HEALTHCARE SECURITY RESPONSE OFFICERS

A Guide to Best Practices

LHA TRUST FUNDS

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Foreword: Need & Purpose

A healthcare facility is a busy public place primarily charged with the responsibility of providing care, comfort and cure to the patient. It is a place visited by thousands of people, every day.

It is difficult to identify antisocial elements in the comings and goings of the many people who are in our healthcare facilities every day, much less foresee anyone's intensions. As a result, unexpected undesirable situations like arguments, noisy scenes, accidents or thefts happen in hospitals, clinics and other healthcare facilities.

The abundance of expensive medical equipment and potentially harmful drugs also puts medical facilities at a heightened risk of theft. Some healthcare security sources and professionals have raised concerns that criminals regard hospitals as "supermarkets without tills".

The Healthcare Facility Security Department (and its Staff) is responsible for ensuring the security and safety of the healthcare facility or hospital buildings, grounds, personnel, patients and public as well as regulating the vehicular and pedestrian traffic on and within the premises.

A core duty of the Healthcare Facility Security Department is to prevent and handle a disturbance or breach in security, so that the hospital or healthcare facility can function smoothly and without disturbance.

In today's world healthcare facilities walk a thin line when it comes to balancing safety protocols with patient comfort and Leadership often has the daunting task of upgrading hospital security without sacrificing a warm welcoming community "feel".

With this information cornerstone in mind, this publication was created for the express purpose of providing members of the LHA Trust Funds with a consolidated reference and resource compilation of information for use in the development of a facility-specific Healthcare Facility Security Program, in addition to providing factual and resourceful information about violence in healthcare along with points to consider with staffing and training healthcare security personnel.

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- U.S. District Court Middle District of Louisiana, 1982
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Bill graduated Louisiana State University Law Center, Baton Rouge, Louisiana, JD 1981 and Louisiana State University, Baton Rouge, Louisiana, B.S. 1977. He is rated AV Preeminent by Martindale-Hubbell.

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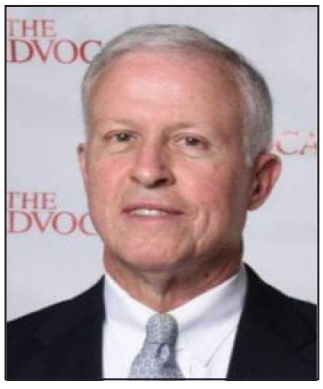


Greg is the Principal of 5940 Training, LLC, providing security consulting services and training to hospitals, churches, and private businesses. He began his law enforcement career with the Baton Rouge Police Department as a Patrolman in 1972. After serving 19 years on the street as a robbery and homicide Detective as well as a member, and later Commander, of the Hostage Rescue Team, Mr. Phares was named Chief of Police in 1991. He led the

Baton Rouge Police Department until his retirement in 2001. The Department achieved national accreditation under his leadership.

From 2001-2003, Phares served as Lead Instructor for the U.S. State Department's Anti-Terrorism Assistance Program (ATAP) Crisis Response Team course, training counter terrorist teams from over a dozen countries.

He joined the East Baton Rouge Sheriff's Office in 2003, initially commanding the Sheriff's Office's emergency services and firearms training. He was later named Chief Criminal Deputy and, upon the resignation of Sheriff Elmer Litchfield due to ill health in 2006, Mr. Phares was named Sheriff and served in that office until December 2007. He joined the Louisiana Office of Inspector General in 2008 and served as an Investigative Supervisor and Chief Investigator.

Greg has been a Police Firearms Instructor since 1981 and currently teaches firearms to law enforcement as well as private citizens. He is a graduate of Louisiana State University, the Baton Rouge Police Department Academy, the FBI National Executive Institute, and numerous professional law enforcement training classes.

Mr. Phares has investigated and/or supervised the investigation of approximately eight uses of deadly force by or against law enforcement officers.

