in EDs. As a result of the data limitations identified during this study, no formal recommendations were made by the Crime Commission. For a complete report of this study, please refer to Senate Document 8 (2010).