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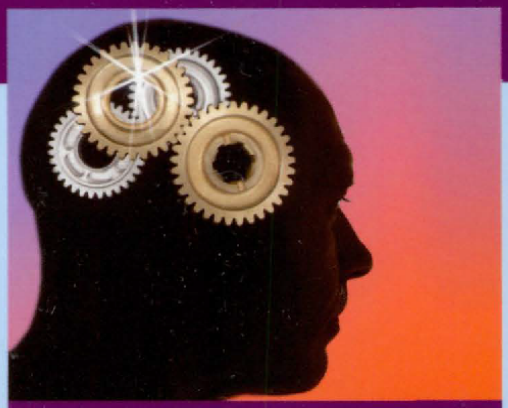

Upgrading Healthcare Security: Preparing For A More Productive Future

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Needed: reliable information on violent incidents and crime in healthcare facilities

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This article, written by the authors of the 2010 IAHSS Crime and Security Trends Survey, reviews recent studies by regulatory organizations and government agencies on healthcare violence. It reports on the legal, public relations, and emotional impact such violence has on he healthcare community, and explains why statistics on healthcare violence and crime may be under-reported.

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Hospitals and healthcare patients, staff and visitors face a significant increase in crimes and violent aggression according to a Sentinel Event Alert from the Joint Commission (June, 2010). While crimes and acts of violence take place every day in every walk of life, the public is often shocked and outraged when crimes occur on hospital campuses and in healthcare facilities, the very institutions that are considered to be shelters of safety, healing and respite care. Moreover, media coverage of violent incidents has heightened both the public's and healthcare facilities' underlying sense of insecurity. The media spotlight, in turn, draws the attention of regulatory agencies including the Joint Commission and the Centers for Medicare/Medicaid Services. These agencies often scrutinize the actions of the healthcare facilities to ensure compliance with regulations. In the aftermath of violent or criminal

incidents, healthcare providers are confronted by a public who wants answers: How could this have happened? How can it be prevented? Could it happen to me?

CRIMES SERIOUSLY UNDER-REPORTED

Healthcare providers, hospital administrators, and public relations officers often have difficulty in answering questions about safety and security in the face of a serious incident. To complicate matters further, the availability of statistics on healthcare facility crime is limited. Experts (Bureau of Labor Statistics, Department of Justice, 2006; Joint Commission, 2010; National Institute of Occupational Safety and Health, 2003) suggest that the types and numbers of crimes that do occur are seriously under-reported. There are a number of reasons for this, but perhaps the primary reason for lack of information is that even minor crimes can give a healthcare organization a poor public image. Hospital administrators fear that a poor public image in the highly competitive contest for patients will result in fewer patients and negatively impact the overall fiduciary success of hospitals. But in the absence of reliable comparative information about crimes, it is difficult for hospitals/healthcare facility administrators to gauge the extent to which their particular hospital or facility is safer or less safe and secure than competing organizations. In addition, some healthcare facilities' policies may limit the efficacy of identification or allocation of security resources that will improve public safety and security and prevent crimes.

THE OPEN ACCESS DILEMMA

Healthcare facilities, particularly large, public hospitals, face serious security issues; they are often spread over large areas with open access to those who need services. Maintaining an open access, however, presents a security dilemma: How to maintain a safe environment for patients, visitors and staff while minimizing or preventing entry of those who provide a security risk. Cases of homicide or child/infant abductions are relatively rare events and the focus of media attention, but they are often due to open healthcare facility access. A recent attempted infant abduction at a large, highly ranked

Southeastern hospital (Campus Safety Magazine, 2010) provides an example of the precariousness nature of open hospital access. When hospital staff recognized an unauthorized woman in the nursery attempting to abduct an infant, hospital security arrested the woman.

THE MONETORY COST OF VIOLENT CRIME

Violent crimes can result in severe monetary loss to hospitals. In March, 2010, an Allentown, Pennsylvania jury awarded families of eight victims of a nurse accused of murder $95 million dollars in punitive damages (www.wfmz .com, 2009). The Hospital Security Reporter (2009) noted that 2009 was the 'year of security driven lawsuits'. The the article stated that assistance was provided to hospital security departments in fifteen lawsuits where significant awards were made to victims of violent sexual and other assaults. In addition, the article stated that advice and support was provided in a number of cases that included claims of child molestation, infant abductions and homicide. When a complaint is made or a lawsuit is filed, according to Carter, the security department is immediately subjected to scrutiny through internal and external review by organizations such as the Joint Commission and/or the Centers for Medicare/Medicaid Services.

