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CAEP position statement on violence mitigation

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Introduction

In 2021 the Canadian Association of Emergency Physicians (CAEP) published its first position statement on violence in the emergency department (ED) [1].

In it, CAEP called for an end to the culture of silence that exists around the reporting of violence. We sought a greater commitment to and accountability for the provision of a safe work environment for ED personnel and patients. We also called for the development of a pan-Canadian strategy to support the adoption of best practices.

Five years later, there is little evidence of substantial change, and data suggest the frequency and severity of violence in EDs has actually increased [2,3]. While some EDs in Canada have proactively implemented violence mitigation strategies, more often than not they are introduced after violent incidents have already occurred [4-6].

It is time for a renewed effort to reduce the incidence and severity of violence in EDs in Canada.

In this revised position paper, we describe mitigation strategies being used to prevent workplace violence and comment on the evidence behind each (where available). Our goal is to stimulate discussion and consideration among staff and leaders at all EDs in Canada.

Given the geographic and demographic diversity of EDs and patient populations across Canada, each hospital will have to consider its unique risks and available resources when developing a practical strategy. Though each hospital's strategy will be unique, it is imperative for every hospital in Canada to have one.

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Definition of workplace violence

Workplace violence tends to be defined as a person being physically or verbally abused, threatened, intimidated, harassed, or assaulted in their work setting. CAEP agrees with recent efforts to expand this definition to also recognize sexual, psychological, and emotional violence. [7].

Four types of workplace violence have been described [8]:

- Type I involves a perpetrator with no association with the workplace or its employees who commits a violent act with criminal intent.
- Type II involves a client or patient in the workplace (or someone accompanying them) who commits an assault while under care. This is the most common scenario in health care violence.
- Type III involves a current or former employee of the institution who assaults someone in the workplace.
- Type IV involves a perpetrator who has a personal relationship with an employee but not with the workplace (e.g., cases of intimate partner violence). Given the high proportion of women in nursing and increasingly in emergency medicine and given the fact that most instances of intimate partner violence are perpetrated against women, this scenario is of particular concern to CAEP.

CAEP recognizes that a substantial amount of reported violence may be beyond the perpetrator's immediate ability to control (e.g., as a result of conditions such as delirium, intoxication, substance abuse, or psychosis) and that their behaviour often signals a need for treatment rather than legal punishment. This, however, in no way diminishes the need for and responsibility of hospitals to prevent harms resulting from such behaviours. We would like to acknowledge as well that overcrowding contributes to the triggering of aggressive behaviours, due to long waits, encroachment on personal space in waiting and care areas, loss of privacy and confidentiality and even through its negative effects on ED staff who may become less patient and empathetic. Many of our patients have experienced personal traumas at the hands of institutions or authority figures and may also be triggered by the loss of control experienced in a very rules based ED encounter; a trauma informed approach should be embedded in all of our encounters

This position paper does not discuss either commonly encountered Code White (violent person) or extremely rare Code Silver (person with a weapon) scenarios; standardized procedures have been established to respond to Code White situations, and these are routinely practised. This paper also does not discuss how to respond to workplace violence after it has occurred. Rather, we present a broad overview of approaches that may lessen or prevent the commission of violent acts in EDs in Canada.

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Scope of the problem

A 2025 survey conducted for the Canadian Federation of Nurses Unions revealed that 59% of respondents had experienced some type of violence or abuse related to their job [9]. The most common types of violence reported were verbal and physical violence from patients and patients' families. Nearly one in five respondents reported experiencing sexual violence from patients or patients' families in the previous year.

Tools and strategies to consider

Numerous well-defined strategies have been used to address workplace violence in health care settings. However, there is no one-size-fits-all solution and a multimodal approach is required to optimize staff and patient safety [10,11].

Here we provide suggestions for mitigating violence in EDs in Canada that are consistent with the spirit of the federal government's 2019 report, *Violence Facing Health Care Workers in Canada*, which called for a pan-Canadian approach based on identified best practices [12].

In most cases there is little scientific evidence of efficacy, but this cannot be an excuse for inaction. A common-sense approach is needed and, as in clinical practice, we must proceed with the best evidence available. Some measures raise ethical concerns with respect to patient confidentiality and duty of care, which must be considered carefully at all times.

ED design

ED design tends to focus on optimizing patient flow and maximizing clinical efficiency [13]. Yet in EDs being designed, built, expanded, or retrofitted, there is a golden opportunity to make appropriate modifications to maximize staff and patient safety [14-16], including the following considerations.

