



# The College of Emergency Medicine

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## CLINICAL EFFECTIVENESS COMMITTEE GUIDELINE FOR INFORMATION SHARING TO REDUCE COMMUNITY VIOLENCE

### 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 agreements between the Emergency department and the CDRP.
3. This data should be shared with the local CDRP and crime analysts in an anonymous and aggregate form.
4. Senior emergency physicians should be supported to participate in CDRP meetings.

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## Scope

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

## Reason for development

This guideline has been prepared to help implement Best Practice.

## Introduction

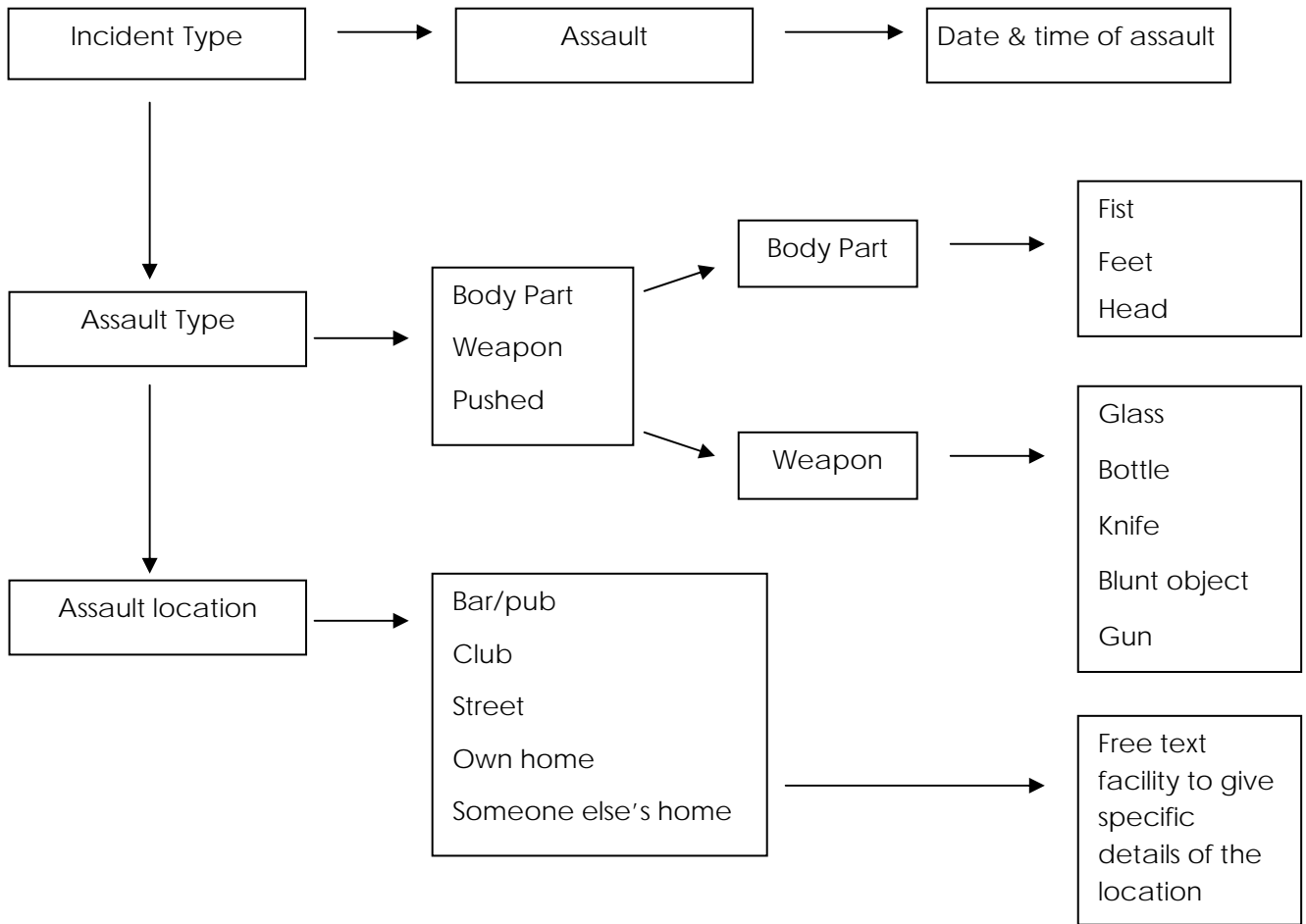
Around 80% of assault victims requiring emergency department treatment do not report their assault to the police. <sup>1 2</sup> Work from Cardiff and the South East of England has shown that data collection by emergency department receptionists that is shared with Crime and Disorder Reduction Partnerships (CDRPs) is very effective in reducing the number of assaults requiring emergency department treatment. <sup>3</sup> (Level 3 evidence) 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.

The effectiveness of this information sharing process is considerably enhanced if a senior emergency physician from the emergency department attends the CDRP 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 [gunshot wounds](#) and [knife wounds](#) should be followed.

**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**

The Clinical Effectiveness Committee approved this guideline in 2009. It will be reviewed in September 2012 or sooner if important evidence becomes available.

**Disclaimers**

The 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
01/03/2009	04:34	WHITE HORSE	01-Mar-09	05:04	Knife
01/03/2009	11:44	WHITE HORSE	01-Mar-09	15:00	Gun
02/03/2009	05:27	WHITE HORSE	02-Mar-09	08:12	Bottle
02/03/2009	13:18	REGENT STREET	02-Mar-09	17:05	Fist
02/03/2009	14:35	OXYGEN NIGHTCLUB	02-Mar-09	17:09	Feet
02/03/2009	18:11	RED LION PUB	02-Mar-09	19:06	Club
03/03/2009	19:26	OUTSIDE OXYGEN NIGHTCLUB	03-Feb-09	23:09	Fist
03/03/2009	21:55	REGENT STREET	03-Mar-09	22:45	Fist
05/03/2009	05:18	HOME	05-Mar-09	08:18	Axe