1 - Violence in Healthcare

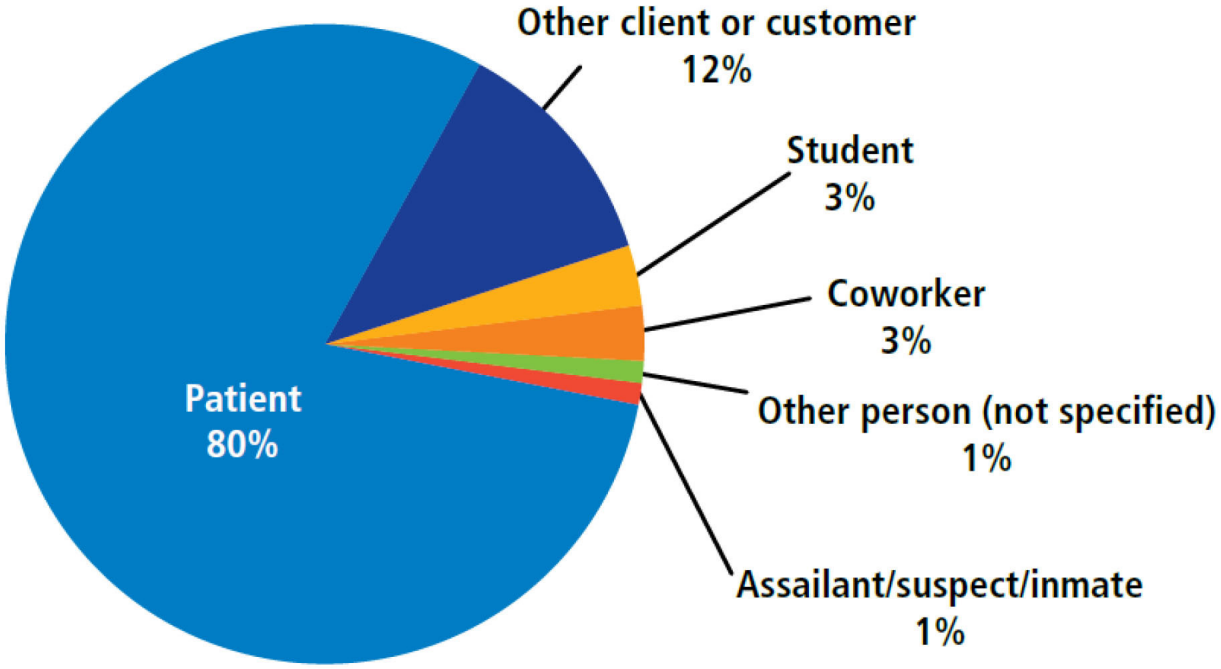
The National Institute of Occupational Health (NIOSH) defines workplace violence as “violent acts”, including physical assaults and threats of assault, directed toward personnel at work or on duty. This includes verbal abuse, hostility and harassment. Verbal aggression causes psychological trauma and can also escalate to physical violence.

In 2016 the Government Accounting Office (GAO) published the analysis of three federal data sets revealing that in 2013 healthcare workers at inpatient facilities, such as hospitals, experienced workplace violence injuries that required time off at a rate that was five times higher that of private sector workers.

OSHA reported that in each year from 2011 to 2013, healthcare workers in the U.S. suffered 15,000 to 20,000 serious workplace violence related injuries.

Although hospitals are often looked at as places of refuge, they are often in fact no longer exempt from the violence factor that is trending upward in the U.S. today.

Healthcare Worker Injuries Resulting in Days Away from Work, by Source



Data source: Bureau of Labor Statistics (BLS), 2013 data. These data cover three broad industry sectors: ambulatory healthcare services, hospitals, and nursing and residential care facilities. Source categories are defined by BLS.

According to OSHA and The Joint Commission the following risk factors for violence are inherent to the provision of healthcare:

- Exchange of money with the public
- Late night or early morning work hours
- Isolated work conducted alone or in small groups, in remote areas or areas with high crime rates (Home Health Staff, Couriers, etc.)
- Setting-specific vulnerabilities of acute care hospitals (EDs, Pharmacy, Labor & Delivery, Maternal-Child Health Unit, ICU, Parking Lots, etc.)
- Economic realities of healthcare (i.e. staff reduction, increased productivity pressure, patients or family members experiencing personal financial situations, etc.)