Parking areas should be well-lit and actively monitored. Patient registration should be welcoming but prevent the ability of a patient or visitor to physically assault clerks. Waiting rooms should be comfortable and provide reasonable amenities to lessen patient anxiety and tension. There should be clear sight lines throughout these spaces.
Registration and triage should be secure areas with an opportunity for rapid egress should the situation demand it. Similarly, treatment areas should be accessible via controlled access door locks, provide good lighting, and have clear sight lines. Treatment areas should also have enclosed workspaces, secured furniture and equipment, and a clear path for egress should a violent attack seem imminent.

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Behavioural assessment rooms or units

Behavioural assessment rooms or units have been designed in recognition of the increasing proportion of patients presenting to EDs with acute psychosocial crises, psychiatric conditions, or substance use issues that can result in aggression or violence.

The rooms provide safe, low-stimulus environments for assessing and managing agitated patients. They allow close observation while prioritizing safety, privacy, and dignity for patients and staff. These rooms have been shown to reduce time in the ED and the need for patient restraint [17,18].

Even in small EDs, opportunities may exist to retrofit design elements to enhance flexibility and functionality, such as the use of roll-down shutters to hide equipment that could be weaponized or prompt conflict (e.g., oxygen tanks, syringes, tubing) [19,20].

Safe nurse-to-patient staffing ratios

The original CAEP position paper on workplace violence called for enhanced nurse staffing to improve the patient experience, promote safety, and lessen the likelihood of patient frustration [1]. This recommendation is consistent with all other major international emergency physician and nursing organizations. However, given the lack of definition and achievement of ideal staffing ratios, it is difficult to find hard evidence that supports this recommendation.

Nevertheless, we were heartened to note the Government of British Columbia's introduction of minimum nurse-to-patient ratios for its EDs in September 2024 [21]. They suggest a nurse-to-patient ratio of 1:3 for general acute care, 1:1 for critical and trauma care, and 1:4 for short stay or observation. They also made staffing recommendations for triage and for small-volume EDs.

British Columbia's leadership in this area shows that it is feasible to implement such strategies, and we strongly encourage other provinces and territories to follow its lead.

De-escalation training

De-escalation training is a method of violence prevention commonly promoted in EDs. It teaches clinical staff how to recognize and respond to signs of potential aggression and how to avoid or reduce the intensity of conflicts.

De-escalation emphasizes trauma-informed care and approaching the patient in a calm, comforting manner [22]. The goals are to give the potential aggressor agency over their actions, lessen the power differential so often evident in clinician–patient interactions, and provide the patient clear options for ongoing management.

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Evidence has shown that de-escalation training improves the confidence of clinicians in approaching and managing patients with the potential for violent behaviour. There are, however, mixed reviews about the longevity of such confidence and whether it actually reduces the ultimate need for patient restraint methods [23-27].

Prediction tools

The implementation of violence risk assessment tools at triage gives nursing staff the opportunity to identify patient behaviours or other factors that indicate a higher risk for aggression and violence.

Nursing experts have developed a number of violence prediction tools that seem to be helpful when used. For example:

- STAMP is a violence risk assessment tool that evaluates five behavioural indicators of potential violence: staring, tone of voice, anxiety, mumbling, and pacing [28-29].
- The Aggressive Behaviour Risk Assessment Tool for EDs (ABRAT-ED) is a simple checklist with high sensitivity and specificity for identifying potentially violent patients in the ED [30]. It consists of 10 indicators of violent behaviour among hospitalized patients (e.g., aggressive or threatening behaviour, agitation, confusion, staring).
- The Workplace Violence Risk Assessment tool, similar to ABRAT-ED, is an 11-item scale that assigns four risk levels, from low risk to very high risk.

There are no studies to suggest superiority of one scale over another. The important thing to note is that when a risk score identifies potentially violent behaviour, mitigating strategies need to be put into action.

Flagging or signage

Once an aggressive or potentially violent patient has been identified, some hospitals use “flagging” to provide a visual clue to staff of potential danger [31,32].

Flagging can be done in a patient’s electronic medical record, on the paper chart, or through the posting of signage (such as a bold exclamation mark) at the patient’s bedside or using colour-coded wristbands. These alert staff to manage patients at high risk for violence with appropriate precautions (e.g., safety protocols and behaviour care plans).

There are conflicting reports about the efficacy of flagging strategies, with some indicating a significant decline in violent incidents after implementation and others showing a return to baseline levels after implementation.

