MARY PAT MCKAY, a physician in the emergency department at The George Washington University Hospital in Washington, D.C., has been slapped, grabbed, spat on, and kicked—all while trying to render medical assistance to patients in the ER. She has narrowly avoided taking some punches too. McKay’s experience is not unique for emergency department workers in the United States. She knows of colleagues who have endured worse. According to the Emergency Nurses Association (ENA), employees in the healthcare industry see four times more nonfatal assaults than those working elsewhere in the private sector. One consultant interviewed for this story cited a case of a nurse whose jaw was broken by a patient. In addition, violent crime sometimes follows patients to the ER. For example, when McKay worked in an emergency department in Pittsburgh, rival gang members showed up with guns because a prominent gang member had been brought to the hospital.

Several factors contribute to danger in the emergency department, including the stress of the situation and the fact that people generally are stuck, sometimes for hours, in overcrowded waiting rooms. These conditions can cause tempers to flare.

Hospitals have a responsibility to staff and patients to mitigate emergency room violence. The key is to know how to evaluate the risk and then develop a security program tailored to those findings.
Risk Assessment
The first step in developing an ER violence prevention program is to assess the existing risk, including current threats and countermeasures.

The threat analysis should begin with a review of crime demographics and indicators in a given distance around the hospital. The hospital can use analytic tools, such as those from CAP Index, says Jeff Aldridge, CPP, president of Security Assessments International in Durham, North Carolina, who has performed risk assessments for hundreds of hospitals. A CAP Index report, based on data from law enforcement, includes probability measures on crimes such as homicides, larcenies, and rapes.

The assessment progresses from the analysis of the threats around the property to an analysis of the threats within the property. This analysis is carried out through an examination of the recorded violent incidents within the hospital and especially within the emergency department. This can be difficult, however, because hospital record retention policies vary widely. Hospitals retain records of violent incidents anywhere from a few months to upwards of 10 years.

Another problem in carrying out this analysis is that emergency department incidents are widely underreported. The ENA estimates that as many as half of the verbal and physical assaults that nurses suffer go unreported.

One reason that incidents are not reported is that medical professionals consider some level of abuse from patients understandable given what the patients are going through, and they take it in stride. Another reason is that reporting takes time, which already short-staffed emergency departments don’t have, says Jonathan Rosen, director of the occupational safety and health department for the New York State Public Employees Federation. Managers might discourage reporting, arguing that the violence is not a big enough deal and that the employees are needed in the emergency department, rather than in the employee health department reporting an incident, says Rosen.

Existing security. The next aspect of the assessment is to examine the existing security, including a complete physical analysis of everything from access controls to cameras to the location of emergency call stations. Protocols and guidelines should also be assessed, along with staff education and training programs. This analysis takes about three days, says Aldridge.

Reducing Risk
Once the hospital has the complete picture of the existing threats and countermeasures, it can work with its security team and consultants as needed to determine where there is remaining risk that is not countered by existing measures. They can then craft adjustments to the security program to address that risk if it exceeds the level deemed acceptable by the administration. The following measures are among those that a hosp-

"Emergency rooms today use a hub-and-spoke design, with a nurse station in the middle that lets staff see into all the treatment rooms."

Whatever the reason, the fact is that in doing a risk assessment, security professionals have to go beyond just looking at official reports and logs. They should interview staff to get a fuller picture of staff experiences and the types and frequency of incidents.
eral may decide it needs to implement or enhance.

Training. Since most emergency room violence occurs between patient and caregiver, it is essential to train staff on how to detect and defuse potentially violent situations. There are, however, no federal standards for hospitals regarding violence-prevention training for emergency room staff, and practices vary.

Some hospitals institute detailed training regimens, while for others, it’s “catch as catch can,” according to McKay. This scattershot approach leaves many staff members vulnerable to attacks that could be avoided.

Ideally, hospitals will train staff to be alert to signs of trouble. When a patient shows signs of agitation, such as rocking, pacing, eyebrow furrowing, or a raised voice, a trained staff member should be able to recognize those signs and to step in to calm the person, says William H. Nesbitt, CPP, president of Security Management Services International Inc.

