journal of healthcare
PROTECTION management
Volume 35, Number 2

Lessons Learned from Coping with Crises

Publication of the International Association for Healthcare Security & Safety

Leading Excellence in Healthcare Security, Safety and Emergency Management

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ON THE COVER: A car that was loaded with explosives and driven into the Emergency Department of Middlesex Hospital, in Connecticut, awaits removal. (Credit: John Woike/Hartford Courant via AP)

JOURNAL OF HEALTHCARE PROTECTION MANAGEMENT

Editor: Ricki Rusting

The Journal of Healthcare Protection Management, a publication of the International Association for Healthcare Security & Safety (IAHSS), is published two times a year—in Winter and Summer. A copy of each issue is distributed free to current paid-up members of IAHSS.

Digital copies of recent issues can be accessed by members in the Member Resources section of the IAHSS website.

The Journal has been selected for citation by the National Library of Medicine's Health Planning and Administration database, which is available online to more than 2,000 organizations in the United States, as well as to many users outside of the United States.

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We welcome proposals and manuscripts for the forthcoming Winter 2020 issue (Volume 36, Number 1) of the Journal of Healthcare Protection Management. The issues that have been published to date have won considerable acclaim in the industry for their contributions to the fields of healthcare security and safety. Subscribers include the membership of IAHSS as well as health facilities and libraries in a number of foreign countries.

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You do not have to be a member of IAHSS to author an article in the journal. Nor do you have to be a professional writer. A straightforward account of how you, your department, or your healthcare institution has successfully carried out a program relating to the subject areas listed above or to other subjects will be welcome. The deadline for articles intended for the Winter 2020 issue is October 15, 2019. Black-and-white, camera-ready illustrative material (such as charts, tables, graphs) will also be considered. If you would like to submit or discuss a possible article, please contact Ricki Rusting at rusting.ricki@gmail.com or (845) 519-4601.

Lessons from the Pulse Nightclub mass casualty incident

Mark J. Lang, MCJ, CCP, CHPA

Mark Lang had been Security Manager at Orlando Regional Medical Center for just eight months when the Emergency Department was suddenly inundated with gunshot victims. The cause turned out to be the second deadliest mass shooting in U. S. history—taking the lives of 49 people (aside from the shooter) who were visiting a nearby nightclub. As the event first unfolded, though, Lang had few details about what had happened. Here, he recalls the incident as he experienced it and offers key lessons.

(Mark J. Lang, MCJ, CCP, CHPA, is the Security Manager of Orlando Regional Medical Center. He is a member of IAHSS.)

THE CALL

The phone rang at approximately 0220 hours, which is never good news. It was Sunday, June 12, 2016. The night shift Security Supervisor at Orlando Regional Medical Center, in Florida, was calling from the hospital. Per protocol, he advised me, as Security Manager, that several gunshot victims were being treated in the Emergency Department (ED) and that more than 20 additional victims could well be coming to the ED. Victims were being brought in on the beds of pick-up trucks and walking in. I told him I was on my way.

I dressed quickly and began the short drive to the hospital. I also turned on my security radio, which was full of chatter confirming the urgency of the supervisor's call. Driving to the hospital, I yielded the right of way several times to marked law enforcement vehicles with lights and sirens activated. The first major intersec-

tion that I could view near the hospital was blocked by dozens of emergency vehicles, so I detoured several blocks north to Miller Street, where I stopped at the traffic light. From there, I could see an ocean of emergency vehicles covering Orange Avenue, the major street fronting the hospital. Seeing these vehicles reminded me of my days in law enforcement, when a Signal 43 (an emergency distress call) went out for backup and everyone from every agency responded…no questions asked. Later, I would find out that is exactly what happened. I would also ultimately learn important lessons about how best to handle mass casualty events.

IN THE HOSPITAL

At approximately 0245, I entered the hospital via the North Tower, located on the back of the hospital campus, and made my way to the ED. Along the way, all appeared calm, as if it were a normal early morning. However, as I swiped my badge and the door opened at the trauma side of the ED, I was met by a deafening noise that seemed somehow to reflect both chaos and efficiency at the same time. The usually clear hallways were congested, full of patients, clinical staff, paramedics, and law enforcement officers. Through the jumble, I noticed a patient attempting to leave his bed. He clearly had gunshot wounds, and the clinical staff was trying to secure him to the bed. I stopped to help by restraining the patient's legs, holding them down so the securing process could begin, when a uniformed police officer approached and said, "I got the legs! You're not wearing gloves!" (He was worried about possible disease transmission.) I backed off and continued to the ambulance bay. This was just the first of many examples of how the community and first responders came together to handle this horrific event.

As I entered the ambulance bay, I saw patients being transported in, and off-loaded from, beds of pickups; many others were just walking into the ED through the chaos. Orlando Health team members were working rapidly to get to everyone. Dozens of heavily armed law enforcement officers were positioned inside the hospital and out in the bay. As I continued surveying the ambulance bay, I looked to my right to-

ward the decontamination shower area. Inside, I noticed the bodies of numerous deceased victims on hospital beds. This was a moment when reality hit. I tried to process this chaos: Who is responsible for this? Is it over? How many more? Are we a target?

The security supervisor for the night shift, who was standing in the bay area, said that the incident had happened a few blocks away on Orange Avenue. The same street that fronted my hospital also fronted the building that was under attack. Other than this, he had no updated information.

I walked up to a very tall uniformed officer from the city of Orlando and asked who was in command at the hospital. The officer said he did not know. I identified myself to him and informed him that we needed information desperately. I then asked for a rundown of any information that he had. He stated there could be multiple suspects as well as possible IEDs (Improvised Explosive Devices). There was no information as to the location of the suspects—whether they were mobile and whether they were still in the area. I was also advised that there were bodies in and around the Pulse Nightclub, a building located less than half a mile from the hospital.

I reentered the ED, where I observed law enforcement officers who appeared to be guarding a patient. I asked if the person was a shooting suspect and was told, "Possible." I acknowledged this and then heard, "Shots fired!" and saw law enforcement running towards the other side of the ED. I yelled for everyone to get down and then joined approximately 15 law enforcement officers, whose leader advised me that they needed to search the hospital. At this point, a "Code Silver," or active shooter, announcement went out over the public announcement system. Groups of law enforcement officers, guns drawn, started clearing areas in the hospital, looking for a possible shooting suspect. I accompanied one such group. Several other groups also went off searching, with security and administration team members assisting.

AN ACTIVE SHOOTER?

Before I became the hospital's security manager, I had been a police officer. The realization that now I was no longer a law

enforcement officer…that I was a civilian…was overwhelming. Unarmed and with empty hands, I continued to assist with the area check, directing several hospital employees who were walking the hall to find a place to hide during the active shooter call.

My group was clearing the cafeteria when I noticed several corrections officers standing in front of an elevator bank. They were there to guard a few patient inmates from the county jail in our care. I informed them of the situation and told them to be on the lookout. As I turned to head back down the main hall, I heard yelling from the stairwell. When I opened the door, I saw the hospital's chief operating officer (COO) in the stairwell along with several police officers. They reported that a few patients had been evacuated from the ED for safety after the active shooter announment. One of the evacuated patients on the sixth floor possibly matched the description of a shooter suspect. I was then asked to escort the stairwell group to that room, thereby freeing the COO to return to the ED.

As we rode the elevator to the sixth floor, my mind was processing and calculating this new information: Was the person who had been delivered to the sixth floor the same individual who had been under guard in the ED earlier? Was this the active shooter from down the street? One thing I knew for sure: I missed my on-duty Glock from my past life.

Exiting the elevator, I saw several clinical staff members hunkered down in an office. I told them that they were safe but directed them to stay in the room while we completed the active shooter sweep. My group and I proceeded to the specified room, and law enforcement officers entered. The room seemed empty at first, but the person of interest was located and then transported via wheelchair with a law enforcement escort to the ED for further investigation. The investigation soon revealed that the person was not a suspect. Moreover, it turned out that no shots had been fired in the ER; the person who thought shots were fired had been mistaken. The active shooter procedure was canceled.

INCIDENT COMMAND

While I was in the ED, I was informed that the Hospital Incident Command (HICS) had been acti-

vated for managing the response to the influx of victims from the Pulse attack. Security is a command staff member in HICS, so I headed for the command post, where I was met by the president of the hospital. We were the only two people in the post at this time, and both of us wished we could be out in the field helping. Numerous times during this emergency, the COO ran into the command post, gave a quick update, and then ran back out. Feeling that I needed to be out there, I did sometimes fleetingly think about sliding out for a while. But that's not how the incident command system works. In that situation, no one should leave unless they have a replacement. Soon, HICS was expanded, and staff appeared to fill designated command positions. Everyone had a job to do, and everyone was doing their job.

I stayed at the command post until late afternoon, and I didn't leave the hospital until the evening. As I exited the parking garage, I could see nothing but law enforcement and news vehicles surrounding the hospital and on Orange Avenue. On the drive home, I reflected that I have seen my share of pain, suffering and violence in my career, but nothing could compare to what I saw that night.

Only later did I find out that just one shooter had been responsible for the carnage at the Pulse Nightclub (including 49 deaths), and he was shot and killed by police at the club. At Orlando Regional Medical Center, 44 victims were treated and nine died.

SUCCESSES, AS WELL AS GAPS

I believe that during this catastrophic event, we had the right people in the right place at the right time. Security was called on and performed admirably. Security officers assisted with the unloading of patients, provided restraints, went out unarmed with law enforcement groups searching for what was thought to be an active shooter, and secured a hospital complex that had not been designed to be secured. Moreover, most of the 10 security officers on duty that early morning worked more than 24 hours straight until they were relieved. These officers maintained an extremely high level of vigilance and acted professionally and with honor.

Nevertheless, we learned lessons that have improved our preparedness for mass casualty and active shooter events. Since the Pulse event, Security has maintained its new heightened level of vigilance, and Orlando Reginal Medical Center is now an IAHSS Program of Distinction.

LESSONS LEARNED

Here are some of the insights we gained as a result of our experience on that terrible night in 2016.

Staging area for family assistance. Know where your family-staging area(s) will be. When the incident began, we did not have a predesignated location. As time progressed, a multipurpose room was designated but turned out to be too small as the number of people there grew. Ultimately the family staging area was moved to a hotel and then to a recreation center.

Donations. The community outpouring of donations was tremendous. Prepared food was left at hospital entrances, but we had no way of knowing its origin, which was a major issue. Also, we had no system for getting donations delivered, and much of the food was discarded. Plan for how you will handle food donations. Meanwhile, blood donations were needed urgently: the hospital on average uses 35 units per day; we used 550 units for the Pulse patients. Preplanned off-site donation locations will help alleviate congestion on the hospital's property.

Threats to the hospital. While caring for the victims and their families, the hospital received numerous threats of harm. The calls were anonymous but still upset the staff. A major event draws out all kinds of people. I handled a phone call from a person who stated angrily that no one died in the night club and this was a false flag. Threats were made to the hospital by some very disturbed, bigoted indiviuals. Be on alert.

Dignitary visitors. During the first few weeks after the incident, the hospital was visited by numerous governmental and high-profile celebrities. Although such visitors are great for morale, they cause logistical nightmares. Manpower is needed for escorts and crowd control. Develop a plan ahead of time with guest services or the volunteer department.

News Media. On a normal day,

the hospital deals with two or three news crews. At one point, we had more than 300 news outlets on the property. The hospital was surrounded for a few weeks. If you're fortunate enough to have a media relations team like ours, it will handle most of the issues smoothly. However, members of the media did try to sneak into the facility, nab employees for interviews, and pretend to be someone else. Be on the lookout.

Lockdown. Just about everyone has had to lock down their ED at one time or another. If you are one of the lucky few that has never had to do that, please plan now. The ED at ORMC is regularly locked down, and security is very proficient at the task. Locking down the entire hospital when there was a risk that a shooter or shooters might be in facility or might try to enter it was challenging. We were able to draw manpower from other Orlando Health hospitals, which solved our short-term issues. To facilitiate future lockdowns and also to improve the control and tracking of people in the building, the hospital went virtually overnight to metal detecting, bag checks and new permanent stationary posts. Before Pulse, we were running on one walk-through metal detector in the ED; today, we are running X-ray and walk-through metal detectors at the three main public entrances. Numerous public entrances are exit-only and are equipped with audible alarms and CCTV cameras. We have also added law enforcement go bags at the main public entrance, which contain master badges, keys, tourniquets, and a basic map of the entire first floor.

An attack on a community hospital: Key takeaways

Jim Hite, MS, FACHE, CHEM, CHSP, and Kevin McGinty, BA, CHEM

In February 2018, a man plowed his car into the waiting area of the Emergency Department at a community hospital in Connecticut and ignited a gasoline-fueled fire. The authors offer firsthand advice on preparing for, and responding to, such sudden violence.

(Jim Hite, MS, FACHE, CHEM, CHSP, is Director of Environmental Safety and Protective Services, at Middlesex Health. Kevin McGinty, BA, CHEM, is Safety and Emergency Management Coordinator at Middlesex Health.)

It is both fascinating and disturbing to see how large-scale acts of violence have evolved since September 11, 2001. In the first years after the turn of the century, we saw large-scale, well-funded, strategically coordinated terrorist attacks. Since then, the internet and social media platforms have flourished in a manner that few anticipated, and our world once again got a little smaller in a way. With improved interconnectivity, the sharing of fringe ideology has taken on an aura of normalcy, as like-minded individuals now have safe virtual meeting areas. As a consequence, lone-wolf incidents have become more common. As if the cards weren't already stacked dangerously, the mental health treatment system is ill-equipped to manage the ever-growing segment of our population with severe mental illness. Because of social complexities, we are less able than ever before to predict when targeted

violence will affect our daily lives. However, this hazard, although fraught with challenges, can be managed, mitigated and prepared for through an all-hazards approach.

IT CAN HAPPEN HERE

A decision made by one mentally ill man on the morning of February 22, 2018, affected the lives of all employees and patients at Middlesex Hospital (the main campus of what is now Middlesex Health), in Middletown, Connecticut—albeit some much more than others. This man loaded his sedan with a gasoline-filled backpack sprayer and canisters of gasoline and drove into the public entrance of the hospital's Emergency Department. A fireball erupted and suddenly engulfed the vestibule in flames. Thanks to the heroic acts of many, no lives other than the driver's were lost. The word "fortunate" isn't typically used to describe incidents like this, but the situation would have had a much more tragic ending if it had gone according to the man's plan.

Middlesex is a community hospital with 275 inpatient beds and a 44-bed emergency department; it is centrally located in Connecticut, alongside the Connecticut River. Community hospitals like it, in relatively quiet cities of 45,000 or so, can be easily lulled into a false sense of security, feeling "it won't happen here." Yet, it can happen anywhere, and in today's world of increasing belief-based, or ideological, violence, it must be included in a well-rounded all-hazards emergency operations plan. As the renowned author Peter Drucker said, "Plans are only good intentions unless they immediately degenerate into hard work." Emergency plans are only as good as the people who support them, and they only work if they are actually applied.

As a result of water intrusion, environmental contamination, and structural damage related to the February 2018 incident, Middlesex Hospital lost the use of its Emergency Department and Crisis Intervention Unit for 10 days. The Critical Care Unit and Radiology Department were also unusable for several days, due to contamination. Continuity of operations plans were quickly activated to maintain quality care for our community. For instance, all outpatient radiology procedures

were rescheduled at other Health System locations, and both the Emergency Department and Critical Care Unit activated their internal surge plans. Many lessons were learned, and they can be grouped into six broad categories.

LESSONS

Relationships

• Protective services, environmental safety, and emergency management leaders clearly benefit from tighter relationships, even if they are in separate business units; craft these partnerships. Middlesex is fortunate to have all of these important functions operate within one department.

• As a health system emergency manager, you should become intimate with the internal core incident response team, which typically consists of department leaders and contracted vendors. The team should meet often and exercise often. Even one-hour tabletop exercises allow for the discovery of areas to improve, and they are an excellent opportunity to bring the team together. A key area that is often understaffed and overworked but critical to response and recovery: facilities engineering. This department cannot be excluded from the inner circle.

• As a member of your incident command team, think about who is on your speed dial. It had better be those critical external contacts: local emergency management, public health, and regional health system emergency managers. Invite them to planning meetings. For situation awareness, build these contacts into your mass-notification system so they know when you have activated your emergency operations plan (EOP). Expand your list to include more than just the key stakeholders in your local community. Include organizations with like resources. Middlesex's list also includes surrounding hospital emergency managers. When you build your healthcare coalition into your regular communication network, emergency communications flows intuitively and efficiently.

Threat Management

• Focus on workplace violence regardless of motive and don't limit yourself to thinking only in terms of terrorists. The damage done through violence perpetrated by someone driven by ideology is just as harmful as the same

violence perpetrated by someone who is disgruntled. Our task is to prevent it from occurring in the first place; the motive is irrelevant. There are various types of violence, and the type involved in the situation at Middlesex demonstrated how a person with a mental disorder and delusions used a motor vehicle as a device to cause harm.

• Develop a threat-assessment team. This does not need to be formal, but to be effective, the team needs to be multidisciplinary, with representation from security, risk management, mental health, human resources, and occasionally local law enforcement. Team situational awareness is paramount for preventing violence. Outside assessment teams—such as the Department of Homeland Security, Russell Phillips & Associates, and Red Teams—should also be considered. Regardless of how you identify risks and threats, identifying them is only the first step. Once hazards are identified, plans and actions must follow. Otherwise, the vulnerabilities will remain.

• When an event happens, always assume that it could have been intentional. Members of the media immediately questioned whether or not our attack was an accident. You need to balance paranoia with reality, but if you cannot absolutely and immediately rule out foul play, consider—and discuss out loud—the question "Is something else coming?"

• Based on risk assessments, harden your facilities with barriers, restrict interior and exterior foot traffic, limit entry points, and identify every person on your campus. Thoughtfully balancing security, customer expectations, and executive leadership's appetite for risk is challenging, but when it is done well, it will prevent harm. There is no panacea. It's about compounding controls that build on one another. Since completing our assessments, we have increased our security force, including implementing a hybrid security officer position that combines the patient greeter and traditional officer role; increased the number of locked departments; expanded our digital camera coverage; and modified our staff education, encouraging staff to report suspicious activity and acts of workplace violence through ad-

ditional channels, including a mobile smartphone application.

Employee Well-Being

• Take care of the caregivers. When the facility has to deviate from normal operations, be flexible with policy compliance, be it staffing ratios, shift durations, or additional responsibilities. Your people need to be with one another in the aftermath of a traumatic event. Even if the census is low, don't send staff home when operating under disaster mode.

• Although this next suggestion may sound basic, it's easily forgotten: ask your team if they're OK. Managers should sincerely and honestly ask, in private if necessary, how staff members are feeling. In the wake of a serious event, staff will prioritize their patients' and coworkers' needs over their own, often to their own detriment. Support them by being present and emotionally supportive.

• Robust mental health response capabilities need to be available in-house or provided by a credible outside resource. Be sure to offer crisis services and defusings at times when staff can use them most; defusing are best conducted in the hours and days after a stressful event. If you don't have the capability to provide these services yourself, you can turn to local and state response teams, which are well exercised. Ensure that any stigma surrounding the employee assistance program (EAP) is managed. It's about getting back to work and finding one's "new normal." It's not about anything else.

Continuity of Operations and Resiliency

• Continuity of operations planning (COOP) is a necessity. What's the plan when you lose your space, your staff, or your stuff? COOP is mandated by the Centers for Medicaid and Medicare Services, but don't stop there. Drill down to the department level (emergency department, lab, pharmacy, critical care, surgery, etc.). Department-level COOP is where the rubber meets the road. In Middlesex's case, the Critical Care Unit was relocated to our Outpatient Infusion area, and the Emergency Department crisis area shifted to the Inpatient Psychiatric Unit.

• Make sure your plans are intuitive and adaptable to "all hazards" and not collecting dust on a bookshelf. At Middlesex, the

Emergency Department staff evacuated 22 patients in less than three minutes to a temporary location and then continued to transfer them to Surgical Services. This became the temporary Emergency Department, and it allowed for surgical cases to continue during the hospital's recovery. Our patient surge plan is written for Emergency Department overflow for community-based disasters, but living to the "all hazards" planning approach resulted in the surge plan being used as a framework for Emergency Department COOP.

Communicating

• Social media will be ahead of your media management department or strike team. Establish a day-to-day social media presence so you can quickly leverage it during disasters. Have a "use it or lose it" mentality.

• Quickly establish a joint information center. Middlesex held regular joint press conferences at Middletown City Hall with the mayor and city officials. Controlling and having a unified message allows for a less-than-ideal situation to take a positive turn. Leverage the positives, because when done right, good things can come from bad events. Because of our pre-established relationship with the media, our public relations department contacted them soon after the attack to offer them a positive story related to our successful response.

• Provide staff updates as soon as possible and as frequently as you can manage. At a minimum, daily bulleted briefings to staff will be appreciated, and they allow you to squelch rumors and show proactive command activity.

Incident Command

• The traditional Hospital Incident Command System (HICS) is a good foundation, but don't be afraid to customize it. For the sake of jurisdictional interoperability, command staff and section chief positions should remain, but the lower position titles can become more intuitive and user friendly for your leadership. For example, configure your Emergency Operations Center (EOC) using an ICS-like departmental structure instead of the standard organizational structure. You drive the command structure. Don't let it drive you.

• Decentralized and virtual command and control: stay in your

lane, not in a silo. This only works when you have a mutually respectful and functional leadership team that uses an ICS departmental structure and a viable, agreed-on communications infrastructure. Use a familiar platform. Middlesex uses Google Hangouts and Google Forms with great success.

LIVE AWARE

Like any other health system with strong community ties, strong leadership, and dedicated employees, Middlesex Health persevered. In addition to such cultural factors, our resilience was aided by using the "all hazards planning" approach, conducting drills and exercises, having strong community relationships, and following the National Response Framework and National Incident Management System (but making it work for us). The motto "all events start local and end local" held true.

The world has changed and will continue to do so. All of us need to adapt to these changes. The message to all of our employees from our Office of Environmental Safety & Protective Services is: "Don't live in fear—live aware" in both your personal lives and the workplace, so that you can better control whatever can be controlled. Learning from horrific events can help to turn a negative into a positive by setting the stage for successful responses in the future.

Feel free to contact Jim Hite (Jim.Hite@midhosp.org; 860-358-6597) or Kevin McGinty (Kevin.McGinty@midhosp.org; 860-358-5908) with any questions.

Illicit-drug trends: No longer the Big Five

Ryan Bonacci, CHPA

Opioids and the other classic Big Five drugs (cannabinoids, cocaine, amphetamines, and PCP) are not the only street drugs popular today. In fact, several older substances are making a comeback. Staying on top of the trends is important because patients and visitors alike are bringing these drugs into your facilities. They will often use slang names for the substances to try to avoid detection.

(Ryan Bonacci, CHPA, is Director of Security and Chief of Police at Mercy Health Youngstown, in Youngstown, OH. He is a member of IAHSS.)

Use of illicit drugs is not merely a policing issue. Patients and visitors may well show up in your facility with these substances. You need to educate yourself, your staff, and the medical staff about which drugs are popular these days, what they're called, and how they can affect users. Many drugs come into hospitals as pills with fake names on them. And, when a patient asks a friend to bring him some bath salts or butter, he may not be talking about relaxing in a tub or making his dinner roll taste better!

