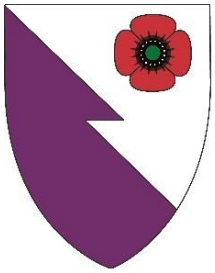
The Royal College of Emergency Medicine

Best Practice Guideline

Guideline for information sharing to reduce community violence



Revised:
September 2017

Summary of recommendations

1. Emergency departments should routinely collect, electronically wherever possible, data about assault victims at registration. Receptionists should collect the **date and time** of the assault, the **location** (name of pub, club, school, street etc) of the assault in free text and which **weapon** (fist, foot and so on was used.)

2. There is no need for a formal information sharing agreement between the Emergency department and the Community Safety Partnership (CSP).

3. This data should be shared with the local CSP and crime analysts in an anonymous and aggregate form.

4. Senior emergency physicians should be supported to participate in CSP meetings.

Scope

This guideline is to assist Emergency Physicians sharing data with Community Safety Partnerships (formerly known as Crime and Disorder Reduction Partnerships in England) to reduce community violence.

Reason for development

This guideline has been prepared to help implement Best Practice.

Introduction

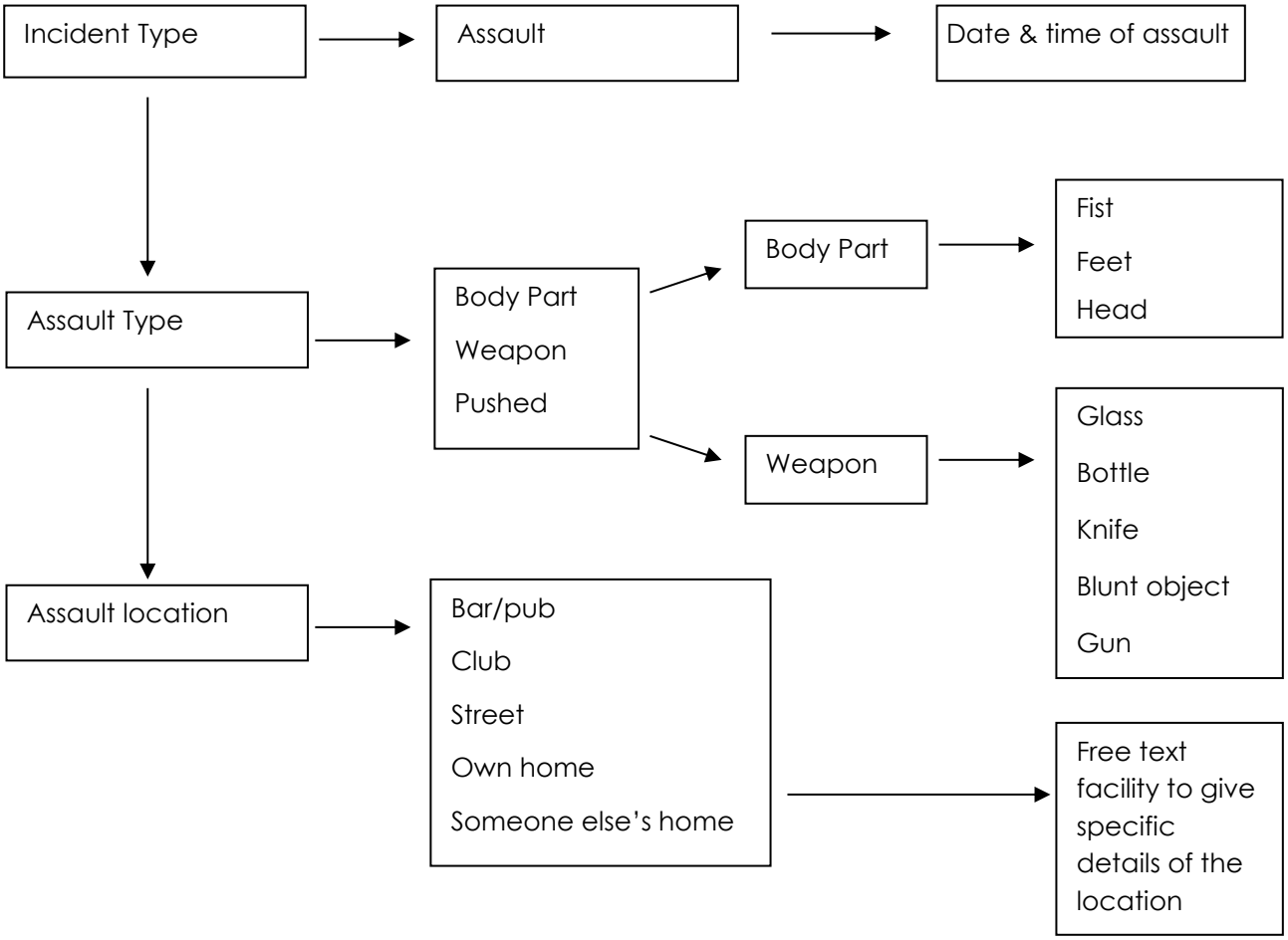
Around 80% of assault victims requiring emergency department treatment do not report their assault to the police. [1] [2] Work from Cardiff and the South East of England has shown that data collection by emergency department receptionists that is shared with Community Safety Partnerships (CSPs) is very effective in reducing the number of assaults requiring emergency department treatment. [3] At best, this can lead to 30% reductions in the number of attendances for assault. Anonymous data needs to be shared monthly with local crime analysts. This informs targeted policing of 'problem premises' and violence hotspots. An example of the data format is shown below.