Just speaking with the person can alleviate tension. The conversation can be as simple as asking patients if they are all-right or need anything. This technique is called verbal de-escalation.

“It’s the most powerful tool that we have,” says Tony York, CPP, CHPA, and senior vice president for Hospital Shared Services, Inc., in Denver, Colorado, the state’s largest hospital security contractor.

Just giving people the chance to verbalize frustrations can often calm them down, because they no longer feel ignored, says York, who is also president of the International Association for Healthcare Security and Safety (IAHSS).

Staff members also need training in how to approach an agitated person. They need to be able to do so in a way that minimizes the risk to themselves while also making sure not to appear confrontational. Some important tips to remember, according to Rosen, are: stand in an open stance, with legs apart, a safe distance from the patient; make short, simple, affirmative statements; and speak in a calm voice.

“Those who’ve gone through good, formal, aggression-management training...understand that there is a way to manage that type of behavior,” says York.

Assistance. Even with training, however, staff will not be able to mitigate every situation on their own. “The problem is, somebody who wants to hurt themselves or do something that’s potentially life-threatening may or may not be able to be talked out of it,” says McKay.

And sometimes, the individuals are mentally unstable, disoriented, intoxicated, or on drugs. “You can’t have a rational conversation with somebody who’s whacked out on PCP, for example,” says McKay.

Staff must know when to call for assistance, and the hospital should provide them with an easy means of doing so. Emergency areas should be equipped with panic buttons, for example, so that staff can quickly summon security if a
visitor or a patient cannot be calmed. If patients are causing the disruption, then they may need to be restrained physically or sedated before receiving medical attention. The decision to use restraints or to sedate a person should be carefully considered, however, and well documented, given that some patients have died in restraints.

“It’s a risky activity, and for the most part you do want to eliminate it,” says Rosen, adding, “but there are situations where prevention fails, and you have no other choice.”

York agrees. “The application of a restraint...is typically a means of last resort.” He adds that the staff members need to document that they took other steps to mitigate the aggressive behavior before resorting to the restraints.

Not all problems arise from the patient, however. If a family member or other visitor is causing any type of disturbance, they should be asked to leave, says Aldridge. And anyone who is actually committing a crime (such as an assault) should be detained by security and arrested by law enforcement.

Sometimes the violence stems from a fight that participants have carried into the hospital, as in cases where gang members continue their turf battles in the ER. In those situations, police should be called immediately.

Reporting. As noted earlier, staff members do not always report incidents they perceive as minor. Hospitals should work to change this attitude, says Aldridge. “There should be a zero tolerance level for violence. People [making] threats to staff should not be tolerated,” he says. “This is what we write into our protocols, and then we educate the staff on the fact that if somebody says ‘if you touch me again, I’ll kill you,’ then you need to call security.”

Design. The design of the emergency room can also play a role in curtailing violence. Design can allow staff members to keep tabs on patients, visitors, and any potential problems brewing in the waiting room or treatment areas. It can calm down agitated individuals. It can also prevent potentially dangerous individuals from even entering the department, when coupled with proper door locking and access control mechanisms.

A key element of a good design is to ensure that staff members have a way to observe patients and anyone in the waiting areas. The shape and layout of the emergency department and its patient rooms can go a long way to improving observation potential.

With that in mind, most emergency departments designed today are following a type of hub-and-spoke approach, according to William Heil, electrical engineer at Harriman Associates in Auburn, Maine. There is a nursing or administrative station in the middle of the room with a birds-eye view of all the treatment rooms. "A nurse can sit and usually look 360 degrees around them into each of the individual patient rooms to actually see what..."
each patient is doing,” says Heil. Additionally, he says, the patient rooms are fitted with full glass panels so that the nurses can see what’s going on inside.

If a patient becomes physically aggressive with a staff member or there is an altercation, someone from the nursing station should be able to see it and send help.

Secure room. The design may include a psychiatric observation room that can be used to contain mentally unstable or intoxicated patients who might otherwise be harmful to themselves or others. These are rooms that are outfitted in such a way that nothing in the interior of the room can be used by patients to harm themselves or others.