Of course, opioids remain the leading cause of overdose deaths in the United States. But it would be a mistake to ignore other increasingly used drugs. The surprising thing about the drug world is that you rarely see new drugs; rather, you will see a resurgence of older substances, often in more powerful forms.

Think of the drug world like a giant merry-go-round: Once we

get a grip on one drug, it cycles around, and we have another to deal with. You might recall a time when grocery stores locked up baby formula to prevent it from being used as a cutting agent. More recently pharmacies have taken to controlling the sale of pseudoephedrine, which is a key ingredient for meth (methamphetamine). In this pages that follow, I will summarize the opioid situation and then highlight other drugs you'll want to look out for. One lesson we all have to understand—and I take no joy in this statement—is that we are never going to win the war on drugs; we have try to minimize the causalities.

THE OPIOID EPIDEMIC

Over the last four years, the number of number of deaths from opioids has been unprecedented. This epidemic has been fueled by overprescribing and promotion of opioid use by the drugs' manufacturers. The U.S. Centers for Disease Control (CDC) estimates that in 2017 alone more than 70,000 Americans died from drug overdoses—exceeding the number of Americans who died in the Vietnam War. About two-thirds of these overdose deaths involved opioids. And the CDC has released reports warning that, if we can't slow the opioid epidemic, it could kill 500,00 people over the next 10 years. The opioid epidemic got so bad in 2017 that eight states declared a public health emergency: Alaska, Florida, Pennsylvania, Virginia, Arizona, Maryland, South Carolina, and Massachusetts. The epidemic has also led numerous states to file a federal lawsuit against several big-name pharmaceutical companies for peddling prescription opioids.

The U.S. government has very recently made important strides in facing this epidemic, but the plans and programs that the government has in place may not yield significant results for another two to three years. In the meantime, the powerful opioid fentanyl remains a major concern. It accounts for a large share of recent opioid-related deaths.

Fentanyl

Like many other abused drugs, fentanyl was originally designed to help people, especially those in pain. First developed in 1959, it is a synthetic opioid used to treat chronic pain. By weight, it is 25 to 40 times more potent than her-

oin, and 50 to 100 times more potent than morphine. It is abused because it provides an intense, albeit short-term, high that produces feelings of euphoria.

One feature that makes fentanyl and other opioids dangerous is that the body develops tolerance to them, which causes a person to have to use more and more of the drug to achieve the desired high. In July 2015, the U.S. Drug Enforcement Agency (DEA) used its emergency scheduling authority and placed fentanyl on the Schedule I list of controlled substances. Schedule I drugs have a high potential for abuse and no accepted medical uses.

For the longest time, a good majority of opioids in the United States came from the Middle East, especially Afghanistan. Then we had the War on Terror. In the Middle East, opioid-eradication teams go around and destroy opium fields. Then South America took control over the opioid game, mass producing heroin and illegally transporting it to the United States. The drug wars between South America and Mexico spurred drug cartels in Mexico to get in on the heroin action, producing heroin on the Sierra Madre Del Sur mountain range. Mexico now produces 90% of our nonpharmaceutical fentanyl and has the monopoly on synthetic opioids. China was able to keep pace with Mexico, but the China Ministry of Public Security started placing new controls on chemical compounds in 2015, which slowed production.

Over the last six years, we have seen a huge spike in the amount of fentanyl being used by addicts, which was initially mixed with heroin but now is being used by itself or with cocaine. Early statistics showed 700 overdose deaths from 2013 to 2014, although that is probably an underestimate, given that we did not know how to test for fentanyl use until 2017. For many years fentanyl hit the East Coast harder than any other part of the country. That's probably because most East Coast states have well-connected north-south and east-west roadways, making distribution easy for drug dealers.

Here are some of the latest street names for fentanyl, according to the DEA: China White, China Girl, Fire, He-Man, Tango & Cash, Goodfella, Birra (fentanyl mixed with heroin), and Butter.

RESURGING DRUGS

Bromo-DragonFLY

Bromo-DragonFLY, a Schedule I drug, is a synthetic psychedelic substance initially synthesized in 1998. It is similar to LSD but not as potent. Its name derives from its chemical structure, which resembles a dragonfly. Bromo-DragonFLY's hallucinogenic effects can last up to three to seven days. It can come on blotter paper or in powder or pill form. Some effects include confusion, agitation, short-term memory loss, visual distortion, seizures, hallucinations, and death. Some current street names: B-Fly, Bro, Bromo, Fly, DOB.

Tenocyclidine (TCP)

TCP was first discovered at Parke Davis in the 1950s and intended for use as an intravenous anesthetic. Aside from being an anesthetic, it is a stimulant and hallucinogen. Its chemical structure is similar to that of PCP, but TCP, which is a Schedule I drug, is more potent and its symptoms last longer. Some of the physical effects are tremors, disorientation, confusion, alterations in sensory perception (including reduced sensitivity to pain), elevated blood pressure, hallucinations, panic, fear, paranoia, respiratory arrest. Often users turn up naked and sweating and show unusual strength. TCP seems to have no street names.

2C-B

2C-B was first synthesized by pharmacologist Alexander Shulgin in 1974 and was intended as a legal substitute for ecstasy. It is a psychedelic, Schedule I drug sold in powder form or pressed into pills and taken orally or vaporized. The effects can include euphoria, nausea, increased blood pressure, increased body temperature, dilated pupils, tactile enhancement, and teeth grinding. Some stree names: 007's, Banana Split, MFT, Spectrum.

Kratom

Derived from a tree native to Southeast Asia, this drug is sold in local head shops and privately owned gas stations. Although it has opioid properties, it is considered a psychotropic drug, and the drug Narcan, which can save the lives of people who overdose on opioids, does not counteract kratom well. Several years ago, the DEA submitted a petition to ban the substance but was met with resistance from Congress and a petition signed by 144,000

people, who argued that kratom was being used to help with opioid withdrawal. The FDA released a statement that kratom, which was originally sold as a diet pill, has not been shown to help with opioid-withdrawal symptoms, and it is currently banned in six states. The DEA has not reiterated its intent to ban the drug, but I am sure that this will change as kratom gains momentum.

Kratom's effects differ depending on the amount used. In low doses, it makes people feel alert and energetic; in high doses, it has sedating effects and can cause psychosis, and delusions. It can also lead to constricted pupils, nausea, sweating, dry mouth, seizures, hallucinations, coma, and death. Having opioid properties, kratom will also cause withdrawal symptoms in users, including cold shakes, chills, sweating, feverlike symptoms, mood swings, anxiety, depression, bone pain, vomiting, insomnia, and diarrhea. Some street names: Herbal Speedball, Ketum, Biak, Thom.

Spice (K2)

Most of you should be familiar with spice: it became popular in 2010 and reached its pinnacle in 2014. It is a mixture of herbs and plant material that is sprayed with a synthetic compound similar to THC, the chemical responsible for marijuana's high. The compound sprayed on the plant material has a very strong psychoactive effect. Like kratom, spice is still legal in most states and sold in head shops and gas stations. It is typically sold is small plastic bags marked "incense" and is often labeled "not for human consumption"—although most packets include rolling papers. Some of the physical effects are loss of control resulting in physically aggressive behavior, lack of pain response, increased agitation, pale skin, seizures, vomiting, paranoia, hallucinations, and increased blood pressure and heart rate.

Spice is usually smoked in joints or bowls, but some users have been known to make tea. The Obama administration worked very diligently to resolve the legality issue and began banning certain chemical compounds used to make the drug. Unfortunately, the producers respond to such moves by pulling the product off the shelf, changing one compound, and sending spice back

out for legal sale.

Spice is making a big comeback and has been linked recently to a major overdose event: In August of 2018, in New Haven, CT, 70 people were taken to the local hospital for overdosing on the substance. This is a volatile situation, as the last time this drug was popular, it caused an increase in overdoses and deaths, mostly from suicide. In 2010, the use of spice resulted in 11,400 emergency room visits; in 2011 the number increased to 28,531. Spice has led to an estimated 500 deaths in the United State since 2010 and is currently banned by all professional sports organizations. Spice has no street names but is identified by the name of the product, such as Bliss, Blaze, Genie, Moon Rocks, and Yucatan Fire.

Bath Salts

Bath salts is an illicit drug that stimulates the central nervous system; it was sometimes disguised as actual bath salts in the past. It is extremely popular with teens and young adults. As with spice, the government tried to stop this product, but it can be made with an endless supply of chemical compounds. The drug is known to contain chemicals such as methylenedioxypyrovalerone (MDPV), mephedrone, and methylone and is labeled "not for human consumption." Sold in packets of 50 and 500 milligrams under various brand names, it is white to light brown in color and is ingested by snorting, swallowing, or smoking; or, it can be put into a solution and injected into the veins. The high from bath salts is similar to that of cocaine, methamphetamine, MDMA, and LSD and can last three to four hours.

The DEA has cited bath salts as an imminent threat to public safety. Its effects include severe paranoia, suicidal thoughts, combative and violent behavior, hallucinations, increased heart rate, sleep deprivation, and teeth grinding. Some street names: Blue Silk, Cloud Nine, Drone, Meow Meow, Stardust.

EDUCATE YOURSELF

Again, you need to educate yourself about the drugs that are out there and the ones that will reemerge. There are resources that can assist in training and education; a particularly interesting one is a website—www.streetrx.com—that can in-

dicate which drugs are being used in your area. This website allows users to post what they bought, how much they paid, and where they bought it, and leave reviews on their experience, free of criminal prosecution.

Know where your area head shops are and what they are selling out of them. Collect as much information and data as you can, share the dangers of these drugs with your senior leaders, and create a multidisciplinary team to find ways to combat these drugs and to plan how to handle them if they are found in your facility.

JOB ONE: SAVE LIVES

One last thought: I know it can be hard to empathize with drug abusers, especially when you see the same people over and over again. In my state, a Chief of Police publicly stated that he will not permit his officers to carry Narcan, that users deserve what they get. Know this: Every life is worth saving; the goal should be to get victims into a rehab program or to otherwise provide them with the means to kick their habit. If you take the time to talk to these people, you will see that a majority want to stop but do not know how. They deserve a chance, and it will take more than one attempt to sober up.

These drugs do not discriminate based on race, religion, sexual orientation, or social economic status. To prove this, let me now share some names with you: Peaches Geldof (actress) died from a heroin overdose in 2014. Philip Seymour Hoffman (actor) died from an overdose of heroin, cocaine, and amphetamines. And Prince (musician) died from a fentanyl overdose.

You will hear people say of addicts, "Well, it is their choice, so they can figure it out." But, in truth, the only choice they made was the first time they decided to use. Once that drug is in their system, they become prisoners. I went into law enforcement because of my father, who was a cop. I am passionate about drug work and have had the opportunity to serve on a narcotics unit. I went into narcotics because a family member became addicted to crack cocaine; he had a highly responsible job when this happened.

I repeat: I deeply believe that everyone affected by drugs deserves to be saved, and I preach this to my officers. Sometimes bad

things happen to good people; they should not be labeled or written off because of what has happened to them.

Resources

Commonly abused drugs charts. National Institute on Drug Abuse.https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts#heroin

Scholl L, Seth P, Kariisa, M, Wilson N, & Baldwin G. (2019) Drug and Opioid-Involved Overdose Deaths —United States, 2013–2017. *MMWR Morb Mortal Wkly Rep,* 67,1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1

Slang terms and code words: A reference for law enforcement personnel. (2018). DEA Intelligence Report. https://ndews.umd.edu/sites/ndews.umd.edu/files/dea-drug-slang-terms-and-code-words-july2018.pdf

The forensic patient: Clinical, legal, and security challenges

Shana Palmieri, LCSW; Mollie Slater, RN, BSN, ESQ; and Kevin Whaley II, CHPA

Forensic patients are far from a rarity. To ensure the safety of everyone concerned, and to minimize liability risks, healthcare facilities should establish management plans that are multidisciplinary and specific to the dangers posed by such patients.

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Is your campus prepared to provide care to the forensic patient in the safest possible way? Adequate preparation for a forensic patient means a purposeful review of the security, environmental, regulatory, staffing, safety, and educational components that must exist to create a thoroughly prepared facility plan. If one of the links is weak, or if one department is not on board with such a plan, disaster can ensue.

A 2016 U.S. Department of Justice report found that state and federal prisoners are significantly *more likely* than the general population to experience serious illnesses that require hospital-level care. Although hospitals are not designed with prisoners in mind, forensic patients may be found, depending on the state, in ambulatory care, outpatient, behavioral health, and acute inpatient care settings.

The case below is a real-life study that illustrates how crucial it is to have department-level and hospital-wide preparedness.

THE DELNOR HOSPITAL INCIDENT

On May 13, 2017, a forensic patient, Tywon Salters—who had been admitted to Delnor Hospital, in Kane County, Chicago, for eating a jail-issued sandal—obtained his guard's 9mm handgun. Salters, an inmate at the Kane County Jail, then took hospital staff members hostage. Nurses were forced to disrobe and were robbed, beaten, and raped during a standoff situation with Salters, who used one hostage's cell phone to make calls to his family. After negotiations failed, a SWAT officer ultimately shot and fatally wounded Salters.

WHO AND WHAT CAUSED THIS?

This incident cannot be traced back to only one mistake or simply human error. This kind of event typically happens when processes, policies, educational programs, communication, and collaboration with law enforcement all break down. James Reason's Swiss Cheese Model of Harm (Seshia et al., 2018) is often used as a visual aid to symbolize systemic failures and is helpful in conceptualizing the process breakdowns that contributed to this incident—that is, how everything "lined up" to enable Salters to obtain his guard's gun. In the model, slices of Swiss cheese stand on end in a domino-like series, and a hole in each slice lines up perfectly with a hole in the other slices; an arrow shoots through these aligned holes. The slices represent barriers to trouble (such as policies and training), and the holes signify failures in the safeguards; together the failures allow the barriers to be breached and unwanted events to occur.

WHO IS RESPONSIBLE FOR FORENSIC PATIENTS?

Treating forensic patients takes planning, patience, and practice. No department or staff member should be expected to handle it alone. Clinical staff (including physicians), safety and security departments, support staff, and the agency that has the patient in custody are all responsible for ensuring safe, effective, and humane care. With that understanding in

mind, see Table 1 for an overview of the clinical, legal, and security considerations to keep in mind.

COMPONENTS OF A PREVENTION AND MANAGEMENT PLAN

All three of us are educators with Healthcare Legal Education & Consulting Network (HLECN), which provides education to clinical staff, administrators, and security personnel on the intersection of healthcare and the law. Evidence-based risk management strategies and a review of case law indicate that any safety and security plan relating to the care and treatment of the forensic patient should be designed to do the following:

- Improve the safety of visitors, colleagues, and other patients while still maintaining the dignity of the forensic patient;
- Employ risk mitigation strategies that arm all front-line staff with the necessary knowledge to safely and effectively care for the forensic patient;

Table 1. CLINICAL, LEGAL, AND SAFETY & SECURITY CONSIDERATIONS

Clinical Considerations	Legal Considerations	Safety & Security Considerations
All clinical staff that interact with forensic patients need to be trained on forensic patient policies and procedures.	The forensic patient needs unique, multidisciplinary considerations for medical decisionmaking.	Develop a procedure for identifying forensic patients as soon as they arrive at the facility.
Utilize interdisciplinary teams to assess risk for violence and self-harm.	Forensic patients retain some right to decline care in the absence of a public health threat (such as tuberculosis). At times, treatment may be compelled.	Ensure that your restraint policy addresses medical restraints separately from law enforcement restraints.
After assessing risk for violence and self-harm, employ care plans that minimize such risk.	A healthcare facility may have liability for the hazards and emotional distress created by an escaped inmate patient.	Develop relationships and partnerships with local law enforcement agencies that utilize your facility for patient care.
Utilizing and employing the chain of command is vital in these circumstances. Remember your support departments.	Ensure your staff knows the guard's role in the comprehensive safety plan of the forensic patient.	Provide education to clinical staff regarding any special considerations for the forensic population to ensure that safety, privacy and patient care needs are met.
Perform a review or debriefing after all forensic patient encounters to assess adequacy of preparedness.	Regardless of where care occurs, prison officials are obligated under the Eighth Amendment to provide prisoners with adequate medical care.	Best practice is a no-visitors policy. If visitation is allowed, coordinate and share the visitation plan with the respective partners (such as security, clinical, support staff, and law enforcement).

- Ensure that your institution has policies and procedures that detail the process for safely managing a forensic patient;
- Provide all staff training on the safety measures and precautions they should take when caring for the forensic patient;
- Integrate a process improvement plan with data-driven metrics to address patients who are known to be aggressive or deemed to be at risk of being aggressive;
- Develop an interdisciplinary committee focused on threat management and at-risk patients;
- Identify organizational opportunities to improve the provision of safe care for the forensic patient.

We also recommend specific assessment and management strategies for the high-risk patient population, including:

- Safety and security tracking of high-risk patients through the entirety of a patient's hospitalization;
- Safety and security patient rounding to develop a safety plan for each shift;
- When appropriate, implementation of behavioral contracts;
- Development of a Code Response Team for the violent patient.

Reference

Seshia, S.S., Young, G. B., Makhinson, M., Smith, P.A., Stobart, K., & Croskerry. P. (2018). Gating the holes in the Swiss cheese (part I): Expanding professor Reason's model for patient safety. *Journal of Evaluation in Clinical Practice*, 24(1), 187-197. doi.org/10.1111/jep.12847

Improving security program effectiveness through data-driven decisionmaking

Katherine Eyestone and Shon Agard, MS, CHPA

Following this step-by-step guide to collecting data can help you to maximize your security resources and explain your decisions to administrators.

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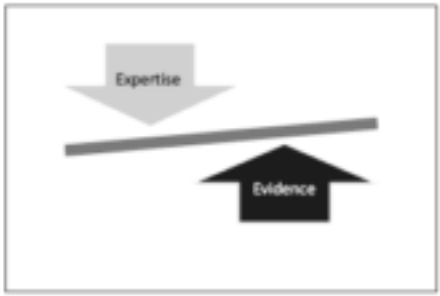
Most healthcare security leaders today are under pressure to figure out how to maintain or improve the quality of their programs while at the same time manage shrinking budgets. The challenge of how to optimize security services can be made harder when it is difficult to quantify the impact of a security program or when the preferences of hospital administrators dictate the design of security. An important tool that can help healthcare security leaders navigate this challenging terrain is utilizing data to objectively inform resourcing decisions. While not a substitute for security experience and expertise, utilizing data can create more of a balance in terms of how expertise and evidence work together to inform security program design, as shown schematically in Figure 1.

Figure 1. The Balance of Security Expertise and Evidence



Data such as benchmarks can help security leaders answer questions such as the following:

- How do I optimize my budget for security?
- What is my justification for increasing my budget?
- How do I know if my security program is effective?
- How does my security program benefit my organization?

It can be challenging to figure out how to utilize data to make security program decisions when this information is not yet widely available in the industry. However, many security leaders, particularly those in multihospital systems, likely have enough data available to get started. In this article, we

- explain why it is important to consider Security's ability to impact security incidents when designing security programs,
- provide data and tools that will help leaders understand how to compare various healthcare facilities based on risk, and
- explain some simple ways that security program leaders can begin to leverage data for decisionmaking.

EXPANDING THE DEFINITION OF HEALTHCARE SECURITY *QUALITY*

When tackling the question of how to optimize security resources, you would be wise to expand your definition of the *quality* of a healthcare security program. Traditionally, the quality of a healthcare security program has been defined largely in terms of *process* and *structure*. Examples of quality *processes* are adhering to well-written post orders, monitoring of rounding, and following protocols for documentation of security incidents and activities. Examples of *structural* quality indicators are training requirements

for officers, staffing schedules, and leadership-to-staff ratios. Process- and structure-focused quality indicators are types of "performance measures."

A new element of quality that we recommend you incorporate into your planning is the impact of your program on *outcomes*—which is to say, security incidents. (See Figure 2.) Because workplace violence is a predominant security concern in healthcare, a good place to start is by looking at the number and severity of assaults that are occurring across the locations for which you are responsible. In addition to tracking assaults documented as security incidents, you might also ask your organization for workers' compensation data for claims related to violence. Assessing security program quality in terms of its ability to impact security incidents produces "effectiveness measures."

The notion of expanding the definition of healthcare security quality to include impact on incidents, or outcomes, parallels what has happened in the field of healthcare delivery over the last roughly two decades. Healthcare quality used to be defined primarily in terms of processes (such as accurately following care protocols) and structure (which relates to things like the proper training and education of care providers) or by the ratio of care providers within a clinical area. Today, the emphasis is on outcomes. Did the patient have to be readmitted? How well did the patient recover from surgery?

Moving into this space of impacting outcomes is important for enabling a security program to demonstrate its full value. Think

Figure 2. The Three Dimensions of Security Program Quality

about it: If you can measure and reduce the cost of assaults over time, you can quantify the value of that achievement to your organization (an amount well above the direct spend on security).

HSS's early efforts to analyze healthcare security data focused on identifying the key drivers of security incidents. By utilizing multivariate regression analysis, HSS analyzed data from the more than 100 healthcare facilities we secure to determine the factors that are statistically significant drivers of security incidents. (HSS's statistical modeling explained 76% of variance in "crimes against people" and 71% of variance in "crimes against property.") Of the many kinds of data studied, the types shown in Figure 3 were found to have a statistically significant impact on security outcomes, particularly crimes against people.

Understanding the statistically significant factors that impact security incidents will be useful as you consider how to best organize your security program. Below are several initial steps a security program director can take to inform data-driven decisions about security program design.

STEP 1: BUILD A DATA SET

The first step toward data-driven decisionmaking is to collect and organize available and relevant data. The spreadsheet in Figure 4 illustrates the kinds of data that may be useful, including:

• **Risk Characteristics.** Overall national crime forecast/index

Figure 3. Statistically Significant Drivers of Security Incidents

Type of Variable	Statistically Significant Variable
Hospital Community Demographics	• Overall National Crime Forecast/Index Score (See note.)
Hospital Size/Volume Characteristics	• Annual Emergency Department (ED) Visits
Security Program Characteristics	• Security Officer Tenure • Presence of TASERs • Presence of Magnetometers

Note. HSS utilized Crimecast by CAP Index score data for the referenced statistical modeling.

score and annual ED visits are important to document because they are known statistically significant drivers of security incidents. Give some consideration to additional characteristics of the hospitals you secure that may increase risk. If there are other important considerations, such as the presence of a behavioral health unit, document that information in a simple spreadsheet by facility, as shown in Figure 4.

• **Security Program Characteristics.** Document basic information about the structure of the security program in place at each location. Unlike the risk characteristics of the hospital, security program characteristics are factors that you can control, and that you might change based on the results of your analysis. You might think of them as levers to be adjusted to improve security program effectiveness. Information such as the number of security officer hours worked per week, management hours worked per week, presence of TASERs or magnetometers, and tenure of the security officers should be documented.

Note that HSS's statistical analysis showed that security officer tenure is a statistical driver of security incidents. This measure is of the tenure of the team of officers in place at a location. As the team tenure increases, security incidents decline. This finding would suggest that officers with more healthcare security experience are able to more proactively manage and de-escalate situations before they become security incidents. This may not be information you have readily available but, because it has been shown to be statistically impactful, it is information worth calculating and documenting.