THE INCREASE IN PHYSICAL ATTACKS AGAINST HEALTH WORKERS

An increasing a matter of concern is violent attacks in hospitals against staff, patients, or visitors (National Institute of Occupational Safety and Health [NIOSH], 2003; Slenko, 2006). At the present time, there is no national or international reporting system whereby healthcare providers are required to report crime and violent incidents. The actual number of occurrences is not known, although it is considered to be extensive. Studies and information collected by government agencies have also shown that healthcare workers are at higher risk of violent assault and homicide in the workplace than all other occupations except fire and police protective industries. The Bureau of Labor Statistics (BLS, 2009) reported 16 homicides in

hospitals and healthcare settings in 2008. Eleven of the healthcare related homicides were by shooting. In comparison, 41 police officers were killed in 2008 (US Department of Justice, FBI Uniform Crime Index, 2009). The BLS also reported a total of 69 homicides in healthcare facilities from 1996–2000.

Although workplace homicides may attract more media attention, the vast majority of workplace violence consists of non-fatal assaults. The Bureau of Labor Statistics' data show that in 2008, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in healthcare settings. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury. In 2008, the rate of injuries by violent assault of 11.9 per 1000 in hospitals and 12.5 among nurses compared to 14.8 for firemen and 14.5 for police officers (Bureau of Labor Statistics, 2009).

The Department of Justice's National Crime Victimization Survey for 1993 to 1999 lists average annual rates of non-fatal violent crime by occupation. The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69. Both sources, the Bureau of Labor Statistics and the Department of Justice, reveal similar high risks for healthcare workers. As significant as these numbers are, the actual occurrence of incidents is probably much higher. Under-reporting criminal violence may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

Emergency Department Violence

A number of studies (Fernandes, C., Bouthillette, F., Raboud, J., Bullock, L., Moore, C., Christenson, J., Grafstein, E., Rae, S., Ouellet, L., Gillrie, C. & Way, M.; Gacki-Smith, Juarez, Boyett, Homeyer, Robinson, and MacLean, 2010; Kennedy, 2005; McPhaul & Lipscomb, 2004) have been conducted on workplace violence in Emergency Departments. Fernandes, et al.,

(1999) studied an Emergency Department in a Canadian hospital and its one-hundred sixty three employees using a retrospective survey. Seventy percent of ED employees reported an increased frequency and severity of assaults. Nearly sixty percent of employees had personally been attacked.

Gacki-Smith, et al. (2010) reported that one-quarter of the 811 nurses in their study reported experiencing physical abuse more than 20 times in the past three years and nearly twenty percent said that they had been verbally abused more than two hundred times during the same period. Those who experienced physical violence were predominantly females working the night and weekend shifts. A reduced risk of violence in Emergency Departments was associated with policies for reporting violent incidents and having a hospital administration committed to elimination of workplace violence against staff in the Emergency Department.

In a review of the literature on workplace violence in Australia, Kennedy (2005) also found increasing violence in healthcare. In particular, Kennedy discussed findings from two Australian studies that found over sixty percent of nurses in hospitals and other healthcare settings had experienced violence and aggression. Kennedy stated that violence was 'nearly universal' in Emergency Departments with almost ninety percent of nurses reporting physical intimidation or assault and one hundred percent experiencing verbal abuse.

McPhaul and Lipscomb (2004) found that the majority of threats and assaults to nurses in Emergency Departments came from patients or families of patients. Nurses described frustration at being largely unable to prevent violent incidents from occurring. Lavioe, Carter, Danzi, and Berg (2009) surveyed the Directors of 170 public teaching hospital Emergency Departments. One hundred twenty-seven hospitals (75%) participated in the study. Forty-one hospitals (one-third) reported at least one verbal assault per day and at least one threat that involved the use of a weapon each month in Emergency Departments. Ninety-eight percent of Emergency Departments reported the use of physical restraint in unruly patients. Of significant interest to security professionals was the finding that

only 40 percent of emergency department personnel had any formal training in recognition and management of violence and aggression.

Why Healthcare Workers Face Increasing Risks

According to the Department of Justice (2009), the reasons that healthcare workers face an increased risk of work-related assaults stem from several factors. These include:

- The prevalence of handguns and other weapons among patients, their families or friends;
- Increasing use of hospitals by police and the criminal justice system for treatment of prisoners and the care of acutely disturbed, violent forensic patients;
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others);
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets;
- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly;
- The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members;
- Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients;
- Isolated work with clients during examinations or treatment;
- Working alone, often in remote locations, with no security backup or ways to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings);
- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior; and,
- Poorly lit entry ways and parking areas.

THE NEED FOR RELIABLE INFORMATION

It is clear that there is a need for reliable information on violent

incidents and crime. There are approximately 30,000 hospitals and healthcare facilities in the United States and Canada (American Association of Hospitals, 2009; Canadian Department of Health Statistics, 2009). Yet, as previously noted, there is little empirical information available on the extent to which crime occurs in these facilities or the types, numbers and locations in which criminal incidents occur.

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