According to the United States FBI National Center for the Analysis of Violent Crime there are four broad categories of workplace violence:

Type 1 - Violent acts by criminals who have no other connection with the workplace, but enter to commit robber or another crime.

Type 2 - Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services

Type 3 - Violence against coworkers, supervisors, or managers by a present or former employee.

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.

Over 65% of nonfatal assaults occurred in the healthcare service industry.

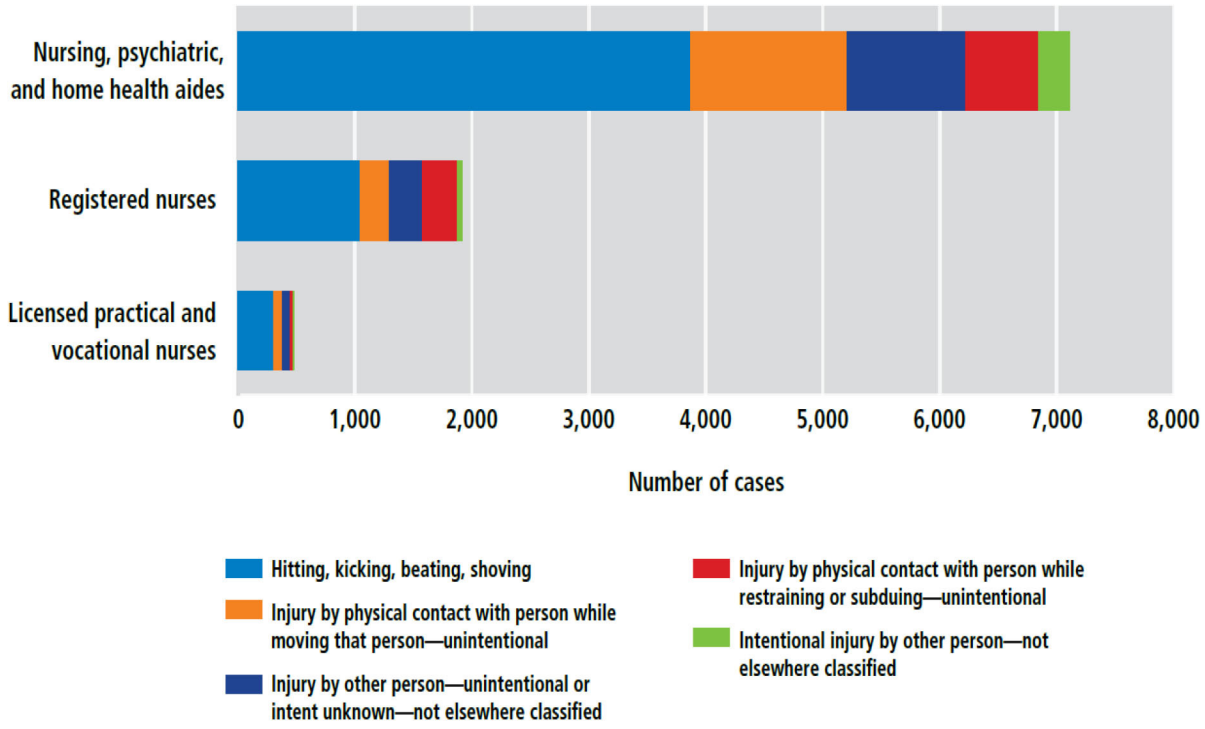
Healthcare workers suffer four times the worker assault rate as compared to private industry —16.2 per 10,000 worker assault rate for healthcare as compared to 4.2 per 10,000 for private industry. (BLS report dated Dec. 16, 2014)

The most common kind of workplace related violence in healthcare is patient/client against employee. In 2013, the most common causes of violent injuries resulting in days away from work across several healthcare occupations were hitting, kicking, beating, and/or shoving (see graph on next page).

Personality conflicts and family/marital problems along with alcohol and drug abuse have been cited as contributing factors in a majority of physically violent episodes.