Figure 4. Building a Data Set

	Risk Characteristics			Security Program Characteristics					Security Outcomes		
	Crime Index	Area ED	BH Unit	# SO Hrs/Wk	# Mgmt Hrs/Wk	TASERs	Magnet	SO Tenure	Assaults	Threats	WC Claims - Assaults
Hosp 1											
Hosp 2											
Hosp 3											
Hosp 4											
Hosp 5											
Hosp 6											

HSS's statistical modeling also revealed that the presence of conducted electrical control devices (TASERs) and magnetometers can reduce the number of security incidents by statistically significant amounts. In our data set, we typically found TASERs and magnetometers in hospitals serving communities with an overall national crime index score of 280 or higher; if TASERS and/or magnetometers were added to the security program in a community with a lower crime index score, they would be unlikely to statistically reduce the number of security incidents.

• **Security Outcomes.** Figure 4 illustrates several types of security-related outcomes data, all of which relate to workplace violence. It is likely that your program collects the number of assaults that occur per location, and that you may be able to obtain data on workers compensation claims due to assaults per facility. You might also collect data on threats of assault. You can begin to quantify security's impact in terms of dollars as a reduction in workers' compensation claims. The point is to utilize available security incident or related data. If thefts or other types of crimes against property or people are a concern within your organization, expand your data collection effort to include that information.

STEP 2: RISK-STRATIFY HOSPITALS

Utilizing a risk-stratification model will enable you to objectively identify the relative risk of each hospital you secure. As noted, in HSS's statistical modeling, we found two characteristics of hospitals to have a statistically significant impact on security incidents: overall national crime index score and annual ED visits. These are the only non-security program characteristics with statistical impact identified to date in our statistical modeling and, as such, they are an initial basis for delineating the relative risk of each hospital covered by your security program.

These two factors can be used to construct a simple risk-stratification model, as shown in Figure 5. If you know the range of annual ED visit volume across the hospitals in the organization that you secure, and you determine the range of crime index scores they represent, you can construct and populate this simple model. From

your specific data set, delineate what sub-range is a "small" number of annual ED visits, versus medium and large. Similarly, determine from across your hospitals what the low end of the crime index score range is, versus medium and high. Facilities that fall into the darkly shaded boxes in the lower left represent relatively lower risk. Facilities that fit into the top left to lower right boxes (light-colored boxes) are medium risk, and the darkly shaded boxes in the upper right indicate the facilities of highest risk based on crime index score and ED visit volume.

Figure 5. 9-Box Risk-Stratification Model

Plot your facilities into the 9-box to see which fall into the low, medium, and high-risk categories. It is important to note that there may be other considerations, such as the presence of a behavioral health unit at one of the hospitals, that increases the risk of that facility compared to the others. In our statistical modeling, we did not specifically test to determine whether the presence of a behavioral health unit within a hospital has a statistically significant impact on security incidents. When your experience and intuition tell you that there are additional important hospital characteristics like this to consider, use your judgment and adjust the plotting of the facilities as appropriate. For example, assign the hospital with the behavioral health unit a "higher" risk if your experience

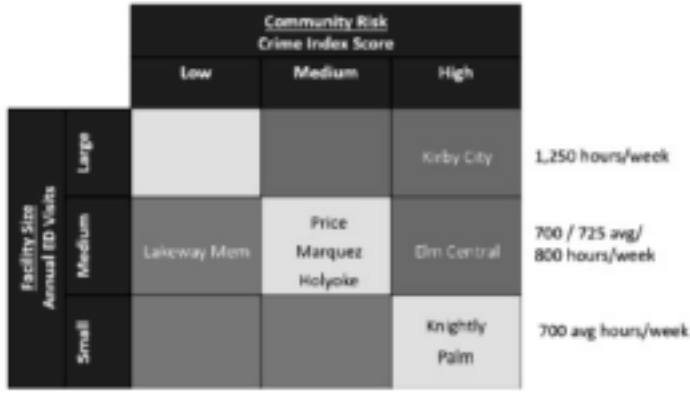
tells you that this assignment would be a more accurate categorization. For most facilities, we expect that the risk stratification based on ED visits and crime index score will produce a fair representation of the relative security risk.

STEP 3: CALCULATE BENCHMARKS

Benchmarks are simple points of comparison. After you have plotted your facilities into the 9-box risk-stratification model, look for boxes with more than one facility in them, and create benchmarks by averaging the data of the facilities in each box. Figure 6 provides an illustration of this process. Note that the names of these facilities were selected at random and do not represent an actual hospital system.

One type of data that can be averaged to create benchmarks is security program data. Let's use security officer hours worked per week as an example. By averaging security officer hours worked per week, you can begin to see approximations of "community standard" security program design for facilities with a given level of risk. This information begins to reveal which facilities at a given level of risk have relatively high or low levels of staffing relative to facilities with a comparable level of risk. As you consider the number of hours

Figure 6. Populated Risk-Stratification Model with Benchmarks



worked to the relative risk present at each location, this information may begin to reveal opportunities to invest or reduce investment in the security program at a given site.

This same technique can be useful for developing simple benchmarks for other security program elements, such as security officer team tenure.

Another type of data that can be averaged to create simple benchmarks is security outcomes data. Again, working with data from hospitals within a particular box of the 9-box, average the number of security incidents by type—assaults, for example (see Figure 7). Remember that the hospitals have been stratified by risk level. It is reasonable to expect a similar number of assaults to occur in hospitals with similar risk. Where variation in the number of assaults is present among facilities of similar risk—particularly when those trends have persisted for numerous reporting periods—it is worth digging deeper to understand what differences in security programs or other factors might be contributing to these varied results.

Use this comparative information to identify potential best practices to improve your security program. In the example shown

Figure 7. Variation in Security Outcomes

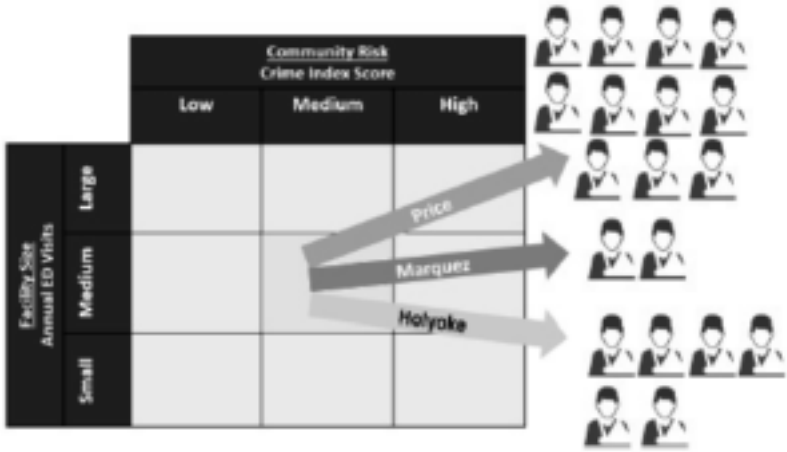


Figure 8. Data-Driven Security Program Adjustments

	Lakeway	Price	Marquez	Holyoke	Kirby City	Elm Central	Knightly	Palm
Risk Stratification	Low	Med	Med	Med	High	High	Med	Med
Current Security Officer (SO) Hours	700	750	750	675	1,250	800	900	500
SO Hours Benchmark	700	725	725	725	1,250	800	700	700
Additional Risk Factors		Behavioral Health						
Assaults	1	10	2	6	15	12	8	12
TASERs	-	-	-	-	-	-	-	-
Magnetometer	-	-	-	-	√	-	-	-
SO Tenure	Low	Low	High	High	Low	High	Low	Low
ACTION		Bump to 800 hrs; Add TASER, Add more experienced officers	Drop to 725 hours	Bump to 725 hours		Add TASER	Drop to 700 hours	Bump to 700 hours

in Figure 8, Price, Marquez and Holyoke Hospitals have similar crime index scores and ED visit volume, yet Marquez has notably fewer assaults than the other two facilities. Price not only has the highest number of assaults but also the additional risk factor of a behavioral health unit. A security director could bolster Price's security program by placing and/or attracting more tenured officers there (since improved officer tenure contributes to reductions in assaults) and could also redistribute security hours from Marquez to Price and Holyoke, as indicated in Figure 8. In this way, statistical data and benchmarks are informing decisions to improve, if not optimize, security program effectiveness across the hospital system.

OVERVIEW

Taking these simple steps to utilize data in decisionmaking will, over time, result in more objective decisions that will help counter preference-based security program design. As your database grows, you will have an improved ability to trend security incidents over multiple study periods, which will lead to greater understanding of the impact your security programs sustain over time. If you lack the data to create the benchmarks described in this article, consider the following:

- Create benchmarks by pooling and averaging data for all the

hospitals in each risk tier. For example, lump the low-risk hospitals together and average their results to create benchmarks.

• Build a network of peers at hospitals with crime index scores and annual ED visit volume roughly equivalent to your facility. Sharing basic data such as shown in Figure 8 will enable you to calculate benchmarks or community standards to which you can compare the structure and effectiveness of your facility.

• Participate in industry-wide efforts to gather data for purposes of developing community standards, such as IAHSS's benchmarking data project.

• Consider utilizing the services of a third-party healthcare security consulting firm that incorporates community standard benchmarking into its risk assessment methodology.

Most importantly, recognize that utilizing data to drive healthcare security program decisions is a journey. Like other fields that preceded healthcare security, early stages often rely on imperfect and incomplete data, which improves over time. The key is to gain experience and confidence in using data to drive decisions and use those early wins to demonstrate how data can enhance the decisionmaking process.

Partner with police to enhance hospital security

Michael S. D'Angelo, CPP, CSC, CHPA

Whether a hospital pays for an off-duty police officer or finds other ways to increase the presence of law enforcement in its facility, it will benefit from having police officers spend more time on its campus.

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Acts of violence in the healthcare setting have finally reached the headline-news level, after years of healthcare security practitioners beating the drum. Unfortunately, it has taken multiple sentinel events and numerous multimillion dollar settlements for this issue to come to the forefront of concerns for healthcare executives in the United States and Canada. Even with the spotlight finally focused, hospital security departments have not been given blank checks for all the preventative measures they need. Security leaders know that the "latest and greatest" in physical security technology comes at a significant financial cost. Balancing expenditures for new technology and acquiring new staff is a regular part of the budget battle. Even with healthcare workplace violence now receiving widespread exposure, "doing more with less" remains the norm.

Security's approach to dealing effectively with violence in hospitals has to be multifaceted. Beyond attending to technology, physical security and staffing, security departments need to partner with local law enforcement.

Patients, visitors and staff are already accustomed to seeing law enforcement in hospitals, so there is no worry that they will be shocked or concerned when seeing police officers on campus. Often the officers are there because they are responding to escalating violent encounters after security has deemed the escalated response necessary. They may also be on campus to follow up with victims of crimes or traffic accidents who may have been transported to the hospital. In some jurisdictions, walking through the hospital may be part of a police officer's regular patrol. In any case, from a security perspective, anytime law enforcement has a presence on campus, that presence enhances the security posture.

Knowing that there is tremendous value to having a regular law enforcement presence in and around the facility, security leaders need to consider ways to increase the frequency and duration. Here, I describe several approaches. For the purposes of this discussion, I will exclude situations where hospitals are required to have local law enforcement on the property and will focus on healthcare facilities that have either proprietary or contract non-sworn security teams and that could enhance their department's overall effectiveness by the additional presence of law enforcement.

OFF-DUTY POLICE DETAILS

Most municipal, county, and state law enforcement agencies allow their officers to work off-duty details to augment their salaries. Some larger agencies have infrastructures in place to handle the scheduling, coordination, and payment for these services. It is important to note that, although there is tremendous value in having even a single off-duty detail police officer on the hospital campus, use of these officers should not be viewed at as a method of replacing a security department FTE.

What enhancements could a sole off-duty officer bring to the facility? First and foremost is the

single most powerful tool a police officer carries: a department-issued radio. The efficiency with which emergency communications can take place when a police officer has such a radio cannot be understated. The speed of communication that can be achieved by an officer who has a direct line of communication to his or her department dispatcher plus a radio link to the hospital's Security Operations Center is difficult to attain by any other means. In the event of an emergency incident (contemplate the worst-case scenario of an active assailant), the delay caused by routing a 911 call from security to PBX (or similar relay process) can mean lives lost. The ability to have real-time, immediate on-scene communications between emergency responders and a police officer on campus can lead to a level of event coordination usually observed only in exercises.

Another point worth discussion is the value of having an armed police officer present. Some healthcare security departments are arming their staff, whereas many more still do not wish to take on the tremendous responsibility and liability necessary to do so. (I refrain here from interjecting my professional opinion on the arming of healthcare security staff. However, I do implore any healthcare facility considering doing so to review and abide by the new IAHSS Guideline pertaining to arming healthcare security.) A viable compromise solution may be having an off-duty police detail on your campus.

Logistically, the ideal situation would be for an officer to be present 24/7. In reality, budgets may render a round-the-clock presence impractical. In determining the hours of operation for this assignment, healthcare security leaders should conduct a thorough analysis of available data to include

- hours of peak calls for security service and hours when the security team may be operating at lower staffing levels,
- frequency and times of calls involving acts of violence or use of force, and
- any other additional information that will help guide the leader in making an intelligent decision.

Likewise, if only a single off-duty officer will be utilized, *where* will be as important a con-

sideration as *when*. I recommend having the officer rove or patrol. This can be either by vehicle or on foot. If you go with a solo officer, the officer should work inside the facility, leaving outside patrols to the regular security force.

When an organization simply does not have the budget to hire off-duty police officers (as is often true of smaller operations), or when the local police agency does not have the staffing levels required to support such a program (as can be the case in more rural healthcare settings), steps can still be taken to increase the police presence in your facility, as the experience described below shows.

POLICE SUBSTATION

After a Miami-area hospital renovated and expanded its Emergency Department (ED), a small storage room just behind the triage areas went essentially unused. None of the nursing staff stored anything in it, and when the ED Manager asked for the reason, the staff replied that they just didn't need the space. The ED Manager conferred with the Director of Security and, together, they decided it would be an ideal space to offer to the local police. A meeting was set between the hospital's and police department's representatives, who agreed that the hospital would supply the room, a desk, a telephone, and a computer terminal. In turn, the police department would adorn the door with a large, color version of its logo, and anytime officers were responding to either a call from the hospital or a call that resulted in a victim being transported to the hospital, officers would open the room and use it as a workspace.

Although this arrangement did not provide the hospital with a round-the-clock police presence, having a comfortable and equipped workspace did make officers more likely to spend time on the property, completing paperwork. For the hospital security leader, this kind of arrangement provides a very visible indicator that there is a police facility on the property, with the general public having no knowledge of when the space is or isn't occupied

Granted, in this example, the available space happened to be in the ED, the location of most cases of violence in the healthcare setting. However, as long as the

space is located somewhere highly visible, the healthcare facility will be able to capitalize on some residual deterrent value. This type of collaboration also has the benefit of going a long way to strengthening the bond between the hospital security team and local law enforcement. A side note: keep the coffee available.

POLICE PARTICIPATION IN DRILLS

Healthcare emergency managers and security directors are well versed at conducting exercises and passing on valuable skills to teams throughout their facilities. Exercises that hospitals conduct run the gamut of emergency drills. If law enforcement is not participating in drilling and exercising, it should be, and doing so will be yet another way to bring police offers to campus. Law enforcement should not only be included in the development of these exercises but should also have seats around the table on the day of a drill. Anytime the facility drills its response to a MCI-related surge, a hazmat decon, or another drill involving patient overload, a component of the drill will involve outside resources.

Law enforcement should be one of the resources tapped in drills that go beyond typical exercises; without doubt, they should be an integral part of reviewing active-shooter or barricaded-subject scenarios and protocols. The more law enforcement is asked to participate in drills, the more comfortable and familiar they will become with your facility, and knowing the layout and geography of the hospital is vital to an emergency response.

Yet another way to encourage a police presence is making police officers aware that the hospital has a late night café they could visit during the overnight shift as an alternative to the usually limited nighttime dining options. Building good relationships involves demonstrating value that is reciprocal.

Besides the value of increasing police presence in your facilities, there is another key takeaway here: Do not let the first time that local law enforcement officers learn their way around your hospital be the day someone is in it shooting! Yes, it has happened and, as remarkable as it may seem, there are still healthcare facilities everywhere that do not talk to their local police.

Is your commonsense approach to customer service a common *practice*?

Dan Beaver, CHPA

Treating everyone who comes through the doors of your facility as you would want to be treated usually goes a long way to smoothing interactions. It also enhances the facility's reputation with its customers. Yet, says the author, such common sense does not always translate into action. He offers a refresher on how to deliver customer service that excels.

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Countless articles stress the importance of excellent service to our customers. Entire websites are devoted only to motivational quotes related to customer service. Given what seems to be an overabundance of such material, I initially hesitated writing anything additional. Yet, believing that there is always room for improvement, I hope I can inspire you to improve your service. (Of course, if your customer satisfaction scores are already at 100%, you can move on to the next article).

"CUSTOMER" DEFINED

Who exactly is our "customer"? I have always considered everyone at my facility, not only the patients, to be a customer. By a reasonable definition, a customer is the recipient of goods, services, or products that are obtained from a vendor, seller, or supplier in exchange for money or some other

valuable consideration. Based on the belief that everyone in your organization, both internally and externally, will at some time request a service that your department has to offer, all visitors, guests, physicians, contractors, vendors, volunteers, clergy, students, and so on should be viewed as customers. Their reasons for being at your facility will vary, just as their need for assistance will. Recognizing these differences is critical to your strategy for providing effective service.

PUT COMMON SENSE INTO ACTION

Being customers ourselves nearly everywhere we go, surely we each have a clear understanding of how we want to be treated, and we know to treat others as we would want to be treated ourselves. This is simple *common sense*. Knowing this fundamental concept, shouldn't we all be reasonably skilled at customer service, able to meet or even exceed our customers' expectations? Although it may be *common sense*, is it *common practice* at your organization as well? I am thinking broadly here, including healthcare customer service related to security, protective services, safety, and police.

People who serve in all these areas are routinely taught, and frequently reminded of, how important their service to customers is. Their attitude, approach, willingness, and actions towards their customers will significantly affect the perception and image that the customer has of the entire organization. Those who have the ability and initiative to consistently demonstrate a customer-service approach that is highly professional, effective, and respectful are likely to understand that their approach certainly aligns with the values and mission of their entire organization. Excellent customer service can most certainly have a positive impact on attitudes, quality of care, and a customer's return and referral to others. Many publications and customer-service training programs are available. The International Association of Healthcare Security and Safety offers numerous resources that are specific to healthcare customer service.

KEY PRINCIPLES

There are numerous methods and a wide scope to improving customer service and ensuring customer satisfaction. Several im-

portant elements of exceptional customer service include effective communication, remaining professional, and being courteous. Remain honest, offering dignity and respect. Always respect the customer as a person, treating the individual fairly. Never argue or demonstrate an indifference to customers. Offer explanations and possible solutions or consequences that are simple and declarative. Heed this comment from business consultant Damon Richards: "Your customer doesn't care how much you know until they know how much you care."

When helping others, you must always recognize your responsibility and that you are accountable, especially with regard to patient interactions. An understanding of appropriate training, limitations, and regulatory requirements is imperative, along with knowing the consequences of failure. Strive for a positive outcome. Remain confident in yourself. Successful and effective customer service never involves dishonesty, abuse, misrepresented authority, or irresponsibility.

The skills and techniques you use to achieve great customer service will clearly vary depending on the needs of the customer. The needs of a lost elderly visitor trying to locate a physician's office will certainly be different from the needs of a belligerent, aggressive, or combative patient. Regardless of the customer's immediate need, your assistance should always demonstrate an ability to remain calm, professional, and respectful. Whether holding a door for a vendor who is delivering supplies, or de-escalating a threatening or confrontational visitor, offer your assistance professionally. Demonstrate diplomacy and a genuine concern for their needs. Always remember that the individual is in your facility for your help, even if they don't seem to want your assistance.

THE IMPORTANCE OF EMPATHY

Perhaps the most important element of excellent and effective customer service is demonstrating genuine empathy. Be able to proactively perceive the personality and the needs of others. The Oxford dictionary defines empathy as "the ability to understand and share the feelings of another." This is not to be confused with

being sympathetic, which is showing pity for another person's circumstances or feelings. Having genuine empathy for someone is being able to put yourself in their shoes, understanding how you would feel if you were experiencing the same circumstances. Attempt to anticipate the customer's expectations as well as their needs.

Maintaining communication and good listening skills can not only provide good customer service but can also help you anticipate problems. This is often very difficult to do at a hospital, as the circumstances that can bring individuals to a healthcare facility are often nearly unimaginable for many of us.

A CASE IN POINT

An experience I had several years ago drove home the importance of empathy in a very personal way. I received a call from a family member advising me to visit my hospitalized grandmother, as her condition had worsened and she was not expected to live to the end of the day. I immediately traveled to the hospital. Not being familiar with the campus, I asked a valet for parking directions. After following what I thought were the directions given to me, I found myself on a dead-end street. I realized that my thoughts were of my grandmother and I had probably not listened clearly. After finding visitor parking, I entered the building and asked an individual at an information desk for directions to the unit. With the proverbial lump in my throat, I said I was in a hurry. After the receptionist told me that she was not sure where to direct me, I proceeded down the hall into the hospital. After asking directions from four additional employees separately over the next nearly 30 minutes, I eventually found the correct nursing unit. On my arrival, I was told that my grandmother had just passed moments ago.

Had any of the employees I encountered taken more time to help and perhaps been more understanding of my circumstances and more *empathetic*, I may have been able to be with my grandmother. I'm typically a rather forgiving person and tend to believe everything happens for a reason. The optimistic side of me was thankful that I was not a clergy member that needed to be with this patient or was not a nine-

year-old child who needed to see grandma before she died.

When I returned to my facility, I gathered all of my team members and told them this story. I asked that they be aware of why people come to a hospital, and to always offer assistance to them, always making sure they find their destination. Since this experience, I have often asked my team to offer their services as though the customer were a personal family member or friend of their own. How would you hope that this person would be treated?

HANDLING CHALLENGING SITUATIONS

Some customers will test your service skills more than others, such as when people are affected by the highly charged emotions that frequently occur in a hospital environment, possibly accompanied by mental health issues, the influence of drugs or alcohol, stresses, uncertainty, or pain. The fact that many of these individuals don't want to be at your facility to begin with needs to be recognized and not underestimated. Approaching individuals who are exhibiting challenging behaviors requires patience, understanding, and sense of awareness. Remember that your customers are not limited to patients and guests but include coworkers and other employees as well: Customer service is still required during disagreements, conflicts, discipline issues, and terminations of employment.

Providing effective, safe, and exceptional service to customers that are distraught, violent, influenced by drugs or alcohol, injured, grieving from the loss of a loved one, or mentally unstable can be daunting. These types of interactions are often exhausting and may leave you feeling less motivated or uninspired.