Receptionists are the best people to collect this data at registration. Only three additional items are required. These are shown in the figure below. The data should be shared monthly with the crime analysts. There is no need for a formal information sharing agreement as the data is anonymous. In England, emergency departments are expected to ensure they collect and share this data through the Information Sharing to Tackle Violence program (ISTV).

The effectiveness of this information sharing process is considerably enhanced if a senior emergency physician from the emergency department attends the CSP meetings.

This guidance does not replace the responsibilities of emergency physicians to promptly inform the police in cases of firearms and stabbings. The GMC guidance on reporting intentional injuries in the public interest should be followed. Technical information can be found here.

Data items to be collected by ED receptionists



References

1. Sutherland I, Sivarajasingham V, Shepherd J. Recording of community violence by medical and police services. Injury Prevention 2002; 8:246-247.

2. Faergemann C, Lauritsen JM, Brink O, Stovring H. The epidemiology of repeat contacts with an Emergency Department or an Institute of Forensic Medicine due to violent victimization in a Danish urban population. Journal of Forensic and Legal Medicine 2007; 14(6):333-339.

3. Warburton AL, Shepherd JP. Development, utilisation, and importance of accident and emergency department derived assault data in violence management. Emerg Med J 2004; 21(4):473-477.

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Review

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Review

The Clinical Effectiveness Committee approved this guideline in 2009. It has been revised and updated by the Best Practice Committee on behalf of the Quality in Emergency Care Committee and in May 2010, August 2011and September 2017.

It will be reviewed in September 2020 or sooner if important evidence becomes available.

Disclaimers

The Royal College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None identified.

Audit standards

Completeness of location recording should be 70% of assault cases.

Key words for search

Violence, assault, information sharing.

Appendix 1

Methodology
Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels
1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

Appendix 2

Specimen data output

Arrival Date	Arrival Time	Incident Location	Incident Date	Incident Time	Weapon
01/03/2017	04:34	WHITE HORSE	01-Mar-09	05:04	Knife
01/03/2017	11:44	WHITE HORSE	01-Mar-09	15:00	Gun
02/03/2017	05:27	WHITE HORSE	02-Mar-09	08:12	Bottle
02/03/2017	13:18	REGENT STREET	02-Mar-09	17:05	Fist
02/03/2017	14:35	OXYGEN NIGHTCLUB	02-Mar-09	17:09	Feet
02/03/2017	18:11	RED LION PUB	02-Mar-09	19:06	Club
03/03/2017	19:26	OUTSIDE OXYGEN NIGHTCLUB	03-Feb-09	23:09	Fist
03/03/2017	21:55	REGENT STREET	03-Mar-09	22:45	Fist
05/03/2017	05:18	HOME	05-Mar-09	08:18	Axe

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