Healthcare organizations that fail to properly protect employees from the dangers of workplace violence face the threat of being fined by OSHA. For example, a Pennsylvania home care provider in 2016 was fined nearly $100,000 after a home care worker was sexually assaulted. OSHA found that the home care provider failed to provide an effective workplace violence prevention program even though there was evidence of numerous reports of verbal, physical, and sexual assaults on employees.

Violent Injuries Resulting in Days Away from Work, by Cause



Data source: Bureau of Labor Statistics, 2013 data.

Section 5(a)(1) of the Occupational Safety and Health Act (the "General Duty Clause") requires an employer to furnish to its employees:

> *"employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees..."*

Employers can be cited for violation of the General Duty Clause if a recognized serious hazard exists in their workplace and the employer does not take reasonable steps to prevent or abate the hazard. The following elements are necessary to prove a violation of the General Duty Clause:

a. *The employer failed to keep the workplace free of a hazard to which employees of that employer were exposed;*
b. *The hazard was recognized;*
c. *The hazard was causing or was likely to cause death or serious physical harm; and*
d. *There was a feasible and useful method to correct the hazard.*

In 2014, OSHA fined a New York hospital $70,000 for willful failure to protect employees from assaults by patients and visitors, resulting from 40 incidents of violence by patients and visitors in a three-month period. OSHA found the organization's workplace violence prevention program ineffective because many employees were unaware of its existence or purpose.

In 2016, OSHA released updated Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. The guidance is advisory in nature; it is not a standard or regulation, and it does not create new legal obligations or alter existing obligations created by OSHA standards or the OSH Act. OSHA is also considering the need for a specific standard to protect healthcare workers from workplace violence.

Regulatory oversight of the new requirements related to the CMS 2016 rule regarding emergency preparedness began after November 16, 2017. One of the major components of this requirement indicates that participating healthcare entities must complete an all hazards assessment. The Security Toolkit, Appendix B, includes an all hazard risk assessment templates for several types of healthcare facilities.

The following Joint Commission standards address workplace violence in accredited healthcare settings and should be considered as a best practice in all healthcare facilities:

- Standard LD.03.01.01 requires leaders to create and maintain a culture of safety and quality throughout the organization, which impacts both patient and worker safety.
- Standard LD.04.04.05 requires an organization-wide safety program, and requires systems for blame-free incident reporting.
- Standard EC.02.01.01 requires organizations to manage safety and security risks.
- Standard EM.02.02.05 requires organizations to maintain emergency operations plans describing how the facility will coordinate security activities with community security agencies.

In addition, The Joint Commission considers the rape, assault (leading to death or permanent loss of function or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization to be a sentinel event. (TJC Sentinel Event Alert 59, April 15, 2018 – Physical and verbal violence against health care workers)

DNV-GL quality management standards require accredited hospitals to maintain safe and secure facilities that are designed and maintained in accordance with national and local laws, hospital policy, regulations and guidelines. DNV standards further specify that the Security Management System shall address issues related to abduction, elopement, visitors, workplace violence, and investigation of property losses and [shall] be proportional to the risk. (DNV-GL, PE 4, SR 3)

Professional associations including the American College of Emergency Physicians, the American Nurses Association, and the Emergency Nurses Association have issued policies, position statements, and resources regarding workplace violence.

It is appropriate to close this section of the writing by reiterating that hospitals (and other healthcare facilities) are no longer the places of refuge they once were perceived to be; they are often subject to the violence factor that is trending upward in public places in the U.S. today.

2 - Healthcare Security Litigation

Negligent Security, Foreseeability, Breach of Duty, Excessive Use of Force and Conscious Disregard for Safety are some of the terms frequently used in connection with litigation related to allegations of negligence involving security response officers of healthcare facilities.

Before we address these terms, let's look at some actual lawsuits where hospital security departments and security response officers are named defendants.