The ability to successfully intervene in even the most hostile situations requires an approach that de-escalates and remains attentive and diligent. These effective customer-service skills can range from effective verbal de-escalation to physical management. When approaching a difficult customer, always attempt to distinguish whether the person is obnoxious, rude, or upset, as opposed to displaying behavior that is threatening, violent, or dangerous. Be prepared that, despite

your efforts to address the needs of these customers, you can be met with name calling, inappropriate language, and raised voices. Avoid getting provoked and do not become argumentative. Don't contradict, but rather respectfully try to explain why their point of view may be incorrect.

Your approach to dealing with a difficult customer should always include an understanding of immediate safety and how to protect yourself and others if needed. As is the case with less-challenging customers, addressing, approaching, and understanding a hostile customer requires professionalism, respect, and appropriate communication. In fact, the need for these skills intensifies and can even be critical when the customer is angry, makes threatening gestures, or becomes violent.

Of course, when violence is occurring or is a serious threat, basic safety and survival skills come first. Intervening in a confrontational or violent situation with a customer requires the elimination or control of the immediate danger. This approach should still be accomplished professionally, however, while you remain focused, attentive, and respectful.

REMOTE CUSTOMERS ARE STILL CUSTOMERS

The customer service guidelines I have outlined so far are not limited to customers that are physically present but include those you encounter on the telephone, social media, e-mail, and so on. Telephone manners and written responses to a customer should be just as timely, professional, and respectful as if the individual were with you in person. I'm sure most of us have experienced the suffering of being sent through 15 menu options just trying to reach a real person (or ironically a customer-service agent) to speak with on the telephone. Ensure that your dispatchers, administrative assistants, and officers answering telephones and intercoms at your facility understand the same values and support your customer-service expectations.

ALL STAFF NEED A CUSTOMER-SERVICE MENTALITY

Employees at every level of the organization need to have a customer-service focus. I suggest taking the following steps to

support that goal:

• Ensure that clear customer-service expectations are communicated to new and potential hires. Depending on people's previous training, background, experience, and overall work ethic, not everyone will necessarily come in understanding the significance of customer service. Your expectations for how customers at your facility should be treated must be made very clear and understood from the start.

• Explain that one's physical appearance and image are as much a direct part of customer service as one's behavior. The uniform worn sends a message. Your appearance represents the organization and facility. The often-stated remark that "you don't get a second chance to make a first impression" remains very accurate.

• Make it clear that the one time that customer service may become less of a priority is during hostile situations that involve the physical management of an individual. Then, training in the use of force, restraint, detention, protection of others and self-defense takes precedence. Even so, proper execution of that training will ultimately contribute significantly to the overall service to this customer.

A CHECKLIST

Clearly, exceptional customer service is of exceptional value. It contributes importantly to fulfilling the objectives and values of an organization and its departments, including security, protective services, safety programs, and police. Good customer service leads to higher-quality interactions and enhanced safety and has the potential to increase both return and referred business.

In writing this article, I intended to remind you of several elements of customer service that you already knew are *common sense* strategies. I offer the following checklist of eight practice guidelines for successful and exceptional customer service, with the hope that your methods result in best *common practices* and indeed exceptional customer service:

☐ Maintain your professionalism.

☐ Remain empathetic; recognize and understand the customer's needs and circumstances.

☐ Communicate clearly and honestly and remain impartial.

☐ Be respectful, courteous, and dignified.
☐ Approach people with a sense of awareness, remaining attentive and observant.
☐ Remain patient and focused; avoid being provoked or becoming argumentative.
☐ De-escalate; do not escalate the problem.
☐ Remain aware of your appearance and of how you are perceived by others; dress for success.

Violence in emergency departments is increasing, harming patients, two surveys find

Vidor Friedman, MD, FACEP

A nationwide poll of emergency physicians by the American College of Emergency Physicians (ACEP) and a study of Michigan emergency physicians reveal that more than 70 % of physicians have experienced violence in the past year and that violence has increased nationally during the past five years. Nationally, almost half of all respondents said hospitals can do more by adding security officers, cameras, security for parking lots, and metal detectors, and by increasing visitor screening inside hospitals, especially in emergency departments.

(Vidor Friedman, MD, FACEP, is President of ACEP.)

The results of a poll of more than 3,500 emergency physicians across the nation have been released, alongside new research about violence in Michigan emergency departments, and presented at the annual meeting of the American College of Emergency Physicians (ACEP). The poll was conducted by Marketing General Incorporated (Marketing General Corporation, 2018).

More needs to be done. Violence in emergency departments is not only affecting medical staff, it is affecting patients. When violence occurs in an emergency department, patients can be injured or traumatized to the point of leaving without being seen. It also can increase wait times and distract emergency staff from focusing on other patients who urgently require a physician's assistance.

VIOLENCE REPORTED INCREASING "GREATLY"

Nearly 7 in 10 say violence has increased in the past 5 years, with 25% reporting it is increasing greatly. Almost half (49%) of all respondents say hospitals can do more by adding security officers, cameras, security for parking lots, and metal detectors, and by increasing visitor screening inside hospitals, especially in emergency departments. Nearly three-quarters (70%) of those assaulted say that their hospital administration or hospital security did respond to the incident, yet among those whose hospital responded, only 3% say that hospital security actually pressed charges. Nearly all women who are emergency physicians (96%) report that a patient or visitor made inappropriate comments or unwanted advances toward them, and 80% of men report the same.

More than a quarter (27%) of emergency physicians who were assaulted in the past year say assaults occurred more than once. Nearly a third (27%) of those assaulted got injured. About half of those injured (44%) report being hit or slapped. Almost one-third say they have also been either punched, kicked or spit on. Almost all (97%) say a patient committed the assault. A quarter (28%) report that they had been assaulted by a patient's family member or friend.

MICHIGAN STUDY: MORE PHYSICIANS FEELING CONSTANTLY FEARFUL

A new study, *Reassessment of Violence Against Emergency Physicians*, published in the Annals of Emergency Medicine and presented at ACEP18 (Omar et al., 2018), found that despite increased security measures in Michigan, the problems of emergency department violence are getting worse.

"Emergency physicians across all demographics experience various forms of violence and are increasingly concerned about becoming a victim of violence," says Terry Kowalenko, MD, FACEP, an emergency physician in Michigan and co-author of the study. "Despite increased risks, our research found that there is very little published on topics such as situational awareness, verbal de-escalation, self-protection techniques or weapons awareness for emergency physicians to use."

According to Kowalenko's research, 72% of emergency physicians in Michigan reported experiencing violence in the past year. More physicians in 2018 reported feeling "constantly fearful" of becoming a victim of violence (8.1% versus 1.2 % in 2005), with 21.9% reporting feeling frequently fearful (up from 9.4% in 2005).

Other findings of the Michigan poll include:

- Almost three-quarters (71%) personally witnessed others being assaulted during their shifts.
- More than 80% of emergency physician respondents say a patient has threatened to return and harm them or their emergency department staff.
- Half of emergency physicians report that at least half of all assaults are committed by people were seeking drugs or who were under the influence of drugs or alcohol.
- More than 40% of emergency physicians believe that more than half of assaults are committed by psychiatric patients.

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Evidence, anecdotes, and actions: A summary of the 2019 Healthcare Crime Survey and other IAHSS Foundation research

Karim H. Vellani, CPP, CSC

Hospital security leaders across the United States provided 345 complete responses to core survey questions about 2018 crime in their facilities. Their reports dovetail with other research showing that patient and visitor violence against staff is an urgent and growing problem that demands a strong response.

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In May, the IAHSS Foundation published the 2019 Healthcare Crime Survey (IAHSS Foundation, 2019) reporting on 2018 data from hospitals in the United States. This article summarizes some key results and compares the new findings with those for 2012 through 2016. (We did not receive enough responses last year to report on 2017.)

The survey examined 10 crimes: murder, rape, robbery, aggravated assault, assault (other), disorderly conduct, burglary, theft (larceny-theft), motor vehicle theft, and vandalism. These categories were defined according to the Uniform Crime Report definitions of the Federal Bureau of Investigation (FBI). Data on workplace violence incidents was also broken down into four types, defined to be consistent with the FBI's Workplace Violence Typol-

ogy (described in the next section) (Rugala & Isaacs, 2003).

Overall, the rate of violent crime is rising, and property crime is falling, as measured by number per 100 beds. And a crime not surveyed in past reports—ransomware attack—turns out to be more common than you might think.

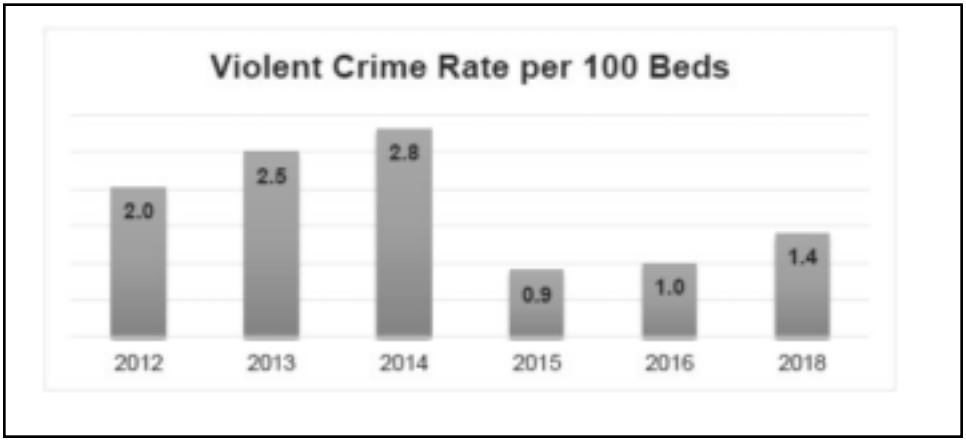
THE FBI'S VIOLENCE CATEGORIES

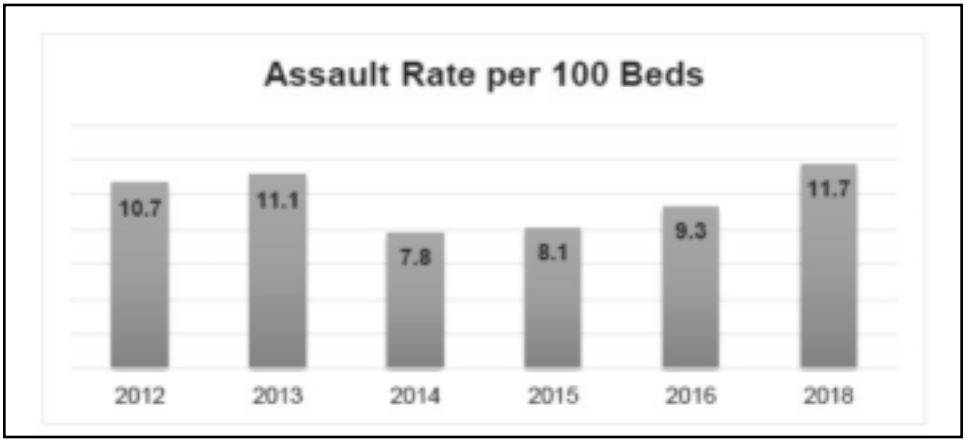
The FBI's Workplace Violence Typology categorizes violence into the types described below, which are distinguished primarily by the perpetrator.

- Workplace Violence Type 1: *Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.*
- Workplace Violence Type 2: *Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services. Examples: patient-on-staff, visitor-on-staff.*
- Workplace Violence Type 3: *Violence against coworkers, supervisors, or managers by a present or former employee. Examples: physician-on-nurse, employee-on-employee*
- Workplace Violence Type 4: *Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.*

RESULTS

The three graphs that follow show rising rates of violent crime (here, combining murder, rape, robbery and aggravated assault); assault (other), and disorderly conduct. The FBI defines *aggravated assault* as an unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury, whereas it defines *assault (other)* as an unlawful physical attack by one person upon another where neither the offender displays a weapon, nor the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness.

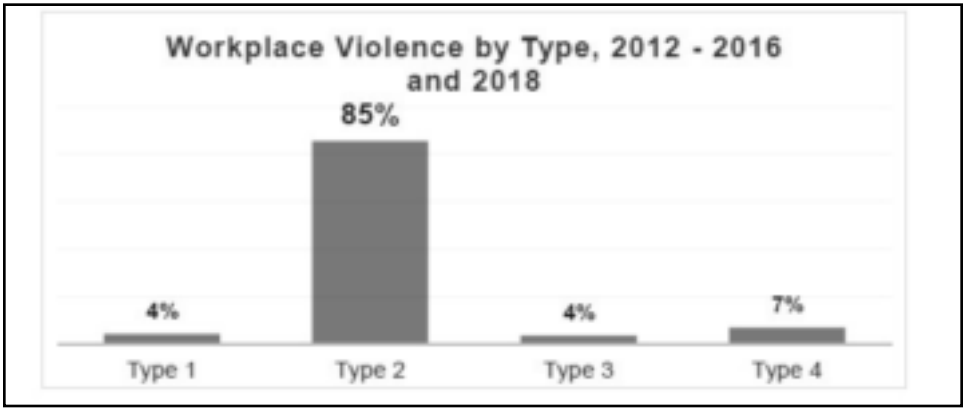

Violent Crime Rate per 100 Beds
2.0
2.5
2.8
0.9
1.0
1.4
2012
2013
2014
2015
2016
2018


Assault Rate per 100 Beds
10.7
11.1
7.8
8.1
9.3
11.7
2012
2013
2014
2015
2016
2018


Disorderly Conduct Rate per 100 Beds
28.0
39.2
18.8
21.4
34.1
45.2
2012
2013
2014
2015
2016
2018

Workplace Violence Type 2 dominates the other types of workplace violence (as shown in the top graph below) and is increasing: healthcare staff are at greatest risk from patients and visitors. The data underlying this graph incorporate aggravated assault and assault (other).

The survey found that Violence Type 2 accounted for 78% of aggravated assaults throughout the history of the IAHSS Foundation Crime Survey and 88% of all assaults (other). Further, as shown in the bottom graph below, the responses indicated that 1.2% of healthcare workers were the victim of an assault (other) by a patient or visitor in 2018 and that 0.2% were the victim of an aggravated assault by a patient or visitor in 2018—although we know from other workplace violence studies and anecdotal evidence that these numbers are likely to be underreported.



LEGAL IMPLICATIONS

Violent crimes on healthcare campuses can sometimes result in litigation under the umbrella of premises liability laws. "Settlements and jury verdicts resulting from these cases can involve hundreds of thousands or even millions of dollars," notes Houston-based healthcare attorney Tina Kristof, adding that the costs "of defending against such a lawsuit can also be very significant, even if the [healthcare facility] eventually wins in court" (Kristof 2018). Anecdotal evidence gathered through discussions with attorneys, media reports, and security experts indicates that negligent-security lawsuits against hospitals are on the rise.

Kristof has identified several strategies to improve the effectiveness of security programs, reduce the risk of crimes, and mitigate the risk of claims and litigation, including:

- Involving all employees in the security program;
- Complying with all legal and regulatory requirements and industry standards;
- Implementing physical security measures;
- Budgeting appropriately for the security program;
- Being aware of local crime (International Association of Professional Security Consultants, 2018);
- Paying attention to all incidents and complaints;
- Providing adequate warnings;
- Hiring a security consultant;
- Documenting security officer actions;
- Providing sufficient training to security officers (Kristof, 2018).

COMBATING TYPE 2 VIOLENCE

Beyond potentially injuring employees, Workplace Violence Type 2 can result in time off from work due to those injuries, career changes, worker's compensation claims, and sometimes litigation. The ongoing violence problem has resulted in the development of workplace violence-prevention toolkits, guidance provided by healthcare and security associations, dissemination of Joint Commission alerts, enactment of state-specific laws, and a bill introduced in the U.S. House of Representatives (H.R.7141, 2018). Workplace Violence Type 2 needs to be addressed at every

hospital. Given the extent of the problem, healthcare organizations should not wait for federal or state governments to create laws or for accreditation bodies to create standards.

Workplace Violence Type 2 incidents per 100 employees is a good starting point to benchmark your hospital against the national trend. The calculation is fairly easy if your internal security and workplace violence data is maintained in a manner consistent with the Healthcare Crime Survey and separates incidents by Workplace Violence Type and by assault (other) versus aggravated assault. For example, to calculate the rate of Workplace Violence Type 2 assaults, security leaders can use the following formula:

Workplace Violence Type 2 Assault Rate = (Workplace Violence Type 2 Assaults / Employees) x 100

Example: (22 Workplace Violence Type 2 Assaults / 1200 employees) = 0.0183 x 100 = 1.8 Workplace Violence Type 2 Assaults per 100 employees

Metrics such as the one suggested above provide information from which to make decisions. Hospital security leaders can improve their data collection by taking the following actions:

- Implement IAHSS Guideline 01.05.01 (Security Incident Reporting);
- Align with the pending IAHSS Guideline that identifies Security Incident Categories;
- Align with the FBI's Uniform Crime Report (UCR) or National Incident Based Reporting System (NIBRS) definitions;
- Incorporate the FBI's Workplace Violence Typology;
- Identify the location of each reported incident (ED, BHU, ICU, and so on).

RANSOMWARE ON THE RADAR

This year, the survey asked respondents about ransomware: a type of malicious software designed to block access to a computer system until a sum of money is paid. Of 245 hospitals that replied to the question, 11% said they had suffered a ransomware attack in 2018.

Resources

IAHSS Foundation. (2019). *Healthcare Crime Survey*. Chicago, IL. IAHSS. https://iahssf.org/assets/2019-Healthcare-

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Workplace Violence Prevention for Health Care and Social Service Workers Act, H.R.7141, 115th Cong. (2018). https://www.congress.gov/bill/115th-congress/house-bill/7141/text

Balancing the roles of patient care with security in resolving behavioral crises

Nicole Dick, BS, and Krisha Goset, BA

Before 2008, security officers at Allina Health, based in Minneapolis, MN, did not receive training in how to respond to behavioral crises, and the care staff did not trust security to do the right thing. Today such training is mandatory, and security officers and clinicians follow a carefully developed protocol to prevent situations from getting out of control. The program works so well that it is used throughout Allina Health's 13 hospitals.

(Nicole Dick, BS, is Security Supervisor at the Mercy Hospital–Unity Campus of Allina Health, and Krisha Goset, BA, is Security Training Supervisor at Allina Health, which is located in Minneapolis, MN. Both are members of IAHSS.)

Imagine your officers are called to respond to a patient acting out in his room. The officers arrive at the room and find that the man has barricaded the door and is actively throwing items around. The patient is not injuring himself or others at this time but certainly needs assistance in regaining self-control. What do your officers do?

Behavioral crisis in healthcare can lead to workplace violence and injury to employees or patients, as well as to the stigmatization and demoralization of patients. Healthcare security officers and patient care employees must work together when creating and implementing an appropriate and safe response to these types of crisis. A one-sided approach that does not include essential members of the care team leads to a negative safety culture,

low morale, and poor patient satisfaction.

In 2008, a team of Allina Health nurses and security officers developed a team approach to behavioral crisis, which is known as Code Green. This approach has opened doors for security across our healthcare system, and we have become an integral part of the Allina Health care team. We believe this approach can benefit healthcare organizations across the globe.

CODE GREEN AT ALLINA HEALTH

The Code Green training program at Allina Health was developed by a team of frontline employees and leaders, including one of the authors (Goset), over several years of trial and error and research after it became apparent that our historical approach was fragmented and ineffective from a safety perspective. When a Code Green is called, it elicits responses from employees across the hospital who are trained in prevention, de-escalation, and a team approach to physical intervention—all of which are designed to preserve the dignity and respect of the patient and the safety of employees and patients.

A typical Code Green response team consists of the following roles:

- **Code Director.** Directs the code, meets with responding employees to determine a plan for the patient, assigns responsibilities to the Code Green team, works with the negotiator and responding team members to identify whether physical intervention is necessary, facilities debriefing, notifies appropriate leaders if injury occurs or follow-up is needed, and dismisses the Code Green team.
- **Primary Nurse.** Ensures or delegates visual contact of the patient until the team arrives; may continue or delegate verbal de-escalation efforts after the team arrives.
- **Negotiator.** The team member who has the best rapport with the patient at the time serves as the sole communicator with the patient during verbal de-escalation, continuously adapting the approach as needed to avoid physical interventions whenever possible, and communicates to the team when physical intervention is necessary.
- **Team Members.** They re-

main in the background but stay close enough to physically intervene if necessary, while maintaining a neutral posture and attitude. Move other patients away from the scene, keep them safe, and engage them in activities. Clear hallways, obtain restraints, and direct patients and visitors to other areas.

At the end of a Code Green, the director leads a de-briefing. In the de-briefing, the team should discuss opportunities to improve responses and outcome, what led up to the event, the plan for the patient going forward, and whether any injuries occurred.

RESPONDER TRAINING

To enhance Code Green responder skills, Allina Health partnered with The Barbara Schneider Foundation (BSF) in 2012 and 2013 to provide the responders with Crisis Intervention Training (CIT). The Foundation's CIT is based on the Memphis Model CIT and includes education on medication, specific diagnoses, and de-escalation and provides coaching through the use of "consumers" and actors. The consumers provide a real-life perspective on living with a mental health condition or being the loved one of someone who has experienced a behavioral health crisis; the actors enable employees to practice de-escalation in realistic conditions but in a controlled environment.

The demand for this training became so significant that, by 2014, BSF had to discontinue our partnership, as BSF was becoming unable to support our needs as well as those of its original audience: corrections and enforcement. With the permission and support of BSF, in 2014 the Allina Health CIT for Healthcare Providers program was created and implemented, incorporating many BSF teachings and techniques.

Both Code Green and CIT classes are mandatory for anyone who will respond to Code Green in our hospitals. Employees on the Code Green team may come from a variety of departments; such as Emergency, Mental Health, Security, Facilities, or Radiology, and they continues to come from an expanding list of disciplines.

CODE GREEN IN ACTION

The purpose of the Code Green

response team is to de-escalate whenever possible in a behavioral crisis, with physical interventions used only as a last resort. Physical interventions may be used if a patient has escalated to the point of being unable to actively participate in the de-escalation process.

The Allina Health security team—by understanding how the Code Green team response works and having the knowledge and practice provided by the CIT training—is able to partner with patient care employees to resolve behavioral crisis such as the one described above. When a patient is at risk for escalating to a point of causing self-harm or harm to others, we support our patient care employees as they attempt to communicate with the patient. Nursing employees work with physicians and pharmacy to determine what, if any, medications are needed. Many times, security serves as the negotiator, and we give our perspective on safety as the Code Green team formulates a plan.

If the behavioral crisis cannot be resolved and escalates to a level that puts anyone at risk, the patient care employees are trained and able to assist us with physical interventions. Like de-escalation and negotiation, the physical interventions we utilize in a Code Green are a team effort and designed to keep safety and dignity at the forefront.

At the end of a Code Green response, the director facilitates a debriefing for the team. The intention of the debriefing is to review the team's response and to formulate a plan should this patient need additional intervention. This is also the time for team members to share any kudos, concerns or injuries that should be reported up through our system tool. Admittedly, this aspect of the Code Green is one that is often bypassed and is an area of opportunity for our team.

IMPACT ON THE ORGANIZATION

The implementation of the Code Green response team and of CIT for Healthcare Providers has brought benefits to our team and organization that we could not have predicted. Training for and responding to behavioral crisis as a team with patient care employees has created a connection that was not otherwise possible. We are no longer seen as just a name

and a badge; we have now become a respected, integral part of the care team. We are relied on daily for expertise and insight in keeping our patients, hospitals, and employees safe.