“Frequently they’re prison-grade type fixtures in that type of a room,” says Heil. For example, if there is an air conditioning vent in the ceiling, it should be of a design type that a patient would not be able to loop a belt through the vent to hang himself. Additionally, the room offers a way to separate the troubled patients from the general patient population. Larger hospitals may even have a second group of observation rooms with their own nursing stations so that those patients can be treated in an area completely separated from the general ER area.

Light. Lighting has an impact on a person’s sense of well-being. Aldridge encourages the use of natural light in emergency departments so that patients feel less claustrophobic and depressed. However, windows—the source of natural light—can also create a security vulnerability, notes Ella Franklin, special projects director at Washington Hospital Center.

Franklin is involved in a project called ER One, which has developed a theoretical design for an emergency room of the future, with the aim of withstanding a mass casualty event. Washington Hospital Center has implemented some of ER One’s innovations in an emergency department extension as part of a “Bridge to ER One” project. But the use of natural light has proved to be a tension point between architects and clinicians, says Franklin.

Perpetrators can come up to the windows from outside, she notes. As a result, “we ended up with this hybrid design where we have the walls at about three-quarters height [from the street], and a window at that level,” Franklin says.

A related question is whether to use bulletproof glass in windows. Aldridge recommends that facilities with entrances that are all glass should have ballistic laminate over the windows. In the case of ER One, however, because the windows were high up, law enforcement said that there was little risk of a direct shot in, and bulletproof glass was not used.

Soothing distractions. Another addition to the environment that can relieve tension is the availability of food and other distractions in the waiting area. That can be achieved with vending machines and televisions. These help people take their minds off the real reasons they are at the emergency room in the first place.
Fast-track area. As waiting times in emergency departments increase, many hospitals are also looking for creative ways to lessen the patient wait time through streamlining. For example, some hospitals now have adopted a fast-track option, where patients with simpler problems can be seen more quickly, often in a separate section of the emergency department.

However, the fast-track strategy is not without its critics. The ER One team toyed with the idea of having a tiered system where there would be fast-track rooms with fewer resources for some patients and fully equipped rooms for patients with more serious troubles. The team chose not to do that, because they wanted all of the rooms to be capable of handling any type of case in a mass casualty event.

There’s another issue with the segregated fast-track approach, according to McKay: “One of the problems that has happened in every hospital that I’ve worked in that uses this technique is it does mean that sometimes, depending upon the flow and who shows up when, the sickest people wait longest, which is really counterintuitive.”

Access control. Access control is one of the most important aspects of emergency department security. Experts agree that all doors to the emergency department patient treatment location should be locked and alarmed, and no one should be able to get through without passing by security.

Aldridge recommends that any double glass doors that can be pried apart be installed with positive locking.

But it is not just a matter of limiting who comes in. Access control in emergency departments must also include rules on who gets out. If individuals were permitted easy exit from the emergency patient treatment area, assailants would have a better chance of getting away, says Aldridge.

Most hospitals have some access controls, but they do not always extend that control specifically to the ER, according to a survey released in 2007 by GE Security and IAHSS. The survey found that while 81 percent of hospitals had implemented electronic access controls generally, only 68 percent had access control technology of any kind in the emergency department. And Aldridge points out that a weak point in many hospitals is that they do not keep all of the entrance doors locked.

Nesbitt says that it’s important for a hospital to be able to place the emergency department in lockdown if needed. There should also be controls in place to prevent individuals from entering through the ambulance area, he says. Hospitals can achieve this level of control through some sort of garage door opener or key lock technology that only ambulance drivers can activate.

Only 11 percent of hospitals in the GE/IAHSS survey used electronic visitor management. Badging does not have to be electronic to be adequate, however,
Aldridge. He says visitors can be required to trade valid government identification, such as a driver’s license, for a visitor’s pass. After the visit, the pass is retrieved in exchange for the return of the identification.

Visitors’ badges should include the following information: name, picture, and expiration date. Preferably, the badges should be sturdier than just stick-on pieces of paper.

To ensure that unauthorized visitors do not accidentally wander into restricted spaces where visitors can sometimes go, an attendant, rather than a card swipe, should control entrance into the patient treatment area, recommends Aldridge. The attendant would be responsible for buzzing in only persons with valid access to the area. Of course, this would require an additional full-time employee.