- Allegations stemming from a 2016 incident in a Houston, TX hospital when a patient was shot by a hospital security response officer who was an off-duty police officer include claims that the security response officers weren't properly trained to de-escalate a mental health crisis. The lawsuit seeks more than $1 million for pain and suffering as well as legal and medical expenses.
- A psychiatric hospital in Atlanta, GA faces a civil lawsuit for negligent security after a teenage female patient was raped on the premises by another patient, as reported by the Associated Press. The psychiatric hospital was treating the 16-year-old female patient for harm and emotional distress sustained as a crime victim of sexual assault.

  According to police reports, the female patient was showering on February 16, 2017. That is when an 18-year-old male patient entered the showers. The male patient proceeded to rape the female patient. The female patient did not report this sexual assault immediately. Apparently, she wanted to avoid further legal issues for the male patient, who apologized the day after the crime. But the female patient did tell her mother about the incident, and the mother then pressed for further action.

  After retaining legal counsel, the mother filed a lawsuit against the psychiatric hospital. The lawsuit alleges negligent security and supervision by the psychiatric hospital, which led to emotional distress, post-traumatic stress and depression for the female patient. The lawsuit requests a trial by jury and an award of damages. The damages account for additional medical treatment and other costs.

Other recent lawsuits filed against hospitals and security response officers in the U.S. include:

- A lawsuit resulting in a million-dollar jury verdict against a hospital and one of its security guards. The plaintiff, a hospital visitor, sued the hospital and the security guard for assault and battery, false imprisonment, and malicious prosecution.
- Two federal lawsuits filed in connection with an incident involving a jail inmate who took two nurses hostage, and raped, tortured and beat one of them, before being killed by a SWAT team.
- A lawsuit was filed seeking $20 million in damages after a special needs teenager was beaten by hospital security response officers.

Below are some of the triggers that could result in a negligent security lawsuit against the hospital and security response officers:

- Lack of awareness of current crime conditions on the property and in the surrounding community.

- Inadequate or outdated security plans and procedures.
- Not consistently following established security plans or procedures.
- Lack of appropriate and adequate training for security response officers.
- Lack of adequate physical security measures.
- Lack of adequate security staff.
- Failure to conduct security background checks on employees and contractors.
- Inadequate lighting at building entrances, in parking garages, or in exterior parking lots.
- Ignoring complaints about crime or security from employees, patients and visitors.
- Inconsistencies in security staffing that are not supported by risk assessment data; for example, having security response officers on duty at some times but not others solely to reduce costs.
- Inconsistencies in security systems that are not supported by risk assessment data; for example, having cameras in one area of the facility but not another exclusively for budgetary reasons.
- Reducing the level of security provided at the facility for budgetary reasons without a corresponding reduction in the level of security risk.

This section opened with partial listing of terminology commonly found in security-related litigation. Below is a listing of that terminology along with definitions, meanings and explanations to further enhance knowledge and understanding as to how each apply to healthcare security litigation.

Negligent Security – Also known as inadequate security, refers to incidents when injury occurs as a result of a criminal act such as sexual assault, rape, robbery, etc. The injured person typically claims that a lack of security was a factor.

Foreseeability – The plaintiff must prove that the act that caused the injury was reasonably foreseeable, or could have been predicted.

Breach of Duty – Includes failure to provide adequate security, failure to conduct adequate inspections and hazard assessment or failure to warn regarding a known criminal hazard (concealment).

Excessive Use of Force – Often referred to as police brutality in public law enforcement policing; force in excess of what a police officer reasonably believes is necessary.

Conscious Disregard for Safety – Means the knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences.

This is best demonstrated by a 2013 lawsuit against a security company for a North Carolina hospital. The case involved the death of a patient who was being transferred to his home after being discharged in protest against the staff's discharge actions. The patient became uncooperative while in his wheelchair, security was called and they strapped him in the transport van. He died while in transport.

Coverage available under your LHA Trust Funds General Liability Policy

Incidents related to violence are more than likely going to be covered under general liability. General Liability covers your organization and your employees for general negligence to third parties. The coverage is rather broad but has specific exclusions that limits coverage.