Being recognized as professionals within our organization has allowed the Allina Health security team to evolve from everyday security officers into trusted partners and a valuable resource. Our footprint is seen across the system, and additional career opportunities in our department are developing every day. The trust we have gained has opened the door to the future, and we are walking along with the rest of Allina Health into the Whole Person Care initiative (designed to consider the full array of a patient's needs) instead of watching from the sidelines.

How to calm patients who have autism

Keith Miller

The author drew media attention when he and his fellow officers settled a potentially violent autistic patient with song and compassion. Here, he offers advice for others who find themselves in a similar situation.

(Keith Miller is a sergeant in the Department of Security and Safety at Loyola University Medical Center, in Maywood, IL. He trains other officers in how to work with patients who have autism.)

Friday, December 28, 2018, started out like any other day. I came in, briefed my officers on the activities of the prior shifts, and handed out assignments. Then we headed to the field to perform our daily duties, which typically consist of dealing with frustrated visitors, agitated and confused patients, and countless issues involving employees. Shortly after 1900 hours, a distress call came over the radio from one of the emergency room units: "We've got a 10-10 in progress," shouted the dispatcher. With a 10-10—signaling an aggressive, possibly violent individual fighting with staff or others—all available officers are to stop what they're doing and report to the area as quickly as possible. When I arrived, all other officers were on the scene with a very large man in his thirties who appeared to be aggressively going after a woman that turned out to be his mother. As I approached

the individual, I noticed something different about him. Unlike most violent individuals, he did not respond to commands of "Stop!" and "Back up!" from the other officers. I realized this patient was autistic.

I immediately instructed the officers to surround the man so that he could no longer target his parents. Then I spoke with medical staff to see if they had a treatment plan, medication, or possibly restraints. No plan had been made yet, because the patient had just arrived and the physician could not determine a plan of action until the patient was examined. I next spoke to the patient's parents, who had earlier been injured when their son, Walker Hughes, unexpectedly became violent. I wanted to get an idea of his ability to take commands and of how severe his violent outburst had been. Exhausted, scared and confused, both parents had a lot of questions but, in the midst of the chaos, just wanted a solution to the problem.

CRISIS AVERTED

After receiving all pertinent information, I turned my attention to patient Hughes, who was six-foot-three and weighed about 230 pounds, possibly more. Several of the officers, including me, made several attempts to communicate with him but were unsuccessful. Then, all of sudden, he yelled out "Mary Poppins." At that point I realized that the best way to deal with him was to connect to him through music and other things he liked.

I then started to sing the theme from "Mr. Rogers' Neighborhood," as other officers joined in. It worked. Hughes started to smile and even started to sing. Staying with the program, the officers and I began talking about different PBS programs we remembered. Again, Hughes responded with smiles of interest and periodically sang some of his favorite Disney songs. For two to three hours, I and seven officers repeated the same process. When one officer left, another would join us, give high fives to Hughes and join in on the singing. The remainder of the shift was about the safety and sanity of Walker Hughes.

NOT AN ISOLATED EXPERIENCE

I have been in public safety at Loyola University Medical Center, in Maywood, IL, for 12 years. In those years, I have en-

countered a number of patients with autism—which is not surprising, given that approximately one in 59 children in the United States has received a diagnosis of autism spectrum disorder (ASD). Approximately 3.5 million Americans have form of the condition, which involves withdrawal from social contact and communication difficulties. In addition, over the next decade, 500,000 teens with autism will enter into adulthood. That averages to 50,000 per year. I am also the father of an autistic child. My experiences with my child and with autistic patients has taught me a lot about their behavior and how to deal with it. As well, I have received certification for teaching others how to deal with and recognize people with autism.

KEYS TO SUCCESS

Success in dealing with autistic patients lies with showing compassion and focusing on the individual. When a first responder arrives to a scene in which an autistic person needs help, the first job is to assess their behavior. Ask yourself the following questions.

Are they violent? Violent autistic people generally possess a strength that may seem superhuman to others but simply stems from their inability to express themselves, which leads to frustration. This frustration will cause them to do whatever they can to get someone to help them. I think we all can remember a time when we tried to explain what we were feeling and the person we were talking to just didn't get it. Frustrating right?

Are they scared? Like difficulty expressing oneself, fear can lead to frustration. New faces, a lot of noise, and being surrounded by a large group of people can be quite scary. We all seek people to comfort us when we are afraid. It's easy when you can simply tell someone, "I'm afraid," and they comfort you, but autistic people will usually find comfort only in people familiar to them. Again, people without autism have similar reactions: How many of us share feelings of fear with total strangers?

Are they in pain? This question, of course, is critical for first responders. People with autism struggle with expressing that something hurts. Some also have a high tolerance for pain, while others simply ignore the pain for

fear that they are doing something wrong. Finding out what's hurting a patient can be as simple as asking, "What's hurting?" or "Can you show me where it hurts?" Asking the question and saying "Let me help you" will let them know you can be trusted.

Once you understand how autistic patients are feeling, you can pick up on their cues to de-escalate the situation and find ways to make them feel safe and comfortable.

A USEFUL PERSPECTIVE

Over the past 12 years, I've learned that, in many ways, autistic people are not much different from any other person. They have a different understanding about life but basically have the same desire to be recognized as just a person. They are often misunderstood because of their impulsive behavior. Nonetheless, I think strides have been made in understanding how to live with, work with, and assist people who have autism.

My theory is that, if life were a road, we'd have red, yellow and green lights defining our boundaries. These lights are things that help control society. However, autistic people may operate outside the boundaries. They are essentially who we all are deep down, though. If they want to scream, they do it. If they want to run, they do it. If they see something they want, they take it—not understanding the consequences of their actions, but acting without malice and with the purest sense of curiosity. Then their behavior collides with the norms of society. I hope that one day we will get to a point where we have a generation of people equipped with more knowledge of autism so that we can treat the individual, not the disorder.

As first responders, it is our job to act with care, concern and compassion. We are obligated to care for these individuals with utmost respect so that they, too, can live peacefully in a society that understands their need to have a sense of pride and dignity. I am happy to answer questions from readers. Contact me at kamiller@lumc.edu; 708-216-9077.

Pilot study reduced violence and improved quality of care by cross-training officers as emergency room psychiatric nursing assistants

Lance Clemsen, MS, LISW; Jeff Vande Berg, MS; and Doug Vance

Facing budget constraints, increased volume in the ED, lengthened stays in the ED, and rising violence against staff, the authors obtained permission to pilot test a way to combat violence without adding to head count. They trained a small number of security officers as psychiatric nursing assistants and had them actively engage with behavioral health patients (such as providing information) and alert the staff to special needs and early warning signs of escalating tension. The yearlong test reduced violence and increased patient and staff satisfaction.

(Lance Clemsen, MS, LISW, is on the emergency medicine staff at the University of Iowa Hospitals and Clinics (UIHC) and was previously UIHC's Behavioral Health Clinic Director. He is Co-Chair of the UIHC Disruptive Patient and Visitors Program as well as an adjunct faculty member in the University of Iowa School of Social Work.)

(Jeff Vande Berg, MS, is a Quality and Operations Improvement Engineer at UIHC. He routinely utilizes Lean, Six Sigma, Engineering and Epidemiologic methods. He teaches courses to UIHC staff in Lean, Six Sigma as well as Team Simulation Design and Debriefing.)

(Doug Vance is Security Director at UIHC. He is Co-Chair of the UIHC Disruptive Patient and Visitors Program and Co-Chair of the Environment of Care Subcommittee. His background is in law enforcement, and he has more than 20 years of experience as a certified officer. As a police officer, Vance worked the Patrol and Detective Divisions, each for 10 years. He is a member of IAHSS.)

The healthcare industry leads all private industry in the incidence of nonfatal workplace assaults [1-4]. The emergency department (ED) is a particularly vulnerable setting [5-7]. Nearly half (47%) of emergency physicians report having been physically assaulted while at work, with 60% saying those assaults occurred in the past year. Nearly 8 in 10 report that patient care is being affected, with 51% of those reporting physical harm to a patient [8-9]. Emergency nurses are regularly victims of violence on the job. In one study, 54% of emergency nurses reported experiencing violence in the workplace within the past seven days [10,11].

This article outlines one specific innovative effort that decreased patient-related violence, increased staff safety, and simultaneously

improved the behavioral health patient's experience in the ED. The University of Iowa Hospitals and Clinics (UIHC) developed a program to cross-train hospital security officers as psychiatric nursing assistants (PNAs) for the ED and measured the effects. Establishing a successful program requires collaboration, a dynamic team, and well-thought-out plan to combat violence in the ED. We offer this innovation as an evidence-based method of risk reduction for an inherently high-risk setting. The results have been remarkable.

CONTEXT

UIHC is located in Iowa City Iowa (population 75,798), home of the University of Iowa. In fiscal year 2017, the hospital had 36,019 total acute admissions, 1,016,448 outpatient visits, and 59,896 Emergency Department visits. UIHC has 811 acute beds, employs 9,972 staff, and 4,500 healthcare students.

During the past five years, the impact of diminished behavioral health resources has had an unprecedented impact on our ED, hospital, and community. A combination of overwhelmed and reduced behavioral health resources resulted in excessive delays in how quickly ED patients received care. Unfortunately, staff assaults and destruction of property became commonplace in the ED, along with an increasing sense of fear among the staff, patients, and visitors [12-14]. Innovation was needed both to provide quality care for our behavioral health patients and to improve overall safety [15-17]. A focused effort was launched to understand the challenge, which was occurring at time when a critical budget shortfall was impeding the addition of new FTEs for the hospital.

Similar to other healthcare institutions, we identified several challenges faced by the ED. Patient volume and length of stay in the ED (or "boarding minutes") had increased (see Figure 1), impairing the rapid-access objective of emergent care [18]. Meanwhile, the volume of behavioral health patients had gradually increased, and the overall ED length of stay dramatically increased. Waiting in a hospital, especially in emergency circumstances, is inherently stressful. Coping skills are stressed, and patients and visitors may be more prone to increased anxiety than in

other situations. This problem is compounded when the environment is noisy and chaotic.

In addition to excessive wait times, other factors also contributed to the volatile environment in the ED, such as overcrowding, substance intoxication, drug seeking, and homelessness. This environment affects all patients accessing ED care, not only those with behavioral health complaints [19]. Arguably, the stress is worse for those seeking emergency care for mental health and substance misuse, given fewer resources and compromised coping abilities.

PRE-STUDY PROCEDURES IN THE ED

An analysis was conducted of our ED workflow to establish a practice and policy baseline. This review led to several discoveries:

- ED triage routinely assigned a security officer "watch"/hold to the majority of behavioral health patients.
- Once placed in a room, all ED behavioral health patients received an initial assessment, typically followed by a lengthy wait for either discharge planning or admission. Security officers were prohibited by policy and practice from interacting with the patients when assigned as a "watch"/hold. The only exception was when protecting or preventing from elopement.
- Iowa was ranked last of 50 states in the per capita ratio of psychiatric beds—two beds for every 100,000 members of the population in 2016 [20]. Our hospital is routinely at full capacity, the statewide system is consistently at maximum occupancy, and transfer options are available only infrequently.
- Minimal behavioral healthcare was provided while patients waited in the ED. This approach seemed to be based on prevailing ED practice, which was to stabilize but not treat behavioral health patients. In other words, the ED would assess patients and wait for them to be admitted or discharged.
- ED staff was unaccustomed to providing ongoing care to behavioral health patients who had excessive ED stays.
- Lengthy stays correlated to patient disruptive events and restrictive actions (steps taken to restrain patients).
- When behavioral health patients were asked about their

experiences later on, they frequently reported that they felt neglected and of lesser priority. Lengthy ED waits contributed to patient dissatisfaction and disruptive behavioral events. Being placed under watch with a security officer who did not communicate could inadvertently have enhanced emotional distress and fear.

THE INTERVENTION

Because UIHC had a budget deficit and no option to hire more staff, we wanted to find a way to better equip existing staff with tools to prevent, detect and recover from disruptive and potentially violent patient or visitor situations in the ED. Changing the dynamic had to be accomplished from within.

On the basis of past experience, we believed that a reactive response to disruption was more expensive and less effective than preventing the disruption in the first place. We therefore sought proactive ways to address and prevent these disruptions, including proactive ways to offset the excessive waits and to reduce the restrictive actions.

The security director hypothesized: What if security officers were able to do more than simply supervise patients and their significant others? [21,22] If security officers could engage, establish a rapport, provide timely information, reinforce crisis-coping strategies, and update and communicate with the treatment team, perhaps these efforts would enhance the therapeutic process, reduce disturbances, and improve the overall patient experience.

An agreement was reached to run a pilot test in which three, or approximately 18%, of our existing security officers, would be cross-trained as psychiatric nursing assistants. The pilot project was carried out for 12 months, from November 2017 through October 2018.

These security officers were redefined as Crisis Stabilization Officers (CSO) and were charged with proactively engaging all behavioral health patients presenting to the ED. Special emphasis was focused on patients who were most impaired or most disruptive. The CSO would intervene with patients and significant others by engaging in communication, providing education regarding the ED process. The CSO would also provide just-in-time

crisis intervention, alert staff to special needs, and identify early warning signs of escalating tension.

Senior leadership approved the plan, and a Quality and Operations Improvement/LEAN Engineer was assigned to provide expertise on processes and analysis. Initially, the psychiatry leadership was a bit skeptical that having CSOs interact with behavioral health patients would be beneficial.

Before the program started, the CSOs underwent special training. This training included a two-week orientation in the tasks of a nursing assistant; orientation and training in child- and adult-inpatient behavioral health units, and a 40-hour Law Enforcement Crisis Intervention training course. The CSOs completed their training in the inpatient adult and child psychiatric units and in the ED during high-census periods. Special emphasis was placed on recognizing warning signs of aggression and violence. Some CSOs sought additional training as mental health peer professionals, which was not required but was approved when requested. After the orientation, two CSOs became eligible and passed the health support professional exam.

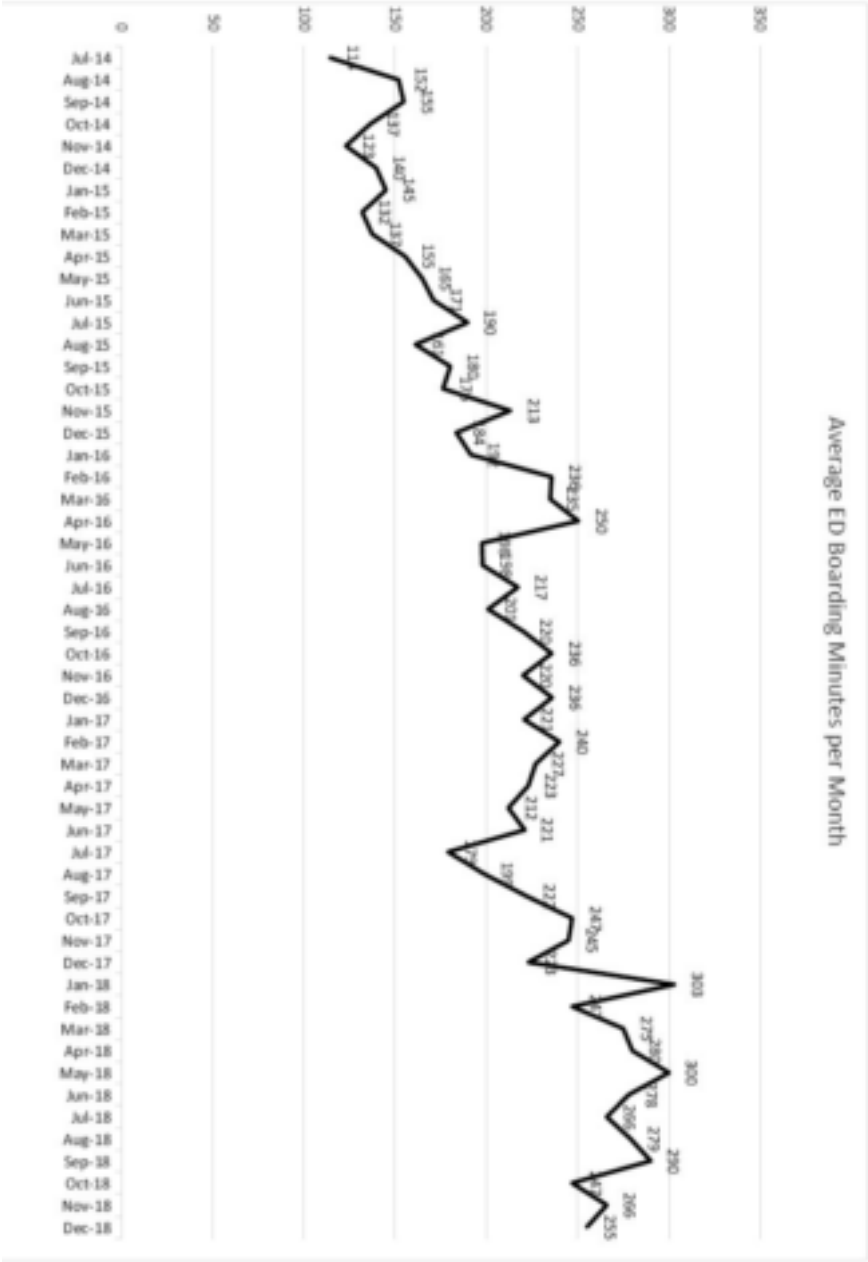
During the CSO pilot period, the officers wore a distinctive polo shirt instead of the traditional security uniform but continued to carry security protection tools. CSOs documented their activities and observations in the nursing care notes of the electronic medical record.

Supervision was provided by a multidisciplinary group comprised of nursing, social work, and psychiatry who met monthly with the CSO's. Schedules were adjusted based on data and patient needs, and the supervisory group identified opportunities to improve the service.

RESULTS

Results are displayed in Figures 2, 3, 4 and 5.

Our study was a quasi-experiment, as we utilized historic data from our own facility instead of randomizing or utilizing concurrent control groups. We also could not control for other simultaneous changes in ED processes or conditions from other causes, which may also have affected our outcomes; yet, we believe that our situation is similar to those of


Average ED Boarding Minutes per Month
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100
150
200
250
300
350
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
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Dec-18

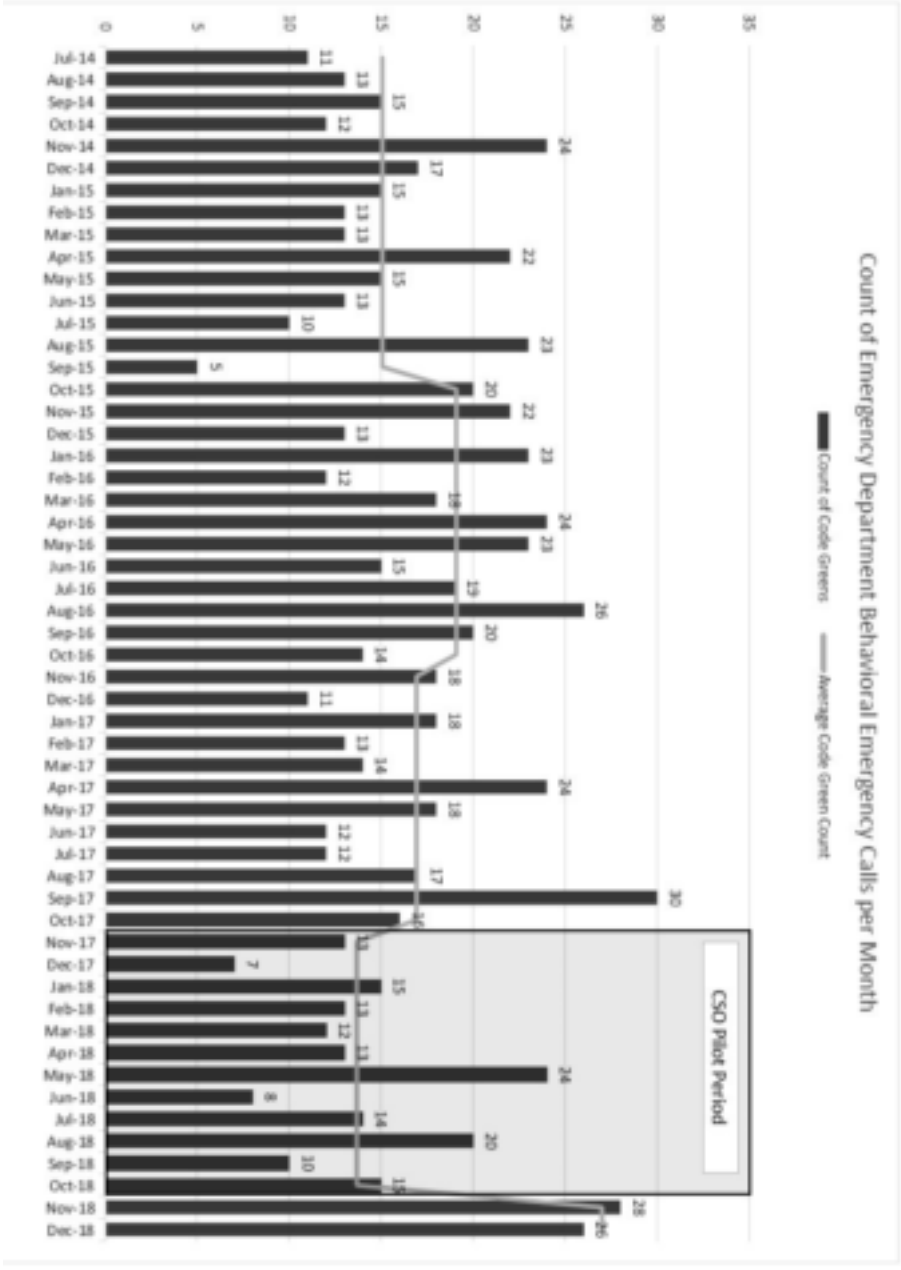
Figure 1

most, if not all, in the audience for this article.

We analyzed the intervention's impact by using routinely gathered safety metrics from our institution. The CSO pilot-period data analyzed for this project included the number of ED behavioral emergency calls, as well as the subset of these calls requiring restrictive actions (for example, restraints, take-downs, or seclusion). We also considered these events over this time period as a rate of ED Boarding Minutes, as this ratio allowed us to control for longer length of stays. Longer boarding increased opportunities for emergency calls and restrictive actions to occur, and not merely among psychiatric-chief-complaint patients, but also among all patients waiting for inpatient beds.

Over the pilot program period, the ED behavioral emergency count decreased 18% (see Figure 2) relative to the prior 12 months, where there were an average of 17 calls per month; our figure includes prior years to show that these calls had been even higher previously. The rate of these ED behavioral emergency calls per 100 boarding minutes decreased 45% (see Figure 3), with the higher percentage decrease demonstrating that there was actually more opportunity for those calls to occur when we consider the length of patient waits as our rate denominator. The Behavioral Emergency rate per 100 boarding minutes in which restrictive action was needed also decreased 40% (see Figure 4).