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Another promising strategy is identifying high risk individuals who have been flagged and referring them to a social worker or committee who can consider developing an individualized care plan so that staff can be informed of patient specific information and strategies.

Body cameras:

Body-worn cameras are being used with increasing frequency in law enforcement, and there has been some interest in using them in health care settings.

It has been suggested that nurses believe the cameras provide support when they are confronted by abusive or aggressive patients or family members, and in some instances their use can help defuse potentially violent situations.

However, there are potential ethical concerns with respect to privacy and the secure storage of recordings, and with insufficient evidence of their efficacy we cannot comment on their usefulness at this time [33-36].

Wireless communication systems

These systems involve users wearing wireless badges that allow hands-free, real-time direct communication with other health care workers. It comes in a variety of formats but a common feature to all—the panic alarm—is appealing from a workplace violence prevention perspective [37].

News articles indicate these communication tools are being considered or implemented in various health care systems in Canada [38-39]. However, few if any studies have examined their effectiveness in preventing workplace violence in health care settings.

We identified only one published study on the experience of a hospital in Upstate New York, in which the authors concluded the system seemed to improve response times to incidents [40].

Weapons detection systems

Weapons detection systems range from basic metal detectors to more sophisticated technology such as artificial intelligence used to distinguish harmless items from dangerous ones. Interest in these systems in Canada appears to be growing in response to serious acts of violence reported in EDs [41-47].

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Weapons detection systems also raise a variety of concerns: negative public perception, privacy issues, costs, and increased staffing requirements, as well as challenges related to having multiple hospital entrance points and queuing for screening [48,49].

The systems are largely effective in detecting weapons, but careful consideration of local risks and effectiveness in a rapidly evolving field are required before committing to implementation.

Security personnel

In our 2021 position statement [1] we called for a visible security presence where feasible. The Royal College of Emergency Medicine (United Kingdom), the Australasian College of Emergency Medicine, and the American College of Emergency Physicians have made similar recommendations [50-52]. However, there is a paucity of literature on the role of security personnel in the ED setting. There is, nevertheless, a sense from ED personnel that they value having security staff readily available [53]. Overall morale and retention are enhanced if staff feel the hospital is committed to a safe work environment.

It is our view that security staff must be trained in non-violent de-escalation techniques. Though these individuals must be readily identifiable as security staff, efforts must be made to choose uniforms or styles of dress that are less triggering to those with prior history of trauma at the hands of authority.
In contrast to views about security personnel, there is a high degree of concern over the permanent presence of armed law enforcement officers in EDs. This is not a usual practice, although it has been trialled in EDs in Canada [54]. Potential issues to consider include compromised patient privacy and confidentiality, heightened tensions in patients and their family members, and decreased patient trust in clinicians. There are also serious concerns with respect to racial bias in how police officers interact with patients in EDs, and many patient groups may find a police presence triggering. [55,56].

Conclusion

Workplace violence in EDs in Canada is a major concern that negatively affects both the resilience of the workforce and the delivery of care.

Echoing the main principles presented in CAEP's original position statement, we present four overarching principles that are essential to fulfilling our dual responsibilities to patients and staff:

1. It must be recognized that many acts of aggression or violence in the ED reflect an underlying medical issue affecting the perpetrator (e.g., delirium, substance use, psychosis). These patients require care, not criminal sanctions, while protecting staff.
2. Emergency staff must be allowed to feel safe from harm.

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3. Hospitals and regional/provincial health authorities must be more accountable in ensuring maximal efforts are made to protect both patients and staff.
4. The unacceptable institutional culture of silence/minimization that surrounds violence in the health care setting must end.

Of the measures we have described, the following are essential for all EDs in Canada:

1. Design considerations in the physical space of EDs must emphasize the safety of both patients and staff.
2. The use of violence risk assessment tools should be mandated in all EDs in Canada.
3. De-escalation training should be mandated for all ED staff.

As well, given the increasing incidence and severity of violence in EDs in Canada, having a visible security presence in each department requires greater consideration. The use of panic alarms (wireless communications systems) should be strongly considered.

In terms of the tools and strategies presented in this statement, it is clear there is not a one-size-fits-all solution to violence in EDs in Canada. Patient demographic characteristics and cost-benefit analyses must factor into which mitigation strategies are chosen in a given setting; however, costs cannot justify any lack of effort (perceived or real) to protect staff.

We hope this updated position statement re-emphasizes the importance of workplace safety and gives individual EDs useful information they can use to advance their efforts.

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