Generally speaking, coverage will be provided for liability for injuries resulting from:

- Reasonable use of force to protect persons or property,
- Injuries to bystanders,
- Negligent hiring (see comments below,)
- False arrest or imprisonment,
- Damage to someone's reputation.

Coverage is not provided for:

- Liability arising from security response officers who are not your employees unless a specific endorsement was added to the coverage agreement,
- Intentional injuries,
- Knowingly violating the rights of another,
- Criminal, malicious or illegal acts including sexual misconduct.

Liability for negligent hiring applies to both employees and contracted security response officers. Consequently, when contracting with a third party security company it is of utmost importance that your contract requires general liability insurance with minimum limits of $1,000,000, naming you as additional insured and indemnification language indemnifying you from their actions.

3 - Threat Management

In a recent CDC web page writing, NIOSH (National Institute for Occupational Safety and Health) said *"Workplace violence is the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty. The impact of workplace violence can range from psychological issues to physical injury, or even death. Violence can occur in any workplace and among any type of worker.....the risk for nonfatal violence resulting in days away from work is greatest for healthcare and social assistance workers."*

For more than two decades the standard model of OSHA's workplace violence typology has included:

Type 1: Violence occurring during the commission of another crime, such as a robbery or trespassing, by a subject with no legitimate business relationship with the targeted organization or employees;

Type 2: Violence perpetrated by a client, customer or patient of an organization or employee during the routine delivery of services;

Type 3: Co-worker-to-co-worker/supervisor violence perpetrated by a current or former employee; and

Type 4: Intimate partner or domestic violence that follows an employee from home to the workplace.

These are essentially the same four types of violence as defined by the United States FBI National Center for the Analysis of Violent Crime. Using these four types of violence as a foundation, let's look at how CMS Conditions of Participation, Joint Commission Standards and OSHA Guidelines connect the pathway to establishing best practices regarding security in the hospital and healthcare provider setting.

This section will be a starting point to address Threat Management and the creation of a Threat Management Unit for establishing, developing and implementing effective operational protocols and intervention strategies used to identify, assess and intervene in cases that threaten hospitals and healthcare provider campuses.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Conditions of Participation

§482.13(c)(2) - The patient has the right to receive care in a safe setting.

§482.15 - The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

The Joint Commission

Accreditation Standards

Identify patient safety risks NPSG.15.01.01 - Find out which patients are at risk for suicide.

Quick Safety 47: De-escalation in healthcare - This Quick Safety presents de-escalation models and interventions for managing aggressive and agitated patients in the ED and inpatient settings.

Quick Safety 5 - Preventing violent and criminal events.

Sentinel Event Alert 59 - Physical and verbal violence against healthcare workers.

OSHA®

Guidelines and Standards

Workplace Violence Prevention for Health Care and Social Service Workers Act
(H.R. 1309) – 42 Co-Sponsors (https://www.congress.gov/bill/116th-congress/house-bill/1309)

The legislation calls on OSHA to issue a standard requiring employers in the health care and social services industries to develop and implement workplace violence prevention plans to protect employees such as nurses, physicians, social workers, emergency responders and other caregivers.

The international Association for Healthcare Security and Safety (IAHSS) defines threat as *any verbal or physical conduct or situation that conveys, or could be implied or perceived to convey, an intent to threaten safety, negatively impact physical or psychological well-being or damage an organization's property.*

Hospitals and healthcare facilities should establish a functioning multi-disciplinary Threat Management Team and who will work cohesively to develop a facility-specific Threat Management Plan (something more than words on paper in a 3 ring binder in a bookshelf). Perhaps it is best to refer to this as a Threat Management System that includes a Threat Management Plan and a Threat Management Team.