In addition, the rate of injuries related to the same events (staff and patient) decreased 50% (0.4 to 0.2 injuries per 100 boarding minutes) relative to the prior 34 months (see Figure 5). We used 34 months instead of just the prior 12 for a comparison rate, as events with injury are relatively rare in both time periods. Further, we saw a considerable reduction in the occurrence of staff injuries in the ED as indicated by our OSHA-required First Report of Staff Injury events (50% reduction in events per month, from 0.6 down to 0.3) and a large reduction in the attributable costs of those events, from between $6,140 to $14,225, down to between $204 to $348 . (See boxes in Figure 5). The dollars indicated in the summary boxes of Figure 5 represent the salaries of the ED staff injured


Count of Emergency Department Behavioral Emergency Calls per Month
Count of Code Greens
Average Code Green Count
CSO Pilot Period
0
5
10
15
20
25
30
35
Jul-14 11
Aug-14 13
Sep-14 15
Oct-14 12
Nov-14 24
Dec-14 17
Jan-15 15
Feb-15 13
Mar-15 13
Apr-15 22
May-15 15
Jun-15 13
Jul-15 10
Aug-15 23
Sep-15 5
Oct-15 20
Nov-15 22
Dec-15 11
Jan-16 23
Feb-16 12
Mar-16 18
Apr-16 24
May-16 23
Jun-16 15
Jul-16 19
Aug-16 26
Sep-16 20
Oct-16 14
Nov-16 18
Dec-16 11
Jan-17 18
Feb-17 13
Mar-17 14
Apr-17 24
May-17 18
Jun-17 12
Jul-17 12
Aug-17 17
Sep-17 30
Oct-17 16
Nov-17 11
Dec-17 7
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Sep-18 10
Oct-18 15
Nov-18 28
Dec-18 26

Figure 2

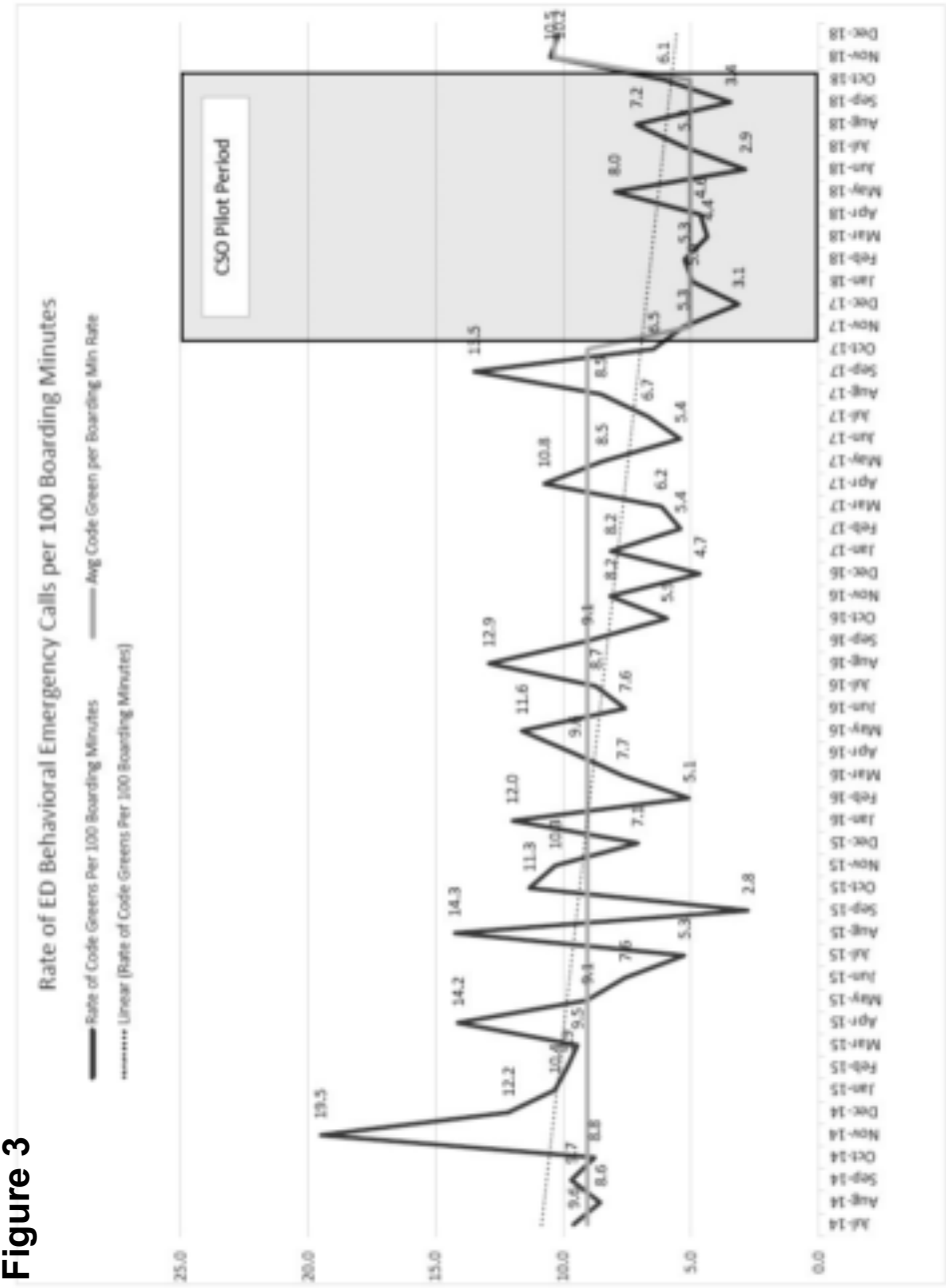
Rate of ED Behavioral Emergency Calls per 100 Boarding Minutes
Rate of Code Greens Per 100 Boarding Minutes
Avg Code Green per Boarding Min Rate
Linear (Rate of Code Greens Per 100 Boarding Minutes)
CSO Pilot Period
25.0
20.0
15.0
10.0
5.0
0.0
Jul-14
Aug-14
Sep-14
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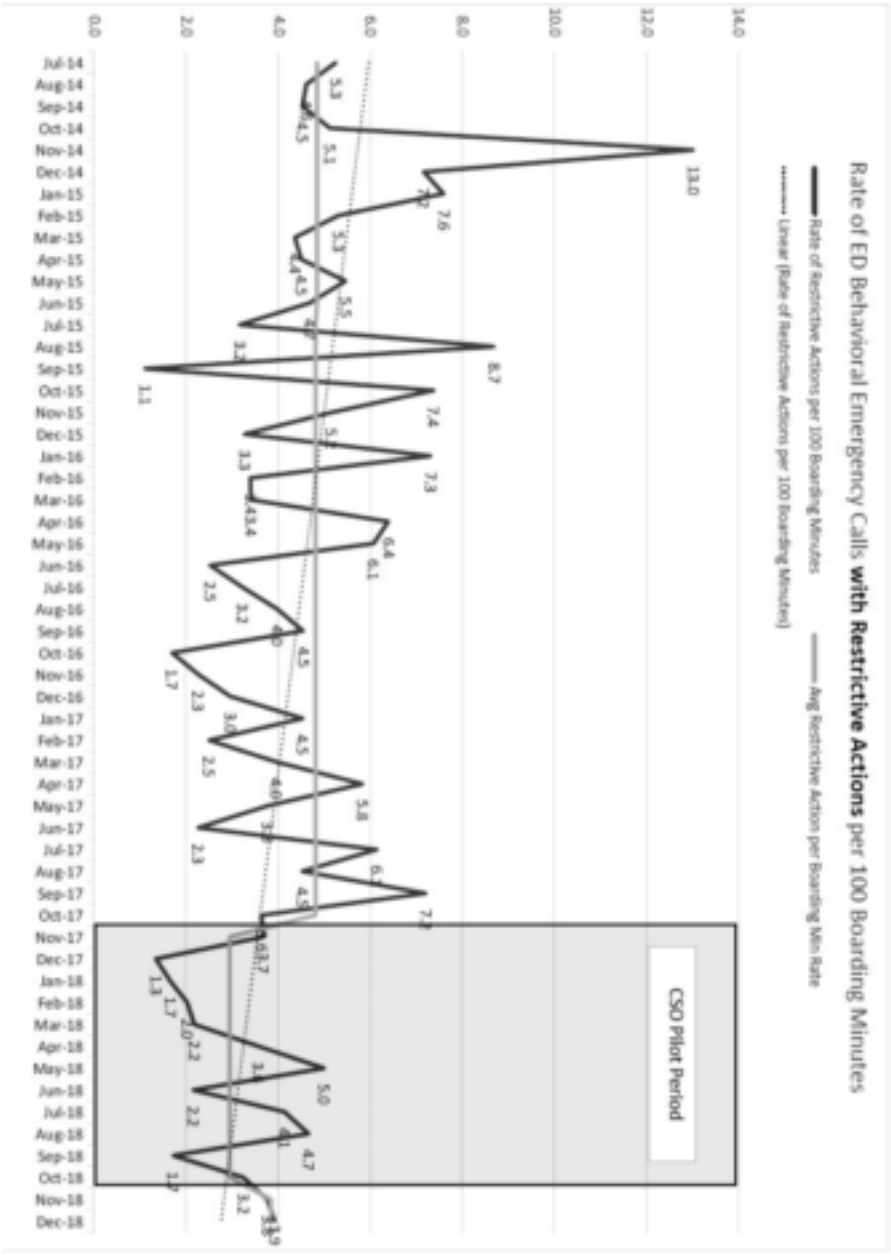
Figure 3


Rate of ED Behavioral Emergency Calls with Restrictive Actions per 100 Boarding Minutes
Rate of Restrictive Actions per 100 Boarding Minutes
Avg Restrictive Action per Boarding Min Rate
Linear (Rate of Restrictive Actions per 100 Boarding Minutes)
CSO Pilot Period
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Jul-14
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Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
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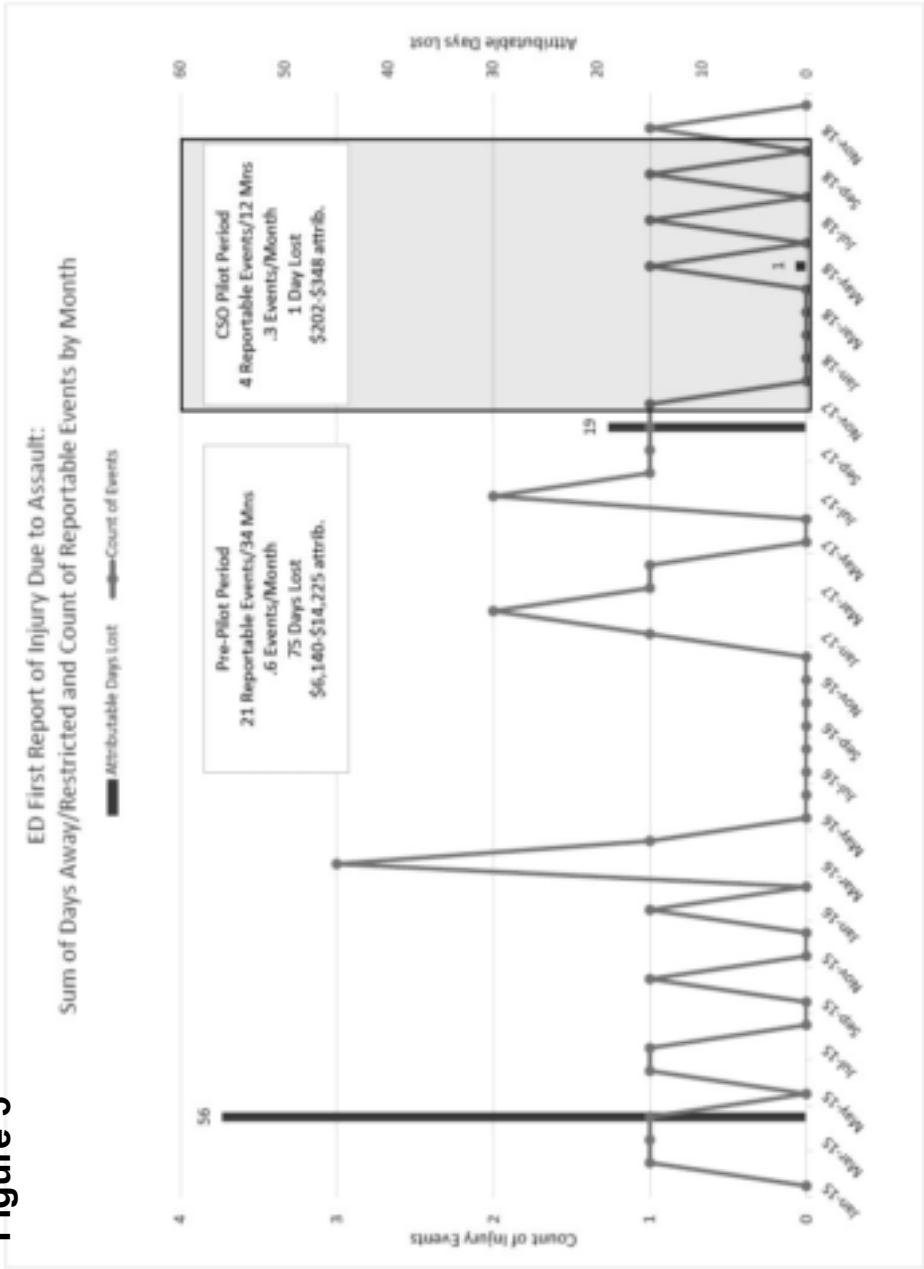
Figure 4

Figure 5



Note. The graph shows the number of OSHA First Report of Injury events due to assault in the ED by month, with the sum of Attributable Days Lost for those events, also by month of event occurrence. Boxes within the graph summarize these counts and days lost for our Pilot Period and 34 months prior to the pilot period, as well as attributable costs in salary for lost days of ED staff injured, by the range of our hourly salaries for the roles injured.

in these events. Days of work lost is a component of this OSHA report and includes the range of salaries for the positions of the staff injured multiplied by the days converted to hours lost for each event. We understand this range to be the cost paid to staff the position that could have been worked by the injured staff, and therefore directly related to the assault events. Of the four reportable Assault First Report of Injury events occurring during the pilot period in our ED, none involved a CSO.

In our results, we included more than three years of monthly data prior to our intervention to help describe the motivation for this work. We have had prior months of very high and very low adverse events related to patient violence, but November 2014 and September 2017 were especially problematic for our ED and hospital administration and highlighted the need for change.

In subjective terms, before the pilot study, more than half of our ED Staff (56%) responded to a survey by disagreeing (strongly through somewhat) with the statement, "I have the support and resources I need to deal with violence from patients." After the addition of CSOs for the 12-month pilot, almost the same percentage (55%) responded "Very Favorably" to the survey statement, "Over the last 6 months, how would you rate your experience with the Psychiatry NA-Trained Security Staff?"

DISCUSSION

Psychiatric nursing assistants (PNA) have the highest reported rate of injuries in the workplace. Our CSO security staff who trained as nursing assistants experienced zero injuries, even when involved in the most volatile situations in our institution. CSOs in this role still had to help implement restrictive actions with patients. We see the CSO role as a continuation of the safety & security officer role and have found that it can reduce violence against PNAs and improve patient care in general.

An unexpected outcome of this pilot initiative was that ED staff and patients in the Behavioral Health Observation Unit reported a significantly improved sense of safety. In addition, psychiatry leadership shifted from skepticism to absolute support. All of this was achieved by redesigning

and retraining an existing resource without adding new costs beyond the costs of training. The success of this pilot study helped lead to the establishment of our new Crisis Stabilization Unit (CSU) [23], designed to expedite ED behavioral health interventions.

Historical experience suggests that increases in ED volume and length of stay lead to rises in events and restrictive outcomes and exacerbate ED staff frustration. Our initiative helped to counter those trends. We discovered that the CSOs were more empowered and more confident in their interactions with behavioral health patients and staff, and they reported feeling that their job was more rewarding.

The behavioral health patients—who typically report the most negative perceptions of their care experience—also expressed more positive perceptions of staff and of their overall experience. Patients who presented repeatedly to our ED often requested the CSOs for their care. This good impression often carried over to how behavioral health patients felt about their inpatient stays. Further, the positive results helped to convince the administration to establish our psychiatric Crisis Stabilization Unit.

CONCLUSION

The objective and subjective data reveal that our CSO intervention had a positive impact on patient-care quality and staff safety. These results were achieved despite increased ED behavioral health volume and increased length-of-stay boarding minutes, and during a budget crisis. The CSO effort had multiple measurable benefits, including enhancing the quality of nursing care, a dramatic improvement in patient satisfaction, and a significant decline in violent events occurring in the ED. These benefits were achieved by augmenting an existing resource to positively influence the overall dynamic of the ED. We did not anticipate these extraordinary results.

We initially intended for the CSOs to focus on the ED behavioral health patients. This focus quickly evolved into using their unique skills with all ED patients. Disruptive events are not exclusive to behavioral health patients; anyone encountering the extraordinary stress of the ED setting may become disruptive.

On the basis of the outcomes in the pilot study, the leadership of the UIHC Department of Psychiatry insisted on staffing its new Crisis Stabilization Unit with CSOs and expanding this role to other inpatient psychiatric units. The CSOs that were trained for the pilot study continue to develop therapeutic rapport with mental health patients while keeping these patients and clinicians safe.

No single approach will solve the epidemic of violence against healthcare workers. During the past 10 years, a variety of efforts have been implemented to improve care for behavioral health patients in the ED. Cross-training hospital security officers as psychiatric nursing assistants for the ED is one such effort. Efforts to shift the paradigm, in particular to promote safety, must be deliberate and explicit. This is especially true in services such as ED behavioral health that experience a high frequency of disruptive events.

Our project was encouraged by the UIHC Disruptive Patient and Visitors Committee (DPVC) [24]. DPVC draws on legal, clinical, law enforcement, compliance, and information technology expertise to try to reduce the number of repeat patient incidents and violent acts of aggression towards healthcare workers. DVPC provides consultation and oversees the medical record disruptive behavior best practice alerts/chart warnings and staff education.

Managing disruptive behaviors and reducing violence requires many dynamic interlocking efforts, including a continuum of behavioral, structural, and organization-cultural modifications. Institutions must create effective and easy-to-access resources to support all staff. Imagine the potential of CSO interventions in patient medical units, mass-causality events, terrorist events, natural disasters, and public emergencies. The CSO effort surpassed our expectations and opened many more potentials.

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Strategic placement of security personnel in the ED decreased assaults on employees: Pilot project finds

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An eight-week pilot project added a security officer to the Emergency Department and positioned the officer in the Special Care area—devoted to patients with behavioral challenges—during the hours when patient violence against staff was most likely to occur. The maneuver reduced patient-on-staff violence in the Special Care area despite an increase in patient volume relative to the same eight week period a year earlier.

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Patient-on-staff (POS) violence in the healthcare setting is not rare (Kelen & Catlett, 2010) and is particularly common i;n hospital emergency departments (EDs) (Blando et al., 2012; Behnam et al., 2011; Kansagra et al., 2008). Some hospitals are fortunate enough to have dedicated security protection staff stationed in or around the ED care area. However, EDs typically consist of irregular geographic spaces that serve different functions and that may be separated by obstacles such as locked units, closed doors, limited sight lines, and nonlinear pathways.

Consequently, it can be difficult to know where in the ED to position security personnel so that they can be maximally effective. In this article, we describe the outcome of a pilot quality-improvement project that strategically

positioned a security officer in a targeted area to determine whether that placement resulted in decreased physical assaults to ED employees in the selected area.

This was a systematic, data-driven change evaluating immediate effects in the patient care environment. The pilot evaluation was deemed a quality-improvement project and was not subject to institutional review board oversight. This eight-week, descriptive project took place from March 2, 2019, to April 27, 2019—a time period defined as the quality monitoring period (QMP).

SETTING

The setting was in the ED at the Hennepin Healthcare Medical Center, an academic, urban, tertiary medical center campus with 450 operating beds located in downtown Minneapolis, MN. The hospital is designated as the county receiving facility and operates as a Level 1 Trauma Center. The ED covers roughly 35,000 square feet and houses a 65-bed unit separated into several different areas for care. It has an annual volume of approximately 103,000 patients, and several training programs, including an emergency medicine residency.

STAFFING AND VOLUME

The hospital employs 43, non-sworn, civilian Medical Center Protection Officers (MCPOs) to preserve public safety within the confines of the hospital campus. The MCPOs provide a uniformed presence around the hospital campus. A minimum of three MCPOs are assigned to the ED area. In 2018, the MCPOs responded to 132,630 calls for service across the entire institution, of which 46,661 (35.2%) calls were for behavioral issues. Behavioral issue calls are defined as those that represent the highest likelihood of a violent occurrence. The ED accounted for a total of 34,762 (26.2% of all MCPO responses) calls for service, and 32,725 (94.1%) of these ED calls were for behavioral issues. The remainder of the calls were for non-violence related issues such as fire alarms, unlocking doors, and responding to persons injured from accidents.

TRAINING

The MCPOs receive significant required training in emergency medical response, verbal de-esca-

lation skills, behavioral emergency response, defensive tactics and intermediate weapon use, including training in using oleoresin capsicum irritant spray, expandable batons, and conducted electrical weapons. The MCPOs must re-certify in all of these areas on a regular basis. All MCPOs must also be enrolled in or have completed the Certified Protection Professional training as recognized by the American Society for Industrial Security (Alexandria, VA). They do not carry a firearm.

DESIGN AND ANALYSIS

POS assault statistics were tracked before and during the QMP. During the QMP, an additional MCPO was stationed in a 16-bed area designated as Special Care (within the ED), which is a locked unit designed to care for patients who are deemed to be elopement risks or to have behavioral challenges. Typical patients in this area include those that are heavily intoxicated, mentally ill, or in protective or legal custody. The MCPO was stationed in Special Care from the hour of 1900 through 0300, seven days a week. These hours were chosen because a review of our ED safety statistics showed that there were a total of 41 POS assaults in the Special Care area of the ED in 2018 and that 21 (51%) of the assaults took place during the hours 1900–0300. On completion of the QMP, descriptive and statistical analysis was performed on the number of POS incidents.

RESULTS

During the project, three POS physical assaults occurred in the Special Care area; of those one occurred within the 1900–0300 time period. (See Table 1.) The single assault during the 1900–0300 time period was when a nurse attempted to assist two MCPOs in restraining a patient and, in the process, got kicked.

We used baseline data from 2018 as our comparison. Recall that there were 41 total POS assaults in Special Care in 2018, with 21 of them occurring in the 1900–0300 time frame. This yielded an expected total rate of 6.3 POS assaults, and an expected rate of 3.2 POS assaults between the hours of 1900 and 0300 in Special Care during the eight-week evaluation period. As noted above, there were three total POS assaults in the Special Care area during the QMP and one during 1900–0300 hours. These findings

represent a decrease in our total POS assault rate in Special Care of 52% and a decrease in our POS assault rate between the hours of 1900 and 0300 of 67%.

Compared to 2018 data, in 2019 the total volume of patients seen in the Special Care area of the ED during the same eight-week period increased by 22% (from 1403 to 1712 patients), and the volume of patients seen in the Special Care area of the ED during the same eight-week period between the hours of 1900 and 0300 increased by 25% (from 616 to 771).