By contrast, card access without an attendant can be used to protect rooms that only staff members are authorized to enter, says Aldridge.

Staff should also have to wear ID badges, but Aldridge notes that it is difficult to get doctors to comply.

Access control guidelines should always be reasonable, says McKay. She knows of a situation in the emergency room where an individual came in because of chest pains, but in his rush, he left his identification at home. As a result, he was not permitted entry until he went home and retrieved it.

The incident led to a change in policy. Now, “If you’re a patient, you get to come in. It’s obviously the reasonable approach,” says McKay.

Visitor protocol. Another aspect of access control is placing a limit on the number of visitors who can enter the treatment area or even the waiting room with a patient. Aldridge recommends two as an acceptable number of visitors to allow at one time per patient in the treatment area.

Restricting the number of visitors in the treatment area is clearly good for security. McKay points out another reason: They faint. “That just makes work for everybody,” she says.

Metal detectors. Many ERs use metal detectors to provide an extra layer of security aimed at ensuring that no weapons get through the doors to the department. Aldridge highly recommends this type of screening for departments in high-crime areas.

A county hospital that Aldridge worked with in North Carolina was not convinced of the need to screen for weapons, but it agreed to try a metal detector out since the manufacturer offered it for free for 30 days. In those 30 days, the department found 48 handguns and more than 100 knives. The metal detector even caught an elderly woman who tried to sneak into the emergency room with a concealed meat cleaver.

The case illustrates the threats hospitals face. There are, however, several factors to consider before installing a metal detector in the ER.
The first factor to consider is the all-in cost of such a system. Not only is there the up-front expense of the equipment and installation, but there is also the ongoing expense of staff to do the screening. According to Nesbitt, one metal detector requires the “full-time equivalent” of 4.3 individuals working during the week to staff it.

In analyzing the cost, the security team must remember that in emergency de-

allowed in the patient care areas at Washington Hospital Center, according to Franklin. However, she says that ER One is “futureproofing,” or preparing for what its team hopes occurs in the future—that the cameras will be allowed to tape patient care areas. Their bridge emergency department has already installed cabling in the ceiling in hopes that cameras can be connected one day.

The second factor is a legal consideration: Once metal detectors are installed, removing them could create a liability. Imagine, says Nesbitt, that a hospital has a metal detector, removes it, and then someone gets shot. “That makes [a legal] liability possibly 10 times worse than it would have been if you didn’t have the metal detector in the first place.” He also warns that saving money is not a strong argument for removal of a metal detector.

That’s why Nesbitt suggests that in some cases it could be useful to employ a magnetometer wand instead of a metal detector. The hospital should post signs that state no weapons are tolerated and that individuals are subject to searches.

McKay points out that some patrons may have a negative reaction to metal detectors. “There are some folks who believe that it is off-putting, meaning that it’s saying, we don’t want...your kind here.” But she adds, “My personal bias is that safety outweighs that problem.”

Surveillance. Experts advocate having surveillance cameras in place at each door and at entrances and exits. Currently, ongoing video surveillance is not

Signage. Signage is an important aspect of a security program, but its role is often overlooked in the emergency department. Signage “50 percent of all hospital security, and it’s probably the least used,” says Aldridge. It’s so important because half of the value of security is its deterrent effect, he explains.

Even just putting up a sign that says weapons are prohibited and that individuals are subject to search has an effect that is visible from security cameras; people often just turn away and leave. The effect, according to Aldridge, is analogous to when burglars avoid homes with alarm signs in the yard.

Guard presence. Another effective measure is to have guards patrolling the waiting room, rather than just sitting at a security station. Patients and visitors are less likely to be confrontational with each other when an officer is present, says York.

Because the need for medical attention is itself stressful and because hospitals are open to the general public, including criminal elements, it’s inevitable that problems will arise. But by implementing staff training, good design, access controls, and appropriate protocols, hospitals can go a long way toward preventing any problems from getting out of hand and resulting in injury or death. ■

Laura Spadanuta is an assistant editor at Security Management.