DISCUSSION

Prior to this project, our MCPOs were assigned to the general area of the ED. One MCPO was assigned to the front entry area of the hospital that also has a view of the ED triage area. The other two MCPOs were expected to make regular foot patrols through the ED at regular intervals; they also have a small office near the ED triage area. This MCPO deployment strategy was largely based on the existing data showing that the ED, in general, represents a disproportionately high number of incidents of violence

Table 1. HOSPITAL STATISTICS AND PROJECT FINDINGS

	2018 Data	2019 QMP Data	Percent Change
Annual incidents in hospital/ for behavioral issues	132,630/ 46,661		
Annual incidents in ED/ for behavioral issues	34,762/ 32,725		
Annual POS assaults in Special Care	41		
Annual POS assaults in Special Care during the hours 1900–0300	21		
POS assaults in Special Care over 8 weeks	6.3 predicted	3	52% decline
POS assaults in Special Care over 8 weeks during the hours 1900–0300	3.2 predicted	1	67% decline
	Patient Volume in 2018	Patient Volume in 2019	
In Special Care over 8 weeks of March and April	1,403	1,712	22% increase
In Special Care over 8 weeks of March and April during the hours 1900–0300	616	771	25% increase

Note. POS: patient-on-staff; QMP: quality monitoring period

directed towards healthcare personnel (Phillips, 2016). It was felt that this strategy provided an adequate number of MCPO personnel in the general area of the ED for quick reactionary response to requests for assistance from the ED staff when needed.

A disadvantage of that deployment strategy is that it is generally reactionary in nature. Although the MCPOs were located within the ED, the geographic layout of the ED is quite large and encompasses several separate patient care areas that are separated by fire doors, locked doors in the Special Care area, and non-straight-line travel pathways. These barriers are intentional and are meant to generally enhance safety and privacy, but they also can have the unintentional consequence of lengthening MCPO response times during emergency responses for violent behavior.

This unintentional consequence was not recognized prior to the QMP, but an uptick in violent events directed towards the ED staff during the year preceding the QMP was noted in our annual review of MCPO calls. Although the cause of this increase in violent events was not clear, it was consistent with the rising rates of violence directed at ED staff described in the medical literature (Kowalenko et al., 2013). We decided to station an additional MCPO in the Special Care area (our highest call-volume area in the ED) for eight hours a day because we suspected that this placement would lessen MCPO response times and thus address the worrisome uptick. The coverage hours we chose reflected the daily time periods of highest call volume and physical assaults.

We saw an immediate improvement in the number of violent events directed towards the staff in the Special Care area. The notable drop in these assaults appears to be largely due to the presence of the MCPO, who was already there when a patient arrived in the Special Care area during the QMP.

Prior to the QMP, it was the expectation that an MCPO would be notified that a patient was expected in the Special Care area and would be part of the arrival process of every patient. However, notification typically occurred after the patient had arrived, delaying the MCPO's arrival. Patients that come into this

area are at high risk for agitated behavior. Before the MCPO was positioned in this area, ED staff would call for MCPO assistance after failing to de-escalate behavior that could lead to violence and would then have to wait for an MCPO to come from another area of the ED. To respond, one or more MCPOs would have to negotiate some of the physical barriers typically inherent in an ED such as locked doors, blind corners, and nonstraight-line travel.

It became clear during the QMP that strategically positioning an MCPO in the Special Care area of the ED shifted the MCPO role from reactive to preemptive. The mere presence of the MCPO apparently became a visual and physical deterrence that kept many agitated patients from escalating their behavior and acting out on the ED staff. During the hours that the MCPO was stationed in Special Care, when a patient did have a behavioral escalation, the MCPO was able to intervene immediately because of already being present.

Having an MCPO stationed in Special Care was not cost neutral. The MCPO assigned to Special Care during the QMP was brought on as an extra position in addition to the minimum ED complement of MCPOs. We believe that the additional cost was well worth it. The dollar cost of a patient assault on staff in terms of days off of work, cost of care for the injured, time in dealing with the injured employee, and time spent processing and prosecuting such an event in the criminal justice system is substantial (Lanza & Millner, 1989). Although we considered shifting one of the MCPOs from the ED front triage area to be the officer stationed in Special Care, we elected to instead bring on an additional MCPO during the QMP because, in addition to being the main check-in area for the hospital's Urgent Care and ED, this area serves as the main entry to the hospital and is the area of highest pedestrian traffic. We felt it was not safe or reasonable to decrease the number of MCPOs at that location given the volume of people that pass through, congregate, and seek assistance continuously.

The potential preventative effect of the data-driven posting of security personnel to a strategic location during higher volume time

periods should not be understated. With this strategy, we experienced a significant drop in the rate of POS assaults in a high-risk section of our emergency department. This occurred even in the setting of a significant increase in our patient volume. Our data suggest that this strategy should be seriously considered as a way of decreasing POS violence within the ED.

LIMITATIONS

This is a simple observation project that may not have applicability to settings that differ from the one described here. This project was performed in an urban, county receiving ED setting with a fairly large geographic footprint. This setting tends to receive some of the most agitated patients in the region. It is possible that similar assault reduction rates from implementing this type of strategy may not be realized in smaller facilities with nonidentical patient populations.

It is also possible that there may have been confounders. For instance, it is common for some people to be better at conflict avoidance and verbal de-escalation than others. If the ED Special Care area were staffed with employees that excelled in these skills during the QMP, it would be expected that our assault rates would decline during that period regardless of whether an MCPO was stationed there. Although we did not control for this possibility, we do not believe that this scenario occurred: we can confidently state that the staffing for this particular area is randomized on a daily basis, making the likelihood of this possibility very remote.

It is also conceivable, but unlikely, that adding the additional MCPO to the ED might have lowered POS assaults even if we had not specifically positioned the extra person in the Special Care area. Although we could have tested for this possibility by undertaking another monitoring period with this additional MCPO stationed elsewhere in the ED, we elected not to do so because of the near-immediate decrease in POS assaults we found with this project. The Special Care area is a fully enclosed, locked unit within the ED. Accessing it requires a radio-frequency identification badge to be scanned at the access door and waiting for the door to then unlock and open be-

fore entry can be made. Given our significant findings with the MCPO stationed within Special Care, it did not make intuitive sense to trial it with the MCPO stationed outside of Special Care knowing that the officer would have to negotiate the locked-access-door obstacle with every new patient arrival.

CONCLUSIONS

We believe that there is an opportunity for consideration of placing security personnel in strategic areas within the ED to decrease the assaults on ED staff members through command presence and visual deterrence and through earlier intervention. Past research supports the value of pre-placing security personnel in the ED at locations of likely violence, and this project supports careful consideration of exact placement of personnel within the ED to maximize their effectiveness in decreasing assaultive behavior towards healthcare employees.

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Breaking the link between stress and violence in hospitals

James R. Sawyer, CHS-Diplomate, CPP, CHPA

Life stresses from job losses to PTSD can precipitate violence by patients, their family members and other visitors. Security officers can ease the pain and reduce violence by homing in on those stresses and offering empathy and practical assistance—and they should be trained accordingly.

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Today's healthcare security professionals need to recognize, and take steps to alleviate, the ever-increasing stresses that can wreak havoc in the lives of the people we serve. In so doing, we can achieve two related goals. One, we can convey the message that every human being deserves respect, support and help in a time of need. And, two, we can help to prevent the stresses from triggering suicide or violence to others, thereby enhancing the safety of everyone in the facility.

MAJOR STRESSES

What are these precipitating factors? Let's review some big ones.

Post-Traumatic Stress Disorder (PTSD)

More than 40 million adults in the United States suffer from PTSD. Consider that we have been in endless wars in Afghanistan and Iraq since October 2001 and March 2003. The toll on mil-

itary personnel is incalculable. It has been estimated that 22 veterans a day commit suicide. We will face an ever growing population of patients, adults and family members suffering from PTSD. Security officers may be the first people these individuals encounter.

Financial Problems or Lack of Medical Benefits

Medical bills are the number one cause of bankruptcy in the United States. More than 25,000 Americans go bankrupt every day because of the bills. These bankruptcies occur in the midst of a period of income inequality that is unrivaled in U.S. history. Income inequality today has created what journalist Chris Hedges has termed a permanent American "underclass." Income inequality has ravaged, hollowed out and gutted the American middle class. Homelessness continues to spiral. Infant mortality in the United States ranks 22nd worldwide and, for the first time in a century, the life span for Americans has shortened. The true impact of income inequality is impossible to quantify, and its lethal tentacles affect U.S. culture and the population in ways that we have yet to fully recognize. However, it's no exaggeration to say that debt, income inequality, and yes, medical bills have shredded the American dream for millions. At Seattle Children's, 30 to 60% of the children we serve do not have adequate food at home. This staggering reality is receiving virtually no media recognition.

Job Loss or Homelessness

Many Americans are a paycheck away from homelessness. More and more people are discovering that their likelihood of buying a house is contingent on their winning the state lottery. In Seattle and other major metropolitan areas, rents today read like ransom notes. Many Americans who work full time live in their cars. Statistics tell us that as many as 1.3 million kids currently enrolled in school are homeless.

Drug and Alcohol Abuse

More than 90 Americans a day are dying from opioid abuse, and the World Health Organization reports that alcohol killed 3 million people in 2018. Opioids, other drugs, and alcohol haunt millions of Americans like a vengeful Dickens ghost.

Mental Illness

Federal statistics advise us that one in four Americans suffers from some form of mental illness. The looming pressures and realities of modern American life will only exacerbate this problem.

WHAT SECURITY PROFESSIONALS CAN DO

To say that our clients and those we serve are facing life stressors is a vast understatement. Uncertainty and fear for the future have indeed become entrenched in the American psyche. Nevertheless, there are some key countermeasures security professionals can take to support those who enter the doors of our facilities:

• As a department, acknowledge the scope of the challenge facing today's patient population. You cannot overcommunicate or overemphasize this.

• Teach all security staff the "10 – 4" principle of optimum customer service. If someone is within 10 feet of you, smile. If someone is within 4 feet, greet them.

• Emphasize to every officer that we have only one chance to make a good impression. Stress the Nonviolent Crisis Intervention (NCI) concept of the integrated experience: How we stand, talk, and approach an individual will affect how they stand, talk, and interact with us.

• Require annual de-escalation training for all security officers.

• Require annual diversity awareness training for all security officers.

• Develop mutual-aid relationships with multiple local motels and hotels, and use these resources to support clients and families in crisis.

• Develop support strategies and programs for families who are living in their cars.

• Give security officers cafeteria vouchers to hand to indigent families, and track their use. Food vouchers are an incredible support for families facing hardship.

• Develop, maintain and update a local shelter list that officers can make available to all clients.

• Provide taxi rides for clients needing transport to a shelter, motel or hotel.

• Maintain a cache of bus vouchers for those needing transportation support.

• Liaison and work hand in hand with social work on developing optimum client-support plans. The times require that the hospital security and social work teams develop and maintain strong client-support strategies.

• Consider holding a safety fair having the theme of supporting clients in crisis. At the fair, cast light on the challenges facing today's patient population and their families and describe your support policies for mitigating stresses.

• Assign one officer to monitor, review and educate team members on factors that currently could trigger violence by patients, families or visitors. Building empathy and awareness into the fabric of your security philosophy is invaluable. This will help build and ensure the overall success of your entire security program.

• Teach all officers the warning signs of abuse of opioids, other drugs, and alcohol. Many people in crisis will inevitably turn to drugs and alcohol for respite. An observant security officer may be able to save a life here.

THE BIG PICTURE

It is incumbent on all security professionals to take a larger overview of what is transpiring in modern American life. We have both an ethical and professional obligation to acknowledge and come to terms with the forces that are shredding the fabric of modern American life. The chickens are indeed coming home to roost. By embracing and acting on a philosophy of compassion, support, and reasoned human intervention, healthcare security planners can become progressive agents of change. Indeed by providing optimum support and empathy for those in crisis, security professionals can both maintain safety and help people in their times of trouble.

Securing off-campus healthcare clinics and other facilities

Shawn Reilly, CHPA, CPP, PSP

Security plans that work for hospitals often will not work for isolated clinics—which require plans tailored to their specific situations.

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Answer these three following questions, and you are on your way to providing a more secure environment for employees who work in isolated locations: How are clinics different from the main hospital when it comes to risk? What risks are staff members exposed to at these locations? How can these risks be mitigated?

I have conducted risk assessments at more than 70 clinics from South Carolina to Texas, and I find that many facilities have common assets, threats, and vulnerabilities (When I use the term *clinic* in this article, I mean any off-site location that is part of your hospital or system, including printing offices, laundries, corporate offices, and other facilities located away from your hospital campus.)

Almost every time I am asked to conduct a risk assessment, I am called in because something happened and the staff is demanding action—security is event driven.

You can be proactive and begin to tackle the big job of conducting assessments at these locations now, or you can wait until something happens. Here, I will offer some basics for carrying out a clinic assessment.

Assessments begin with identifying critical assets that need protection and evaluating threats and vulnerabilities. They also involve ranking risks so the risks can be addressed in priority order. When attempting to mitigate risks, it is wise to think in terms of the Physical Protection System (PPS). The PPS has three foundational elements: policies and procedures; security equipment; and security manpower. Although the security force is essential to most healthcare settings, clinics usually are just not large enough or do not report enough incidents to warrant the cost of a security FTE. If the clinic is a stand-alone emergency center, it may have a need for a security officer, but few others clinics can justify the expense. So, the other two legs of the PPS become very important for securing a clinic environment.

COMMON RISK FACTORS

Although each clinic or off-site location is unique, there are common categories of assets that should be considered. These categories include people, facilities, equipment, and information as well as such aspects as drugs, money, and reputation. Be sure to consider all of these when determining which assets are at risk.

Clinics can be located away from the hospital, or they can be right next door in a medical office building. When the clinic is close by, it may be supported by the security program of the hospital. But that security force might not have the capacity to support the clinic adequately. When security is based farther away—even a few blocks—the clinic staff may basically be on its own. Clinics can be affected by many factors, including those described below.

Neighbors

I have seen some clinics that took no extra precautions even though mental health and even correctional facilities were nearby. Other high-risk neighbors could include homeless shelters, food pantries, and bus and train stations. It is important to know who is around your clinic and what risks they may pose. At one clinic, which was located next to a mental health facility, a man

came in through the employee entrance (unlocked), went into the bathroom, locked the door, and refused to come out. No one was hurt, and no money or drugs were taken, but hours' worth of revenue were lost while the staff talked the man out of the bathroom. If the incident tarnished the clinic's reputation, it may also have experienced a long-term loss of revenue. The question becomes, what did the inconvenience of locking the door ultimately cost the facility?

Crime Rates

The amount of social disorganization in an area directly correlates with the risk of crime at a clinic serving that area. (The term *social disorganization*, from the CAP Index®, reflects a host of influences on crime, such as population size, age distribution, homelessness, home values, and the number of people living in group quarters.) Have you done any research on crime statistics in your clinic's area? There are lots of great ways to gather these statistics. Local law enforcement with jurisdiction over the area can be the best source for relevant and current data. Open-source websites provide crime data for almost any location, although the information is generally two- to three-years old. Your marketing department may also be a source of data. Alternatively, for a price, commercial companies will do all the data gathering for you.

Access to Services

Knowing the typical response times of your local law enforcement, fire and ambulance can be a great help when considering how long clinic personnel will have to defend themselves or give first aid before first responders arrive. The law enforcement annual report often contains the average response times for your community.

Variable Staffing

Another aspect of the clinic is the day-to-day fluctuations in staffing. How many staff members arrive early in the morning, and do they arrive alone? How many are present during the prime hours, at lunch, and at closing? And, is a single person allowed to stay alone in the evenings? Do the doctors work late, alone?

Some of the best security practices are those that staff members come up with on their own. I used to have a quote under my e-mail

signature saying, "Security is everyone's responsibility." When staff members take their own security seriously, they will be better protected. Many clinic staffers take that concept seriously and practice it daily. For example, the first person who arrives in the morning locks him- or herself in after entering the building; at night, as a rule, no one leaves last and alone. Both practices render employees a harder target. Clinics are typically open from 8 a.m. to 4 p.m., Monday through Friday, but we are seeing an explosion of urgent care facilities that are open late and on weekends. These locations can be thought of as small emergency departments—and you know the risks in the ED.

Physical Structure

Clinics come in a large variety of structural configurations: large, multi-tenant medical office buildings; small stand-alone offices; storefronts in a strip malls; old homes that have been converted to clinics. Each configuration has its own set of risks.

These risks can be exacerbated if the facility is leased rather than owned by a hospital. If a hospital acquires a doctor's practice, the doctor may retain ownership of the building, with the hospital leasing the space. Leased space is always harder to secure than owned space. As I'm writing this article, I have just assessed a clinic in a leased building with security cameras. The staff has requested footage three times, and each time, it was unavailable. Looking at the lease, I found that the building owner is required to provide video reviews and has 15 days to fix broken equipment. Have you checked the lease to see what security the landlord offers? Is it in effect, and is it adequate? If your clinic is in a large, multi-tenant building, you need to see what other operations are in the building. An internal medicine clinic has a relatively low-risk profile, but when you put it next door to a pain clinic, the risk can go up. In the case of small facilities, they typically are not well designed from a security and safety perspective.

When we look at the design from a Crime Prevention Through Environmental Design (CPTED) point of view, we see that there are layers to the spaces, and each has a different use. The property perimeter and parking

area is the public space; the waiting room is the semiprivate space, and the treatment areas and offices are the private space. Each area has its own risks.

Parking lots have no restrictions on who can enter them. I always tell employees in my crime-prevention classes that anyone not coming or going in a parking lot is suspicious; no one stands around in a parking lot for a good reason, including those trying to smoke without being seen.

Another common issue at the outer ring is vegetation control. If someone is not charged with caring for the landscaping, it can grow up over windows, cover light fixtures and even block camera views. If a security professional is not looking at the facility, this condition can go uncorrected for years.

The semiprivate space—the waiting room—is designed for people with a valid need to be there. Some common issues are people looking for bathrooms, homeless individuals looking to get out of the weather, and people seeking drugs for an illegal reason. The key to controlling what happens after a nonpatient enters the waiting room is to have a locked door between the waiting room and the treatment area. The locked door should be electronically controlled by the receptionist or another staff member from inside the treatment area. The physical therapy clinics I visit generally do not have doors separating the waiting room and treatment areas, and access cannot be controlled.

The treatment area is the innermost ring and where most of the assets are located. Addressing risks here is very important.

USING THE PPS SYSTEM

Policies and Procedures

Clinics typically lack security policies and procedures of their own; clinics that do have them may base them on the hospital setting—which means they may not be applicable to the clinic. Consider the hospital's active shooter plans and see if it would apply or would need modification to be effective. An important aspect of having your own policies and procedures is that they are a low- or no-cost way to reduce risks. Take advantage of free options whenever possible.

The most common poor procedure I see, other than inadequate access control, relates to cash

handling. Clinics may think of $100 or $200 as nothing to worry about; yet, by encouraging a break-in, even relatively small amounts of cash on hand can affect operations. As is true of the person locked in the bathroom, theft attempts can cost the clinic significant downtime (which equals revenue) if the area becomes a crime scene or an intruder destroys equipment looking for drugs or other valuables. Worse, an intruder may attempt to take the money while the clinic is open, putting people at risk.

Cash drawers are commonly right near the window of the front desk, and the receptionist often stores the money in a drawer that does not lock or keeps the key in a coffee mug at the reception desk. Anyone at the window sees just where the key is and where the cash is kept. Auditing is also an issue. Many times, the cash is not counted or is counted by the same person handling the money. To keep staff from being accused of theft, cash-handling controls need to be documented and put into practice.

Another common issue is the proper handling of protected health information (PHI). I have seen shred bins standing open, locks unlocked, and paperwork sticking out of overfull bins for a week before being put in a secure container. Anything other than properly securing the PHI should not be allowed: What you permit, you promote.

While you are writing clinic policies, be sure to include robbery procedures and opening and closing procedures, as well as plans for handling aggressive-patient, active-shooter and emergency-management events. Good security is inconvenient. Therefore, staff should help write these procedures and agree to them. It does no good to write something that staff will not follow.

Equipment

Security equipment can be a force multiplier for staff, especially if no security manpower is present. Good access control, video coverage, and alarms can all add to the overall security of the assets of these locations. Each clinic is unique and should have a security program created by a healthcare security professional together with clinic leadership.

Doors. As my comments above suggest, the greatest access control issue found at the various

rings and layers is improper door control. It is common to find doors propped open, door latches taped down, debris stuffed into the latch plate, and just about any other interventions that an employee can invent to circumvent door security. And don't forget to look at key control. Most likely there are missing keys. If a disgruntled employee left without giving back a key, take some action to mitigate that vulnerability. Pin pad locks are convenient but also vulnerable. I believe I can get into 50% of these locks just by looking at worn out buttons or the code written on the door frame, by knowing the building address or phone number, or of course, by trying the old standby of 1,2,3,4.

Signage. Beyond poor door control, I typically see a lack of signage stating that weapons are prohibited, no drugs are on site, and money is removed each night. These signs can deter a criminal act. If the clinic has an alarm system, are there signs or stickers? Are they in good repair? If not, get some new ones. Measuring how effective these signs are is difficult, but you can look back and see if the level of crime drops after signs are added.

Alarms. Detection and delay is the key to a good security design, and the rule of thumb is to detect as far out as possible. This gives employees time to react. Any increase in time for reacting is good. Adding a wider or higher reception desk that is harder for an aggressive patient to reach over is an example of detection and delay. Granted, a higher desk may be worth just a second or two, but that time may enable the receptionist to avoid injury. You also want to be signaled when someone forces a door open, as a person will need to do to get past a locked door to a staff member. The more ways you employ to detect and delay, the better chance you have of mitigating the effect of an event. Remember: without detection, delay is ineffective.

Alarms are a great way to detect and deter an intruder. The alarm system has to be used properly to be effective, though. I often find that alarms exist but the staff doesn't use them. The most common explanation is, "We don't know how it works." So, a monthly fee paid for an alarm service goes to waste.

Another alarm-related problem is the failure to set up supervision,

with the result that breaks in communication go undiscovered. At one clinic, the office manager had a stack of letters from the alarm company warning that the clinic was at risk because the supervision function was not turned on. The letters piled up because she did not know how she was supposed to respond to them.

Many facilities also fail to make sure that the alarm-monitoring company has the correct address for the clinic. The monitoring company may end up with the wrong address, for instance, if it has set up alarms at many locations in one building. Often, the wrong address turns out to be that of the main hospital, which won't help the clinic in an emergency. If the person testing alarms worries only about whether the monitoring station gets the alarm, you may never know that your correct address is not recorded. In a large facility, it is important to identify the suite and floor, not just the street address. The same issue arises with 911. I call 911 at every facility I check, and more than half have had to correct some information.

Finally, when you assess alarms, remember to consider panic, or duress, buttons. I hope to go to a location one day where the buttons operate as planned. Most clinics do not have these alarms, but the ones that do commonly have at least one of the following issues: They don't know they have the alarm; they don't know where it is; they don't know how it operates (pull, push, slide); the button is not operational or has not been reset; the monitoring location has the wrong address; the responding force does not know where the office is located; or staffers want a response force person (security or law enforcement) but get only a call asking if anything is wrong.

OVERVIEW

I hope I have given you enough information to get started with an assessment. Before you start installing security equipment, writing policies and procedures, or suggesting the addition of manpower, conduct a risk assessment. The document gives credibility to your requests and puts them in a priority order. If you can't do it, find a trained person who can. Finally, don't stick the report in your desk. It's a living document and needs air. Keep it out in front of you, and go over it with your people and your bosses.

Preferences for emergency announcements

James Kendig, MS, CHSP, CHCM, CHEM, LHRM

Hospital executives favor plain language or a blend of plain and coded language in emergency alerts.

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Whether to use coded or plain language—or a blend of the two formats—over hospital public address systems remains a matter of debate. "Code Pink" (for an infant abduction), "Code Black" (for a bomb threat), and similar announcements may minimize public panic and the likelihood that someone will overreact or incorrectly perceive innocent behavior and situations.

For example, if "Bomb Threat on 3 North" is announced, what will be the reaction of patients and visitors if they are in this unit? And if an "Infant Abduction Male 0" is heard over the PA system, will visitors and others attempt to intervene although not trained to do so? This could cause confusion and perhaps altercations with—or even physical restraint or tackling of—parents exiting the building with their own infants.

That said, if an active shooter is threatening one floor of a hospital

or a fire is blazing in a specific wing, announcing "Code Silver" or "Code Red" does not communicate to the public what is happening and what individuals need to do to stay safe.

Indeed, the proliferation of coded alerts in healthcare settings and the complexity of these codes, which sometimes include numbers, letters, and cryptic phrases as well as colors, have raised concerns. Moreover, from state to state, from one health care organization to another, and even within large health systems, the emergency alert codes often are not standardized. Consequently, hospital staff as well as patients and visitors can be confused by the messages.

Several state hospital associations and clinical specialty organizations, such as the Emergency Nurses Association (Winger, 2017), support the use of plain language in overhead emergency alerts. A few state hospital associations, most notably the Florida Hospital Association, have issued recommendations for emergency code standardization (Florida Hospital Association, 2014).

The Joint Commission does not require coded announcements or the use of plain language in emergency alerts but has been encouraging healthcare organizations to consider this issue. During four recent Joint Commission Hospital Executive Briefing (HEB) programs—in Los Angeles; Austin, Texas; New York; and the Chicago area—The Joint Commission informally polled attendees to determine whether their organizations use plain or coded emergency alerts or a mixture of the two formats. The attendees were also asked to indicate their personal preferences for each of the three options.

Regarding what type of emergency alert language their hospitals currently use, the respondents revealed regional differences, as the Table 1 shows.

Of those polled, 40% of the New York HEB respondents said their health care organizations use plain language alerts, compared to only 22% of the Chicago and Austin respondents and 7% of the Los Angeles respondents. The Chicago HEB had the largest proportion of poll respondents (41%) whose organizations use a mixture of coded and plain language alerts, whereas the majority of respondents at the Los Angeles

Table 1

What emergency alert format is your healthcare organization using now?

	Plain language	Coded language	Mixture of both
Los Angeles	7%	67%	26%
Austin, TX	22%	52%	26%
New York	40%	36%	24%
Chicago Area	22%	37%	41%

At four Joint Commission Hospital Executive Briefing programs, a total of 278 attendees responded to the question of whether their healthcare organization uses coded or plain language emergency alerts or a blend of these options.

(67%) and Austin (52%) HEBs indicated that their organizations use coded alerts.

When asked about their preferences, most attendees who responded to that question favored either plain language or a mixture of plain and coded language, as Table 2 makes clear.

A significant majority of the Chicago (67%) and New York (63%) HEB attendees expressed a preference for plain language emergency alerts. In Los Angeles and Austin, however, respondents were evenly split between those preferring plain language and those preferring a mix of coded and plain language. Only a small minority of attendees noted a preference for coded language: 22% in Los Angeles, 17% in Aus-

Table 2

What emergency alert format do you prefer?

	Plain language	Coded language	Mixture of both
Los Angeles	39%	22%	39%
Austin, TX	42%	17%	42%
New York	63%	9%	28%
Chicago Area	67%	9%	24%

At four Joint Commission Hospital Executive Briefing programs, a total of 253 attendees responded to the question of whether they prefer coded or plain language emergency alerts or a blend of these options.

tin, and 9% in both New York and Chicago.

To promote public safety, the most effective process for announcing emergencies might well be a combination of coded announcements and plain language. This would ensure that hospital staff can implement the appropriate emergency response and plan the best course of action, while also providing visitors with the information they need to avoid imminent danger.

Of course, it is important to be cautious about drawing broad conclusions from these data. The number of respondents is small. The polling was conducted via a polling app during plenary speakers' presentations. In addition, the responses represent only a fraction of U.S. hospitals and reflect the personal opinions of attendees. Nonetheless, these numbers are relevant because they highlight the need to effectively inform staff, patients, and visitors of an emergency.

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Effective interview techniques

Anthony Luizzo, PhD, CFE, CST, PI (Ret. NYPD)

Security and safety officers often have to interview people to find out what exactly happened in situations ranging from a visitor who has fallen to someone who might have stolen something from a patient's room. In this article, the author presents a comprehensive guide to conducting successful interviews.

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WHAT IS THE OBJECT OF AN INTERVIEW?

The object of conducting an interview is to collect accurate information through a systematic and structured format. One of the most important skills an interviewer should posses is being able to recognize truths and untruths. Research suggests that people are surprisingly bad at detecting lies. According to an excellent article by Kendra Cherry, research indicates that 96% of people admit to lying at least sometimes (Cherry, 2018). Cherry's article also notes that a laboratory study found that only 54% of participants were able to detect lying accurately. The article goes on to mention that even trained investigators can be remarkably poor at deciphering untruths. Obviously, deception is big business, and deciphering it is *vital*!

THE INTERVIEW DEFINED

In essence, an interview is a

conversation carried out in a question-and-answer format. Seasoned investigators consider the investigative exercise to be the meat and potatoes of their profession and often describe it as the artery through which facts are discovered, gathered, preserved, and prepared as evidence for legal or contractual purposes.

HOW DO INTERVIEWS AND INTERROGATIONS DIFFER?

From a purely investigative perspective, an interview is a *leisurely* conversation between two individuals (an interviewer and an interviewee). An interrogation is a probing conversation with an unwilling subject. The interview is typically a *less formal, less accusatory* chat intended mainly to elicit information, whereas an interrogation is a much *more formal* conversation, designed to elicit secret information or a confession. Interrogation involves probing and extracting information from an unwilling subject by asking trenchant questions meant to yield evidence and an admission of responsibility or guilt. Regardless of who is conducting the interview or interrogation (private security, healthcare agencies, law enforcement, or others), the goal of the art and science of the exercise is the same for all: to obtain information and get to the truth.

For simplicity, in the text that follows, my advice for "interviewing" refers to both interviews and interrogations, unless I state otherwise.

AN INVESTIGATIVE SNAPSHOT

One of the tenets of the investigative process is to gather as much pertinent information as possible during the interview. Often, watching an interview is like watching a well-acted movie script in which the interviewer and interviewee are the lead performers. An investigator assesses facts, criticizes declarations, and integrates conclusions. From a business perspective, security operatives call this peeling the onion. Looking even deeper into the interview process, it is most important that interviewers use control-type questions while plying their trade. (Such questions are designed to arouse a subject's concern about their past truthfulness.) "The Control Question: A Technique for Effective Introduction," an article by Stanley Abrams, is an excellent resource

on control questioning (Abrams, 2009).

Further, when preparing for an interview, always have an open mind, so that you can follow the facts presented easily, without being misled by preconceptions. Be objective, listen intently, be well prepared, employ sound observation skills, and observe body language and related mannerisms.

Never forget that the first stage of any interview is developing rapport. A successful interview depends on the interviewee as much as the interviewer. How comfortable you make the subject may determine the success of your fact-finding exercise. *Often, interviewees are ready and able to tell what they know, and the interviewer should always allow them ample time to tell their story uninterrupted*. If the interviewee in an initially informal question-and-answer discussion is not willing to cooperate, then it's time to consider moving from a friendly interview to a more formal interrogation.

INTERVIEW TYPES

There are two main types:

• **Standard**. The interviewee usually consents to the process, and the question-and-answer process is *overt.*

• **Undercover**. Usually, these types of interviews are conducted under the guise of fact-finding with an interviewee (possible target) to obtain as much information as possible.

INTERVIEW TIPS

Here are some actions you should always take in interviews. These tips, and those in the note-taking section below, are meant specifically for standard interviews; some may not apply to certain interrogations of suspects.

• Put the interviewee at ease.

• Structure interview questions so that they are easily understood.

• Keep interviews conversational.

• Listen carefully.

• Pre-plan interview questions.

• Try to schedule interviews at times when you feel the most energetic.

• Select interview locations that offer a distraction-free environment.

• Allow ample time to conduct the interview.

• Maintain control of the interview flow.

• Establish rapport with the interviewee.
• Accept emotional responses without criticism.
• Refrain for taking extensive notes during the interview—shorthand helps.
• Refrain from interrupting the interviewee.
• Leave the door open to follow-up interviews.
• Try to obtain a written statement from the interviewee describing the sum and substance of the interview.
• REMEMBER: When using interpreters, make sure that all communication takes place between the interviewer and interviewee—not between the interpreter and the interviewee.

NOTE-TAKING TIPS

• Know what information must be learned.
• Refrain from trying to write verbatim responses.
• Avoid becoming distracted by extensive note taking.
• Always preserve interview notes for future use.

SHORTHAND ABBREVIATIONS

Whether to use shorthand is purely an individual choice. More experienced investigative professionals devise and use their own list of abbreviations. Some examples include but are not limited to:

• DOB: date of birth
• POB: place of birth
• RQ: repeat question
• RA: repeat answer
• IE: interviewee
• IR: interviewer
• IW: interview
• MVI: motor vehicle information
• LEI: law enforcement information
• AKA: alias, or also known as
• MPH: miles per hour
• NA: not applicable
• ID: identification
• CM: crime method
• ICB: internal control break (a fraud and audit term)
• SSF: security system failure
• AF: audit failure
• SF: security failure
• BSR: background search required

INTERVIEW METHODS AND TECHNIQUES

• **Good Guy–Bad Guy.** One interviewer verbally attacks the interviewee, and the other defends him or her.
• **Role Reversal.** The inter-

viewer reverses roles with the interviewee—asking, for instance, "If you were looking into to this matter, what would you do?"

• **Pregnant Pause.** The questioner stays silent so that interviewee feels compelled to continue talking.

• **Trade-Off.** The interviewer promises to assist the interviewee in some way in exchange for his or her assistance

• **Breaking Down the Story.** The interviewer continually challenges the interviewee by pointing out inconsistencies.

• **Graceful Exit.** The questioner offers a sympathetic ear to excuses raised, thus keeping the door open for future cooperation.

VERBAL CLUES TO TRUTHFUL AND UNTRUTHFUL STATEMENTS

Distinguishing true from false statements is an inexact science, but these rules of thumb can help:

• **Truthful** subjects tend to be direct when answering questions.

Untruthful subjects tend to be somewhat circumspect with their answers.

• **Truthful** subjects tend to answer questions quickly.

Untruthful subjects tend to take their time in responding while sometimes using delaying tactics, such as asking, "Who me?" or "Why would I do that?"

• **Truthful** subjects tend to not repeat answers.

Untruthful subjects often repeat questions as a ruse to gain time to formulate answers and often repeat answers verbatim or repeatedly asks the interviewer to reiterate previously asked questions.

• **Truthful** subjects tend to use complete sentences.

Untruthful subjects often use fragmented or incomplete sentences.

• **Truthful** subjects usually don't take an accusation lightly.

Untruthful subjects sometimes try to be polite when addressing the accusation and might use flattering terms, such as "Sir" or "Madam."

• **Truthful** subjects tend to be vehement in their denials.

Untruthful subjects tend to recite oaths when confronted, such as: "I swear to God, I did not do that," or "I swear on my

father's grave."

• **Truthful** subjects tend to respond to questions forthrightly and with clarity.

Untruthful subjects sometimes mumble or talk softly and are evasive.

• **Truthful** subjects usually have little problem denying an allegation in specific terms, as in, "I did not steal the money."

Untruthful subjects tend to have trouble denying an allegation forthrightly; their responses usually skirt the issue at hand and are less specific, as in, "I did not take it."

VERBAL RED FLAGS LINKED TO DECEPTION

• Consistently offering dim or hazy responses (being vague).

• Consistently repeating questions before answering them.

• Consistently offering fragmented answers and sparse details in response to queries.

• Consistently overthinking answers.

NONVERBAL CLUES TO DECPTION

Certain behaviors may suggest deception. These include:

• Not looking directly at the interviewer when answering a question, or answering with an emblem expression, such as a thumbs-up gesture, a circled finger, a broad wink, or a shrug of the shoulders (often to indicate ignorance of the event under scrutiny).

• Engaging in "manipulators," such as touching oneself, grooming hair constantly, wringing hands, or picking at imaginary lint.

• Irregular breathing patterns.

• Excessive perspiration.

• Frequent swallowing.

• Muscles tightening around the eyebrows.

DON'T FORGET THE OBVIOUS

Investigators can gather a bushelful of information about a subject by simply paying attention to the obvious clues staring at them. The trick is knowing where to look:

• The location or décor of a person's office indicates status; portraits adorning the walls indicate family connections and whether the person is an adventurer or outdoorsy and the like.

• A lapel pin indicates association affiliation

• The type of jacket worn can

reveal whether a person is an academician or conservative in philosophy.

• Suspenders may indicate a staunch, established professional, or possibly a young millennial.

• A bow tie may signal a nonconformist or a person of the liberal persuasion.

Clues abound. All one must do is seek them!

PERFORMING DUE DILIGENCE

Once the interview is completed, it's time to test the accuracy of the information. Each assertion offered during the interview must be truth-tested. Witnesses must be located and interviewed; background checks and related due diligence must be performed; and tips and leads must be verified.

CONCLUSION

Many, many articles have been written offering suggestions for deciphering dishonesty. In practice, one of the subtler methods of achieving this elusive goal might be to listen to and follow your innate INSTINCTS.

Closely observing gestures during Q & A sessions helps the seasoned sleuth to frame investigative conclusions. In law enforcement and private security parlance, this is often called "reading the target." This is a special gift that law enforcement, private investigators, and hospital security operatives develop over years of interacting with humanity. As such, these sleuths become quite proficient at quickly recognizing deceit, impostures, flimflams, fraudsters, terrorists, hoaxes, phonies, swindlers, liars, and the like. Having these perceptive professionals on board is truly a divine asset!

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Work-safety-crew best practices that cut costs

Chief Donald E. White

Three relatively simple steps—using lockable tool carts, equipping them with simple emergency supplies, and relying on containers that control the amount of product that is dispensed—can enhance safety and save money.

(Chief Donald E. White was Director of Safety & Security at the Northern Virginia Mental Health Institute in Falls Church, VA, for 25 years. He was also a board-certified healthcare safety professional (CHSP), a hazard control manager (CHCM), and a healthcare emergency professional (CHEP). Chief White is a NFPA Fire Instructor-III, Virginia Emergency Medical Technician (EMT/B), and American Red Cross Disaster Instructor. During the past 49 years, he has worked at airports, hotels, hospitals, jails, prisons, fire stations, command centers, apartment complexes, and office buildings.)

Got healthcare cleaning or maintenance workers scattered on different floors? Dispersed across campus? Traveling across town? Working shifts around the clock, often without direct supervision? That's a recipe for devastating consequences.

Healthcare cleaning and maintenance crews are tool-driven and chemical-laden workers who can suffer mishaps. Whatever the causes—human error, equipment defects, and so on—the end results are costly and disruptive for healthcare supervisors, managers, and safety/security directors alike. A few proactive, low-cost best practices can prevent problems and provide a quick return on investment by avoiding work stoppages, medical emergencies, workers compensation claims, and even the need to hire fill-in or replacement workers.

TOOL CARTS: WORKSTATIONS ON WHEELS

Lockable carts are the better solution for today's times. They protect in many ways, by:

- Deterring theft of costly supplies and equipment;
- Avoiding accidental injuries from chemical product splashes, and spills;
- Preventing self-harm attempts by suicidal patients, staff, and others.

What emergency supplies should be included in your lockable carts? Regardless of whether the following items are used for healthcare cleaning, maintenance, or other jobs, proactive managers should outfit lockable carts with:

- LED flashlights (palm size with clickable on/off switches);
- Bottled water (for quickly diluting accidental spills or splashes);
- Mini first aid kit (mainly antiseptic wipes and band-aids for cuts).

Lockable carts, using these three low-cost emergency supplies, can cut your costs by eliminating such billable expenses as:

- $3,000 emergency room visit costs;
- $1,000 premium increase for workers compensation coverage;
- $1,000 for replacement of the cart contents;
- $50,000 settlement cost for negligence involving workers or clients.

These costs do not include whatever you would need to spend to hire fill-in or replacement workers for those who were injured. Altogether, you could save the equivalent of the salary of a cleaner or maintenance worker or two.

PORTION CONTROL: THE CORRECT SOLUTION

Healthcare cleaning and maintenance staff typically use chemical products such as cleaners, degreasers, lubricants, fuels, deicers, and more. Portion-control dispensers—whether in the form of bottles, bags, barrels or sacks—are the way to go. They protect in many ways:

- Avoid waste by dispensing the correct amounts;
- Minimize accidental spills that result from carelessness;
- Quicken cleanup of accidental spills and leaks.

What type to use? Choose containers featuring the following kinds of tops, or replace existing twist-off and barrel-lid tops with:

- Flip tops, such as found on shampoos bottles;
- Pump tops, like those used for hand lotions;
- Push levers, found on wall-mounted liquid soap dispensers;
- Spreaders, which can be used year-round and work well for fertilizers in summer and for de-icers in winter.

SUMMARY

Scattered cleaning and maintenance workers are tool-driven and chemical-laden people who are likely to have mishaps at some point or another. Healthcare facility accidents are costly disruptions that stop business, incur bills, and invite lawsuits—all of which are potentially preventable. Provide your healthcare work crews with lockable carts containing three basic emergency supplies and use portion-control chemical products to prevent costly waste, messy spills, and serious injuries. A winning solution!

Transitioning from law enforcement to private-sector security

Marc B. Sano

The author moved into private-sector security after a long career in law enforcement. Making the switch, he says, involves many changes, such as a need to emphasize customer service over authority, an initial reduction in salary, and an altered mindset. But, he notes, the changes come with rewards as well.

(Marc B. Sano is Director of Safety and Security at Virtua Health, based in Voorhees, NJ. He joined Virtua after a career in law enforcement that included service as Chief of Police of the Lumberton Township Police Department. He is a member of IAHSS.)

I worked in law enforcement for 32 years before transitioning to private-sector security about eight years ago. I am glad I made the switch instead of retiring. As a hiring manager, I have seen some challenges for individuals I have hired who were making the same transition.

Every day of my law enforcement career, when I put on my uniform, I expected to make use of all the tools I had been trained on to protect the public, my fellow officers, and myself. Part of the responsibility I felt came from my personal beliefs; I wanted to protect those who could not defend themselves.

Much of my authority was afforded to me by virtue of the position I held. Having the title "Law Enforcement Officer" garnered respect from much of the public. The mere fact that I wore a uniform gave me a constructive authority—meaning that people usually would do what I asked be-

cause they recognized my role as an officer. When officers show up to a situation after being summoned, people generally understand it is in their best interest to comply with the officers' requests and instructions.

Over time, you develop a sense that "people need to listen to me because I wear a uniform and am in charge." Used appropriately, this power enables officers to protect those who needed protection and to enforce the laws they have sworn to uphold. As you rise through the ranks of the police department, your authority grows in the eyes of those around you. You now may be responsible for the lives of all the subordinates who work for you as well as for the public. When you reach retirement age, your sense of responsibility and power may be at an all-time high. Therefore, you may be in for something of a shock if you move into another career, such as into private security.

A CHANGE IN MINDSET

When you enter the private-sector security world, things change. The authority you once enjoyed no longer exists. You are now a private citizen who wears a uniform. At first, there may be a sense of frustration and loss. Instead of giving an ultimatum to individuals who would face incarceration for disobeying you, you now have to handle situations with more of a customer-service perspective in mind. This is not a bad thing, just a change in your mindset. You have to become the best customer-service representative for your organization.

You will certainly face challenges dealing with difficult individuals from time to time, but through retraining yourself to use the tools you now have, you will most often be successful. Building your ability to communicate well and de-escalate situations becomes paramount. You always have the option of calling in local law enforcement to assist with situations beyond your authority. Adjusting the way you operate is important. Those who do not change will find themselves less successful in this atmosphere. Use of force is completely different from law enforcement to private security. As a police officer, you are charged with the responsibility to move forward and not retreat in most circumstances requiring the use of force. You are governed under a strict guideline

established by your state attorney general's office. As a security officer, you are acting as a civilian with a responsibility any other civilian would have as it relates to use-of-force situations.

PAY STATUS AND WORK HOURS

If you have worked in law enforcement for 25 or 30 years, your salary might be rather high because of the significant risks you accepted and your long service record. You may have expectations for similar pay in a new position, because you have a lot to offer in experience. Unfortunately, there are not a lot of positions available for your experience. Understand that the private sector does not always have the funding to support your expectations. Eventually through hard work, you may be get close to the level you once enjoyed.

You may have to work nights, holidays and weekends again, until the position you want becomes available. It is not easy for some to accept this reality.

PREPARE FOR THE CHANGE

If you are one of the thousands of officers who want to continue to work and start a new career after law enforcement, you must prepare yourself before the last call. Educate yourself in the direction you want to go. Understand and prepare for the regulatory aspects of the positions out there in the private-sector security realm.

I recommend taking verbal de-escalation training while you are still in your current position and prepare mentally for the future change in your authority. Continue to educate yourself and get additional training beyond de-escalation, either while still on the job or later.

Prepare for job interviews and dress appropriately. Research the position you are applying for and the organization where you hope to work. Having general knowledge of the organization can often impress the interviewers and show you truly have an interest in the organization. I have seen several former officers attempt to ride on their experience as an officer to get them through the interview process, some wearing jeans and a ball cap for the interview. This approach can work against winning the job.

Networking is always a key component to successfully ob-

taining a job. Depending on the position, you should join organizations supporting the sector you are looking to join. Many professional organizations supporting the security field exist.

In my own case, I began by researching opportunities in security, and I networked with members of law enforcement who had made the transition already. I also attended meetings and joined organizations like the IAHSS to provide myself with the opportunity to network with individuals in the fields of interest to me. I found there were a vast number of experienced individuals in the IAHSS who were always willing to help and share ideas. I also researched individuals who were foremost experts and read white papers written by them to get a general understanding of what to look for in the private-security realm.

PRIVATE SECURITY

In my last job in law enforcement, I had the honor of working with one of the best teams I could imagine. I did not think I would make the leap to another great team, but I have. For the past eight years, I have had the good fortune to work with outstanding and experienced security professionals. I have also gained renewed respect for security professionals. I thought I had seen almost every situation, but I am amazed at what they deal with every day. Certainly, the training and experience received while on the job helps, but it is not all we need: preparation and having the right mindset are important, too. I can say I enjoy my new career, and I tell all of my former colleagues there is a good life after law enforcement.