The **Threat Management Team (TMT)** should receive, validate, interpret, respond to and manage threats and behaviors of concern. The **TMT** should include:

- Security
- Behavioral Health
- Human Resources
- Nursing
- Safety
- Risk Management / Legal

- Plant / Facilities Manager as needed with respective threat(s)
- Senior Leadership from the effected department
- Law Enforcement as deemed appropriate for specific incidents

The Threat Management Plan should include:

- Mechanism for identifying threats
- Classification of the seriousness and severity of each threat
- Intervention plan to protect potential victim
- Address the problem or conflict that precipitated the conflict
- Training for the TMT
- Threat response drills; ensure competency of all participants
- Method for documenting the threat assessment process; ensure privacy
- Method for conducting after-action review; debriefing

4 - Access Control, Patient Safety and Patient Management

It is incumbent upon healthcare facilities to establish a reasonable level of protection by implementing security controls including appropriately trained, competent security response officers and well planned access control deemed necessary to protect people, property, systems, equipment and other assets.

Emergency Lockdown should be addressed in the facility-wide emergency preparedness plan.

Well defined security plans should be developed with a team approach for cash handling areas, Pharmacy, sterile work environments, infant care areas and IT departments/equipment rooms.

Key control and staff/physician badge control procedures are of paramount importance. Issuance, accountability and recovery of keys and/or badges at time of separation/termination should be well defined, documented, followed and tested routinely. Our security expert, Greg Phares, recommends that electronic badge key control turn-off be done remotely from a single-source access point, i.e. HR Director's workstation, or perhaps the Chief Security Officer's workstation or mobile phone application.

Pedestrian traffic flow for patients, visitors, staff and vendors should be designed with optimum ingress and egress controls in place while ensuring minimal disruption to the various populations that are affected and involved.

In addition to appropriately designed identification systems for staff and physicians (photo ID badges), consideration should be given to a similar identification system at a minimum for contractors and vendors as well as well as visitors after normal business office hours and on weekends.

When considering and planning visitor access refer to **CMS 42 CFR Parts 482 and 485** ***Changes to the Hospital and Critical Access Hospital Conditions of Participation to Ensure Visitation Rights for All Patients***

§ 482.13 Condition of Participation: Patient's Rights.

h) *Standard: Patient visitation rights.* A hospital *must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:*

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

Subpart F - Conditions of Participation: Critical Access Hospitals (CAHs)

§ 485.635 Condition of Participation: Provision of Services

(f) *Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limita*tion *that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:*

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

Security processes should integrate with patient related services and should include addressing the security needs of a variety of patient types and security sensitive areas. The healthcare facility security team must support and assist with the safe management of aggressive patients and at risk patients.

We addressed restraints, handcuffs, weapons and firearms and body-worn cameras elsewhere in this publication. The remaining part of this section will touch one role of the security team in patient management and more specifically prisoner patients, pediatrics/ infants, patients in the ED, behavioral health patients and patient elopement.

Prisoner Patients

In addition to mandating that Law Enforcement remain present with the prisoner patient at all times, prisoner patient security measures should include orientation of security and clinical staff to the prisoner patient security policies. Research conducted on behalf of the International Healthcare Security and Safety Foundation in 2011 indicated nearly one-third of prisoner escape incidents occurred when the prisoner was in the restroom. Nearly sixty-nine percent of all escape incidents from healthcare facilities occurred when the forensic restraints were removed.

Pediatrics/Infants

Pediatric patients present abduction risks, parental custody issues, physical assaults, elopement and wander along with other issues including contraband and possible gang related activity. Related protective measures should be in a format that is readily accessible by patient care staff. The National Center for Missing and Exploited Children (NCMEC) has developed ***Guidelines on Prevention of and Response to Infant Abductions*** to assist healthcare organizations in developing security measures to protect this population.

Patients in the ED

Resources for developing ED-specific security polices include:

- Emergency Nurses Association Position Statement,
  Violence and Its Impact on the Emergency Nurse
  https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/violenceintheemergencycaresetting.pdf
- Emergency Nurses Association and American Organization of Nurse Executives
  Toolkit for Mitigating Violence in the Workplace

- American College of Emergency Physicians (2018)
  Violence in the Emergency Department: Resources for a Safer Workplace https://www.acep.org/administration/violence-in-the-emergency-department-resources-for-a-safer-workplace/

- TJC Sentinel Event Alert, Issue 45, June 3, 2010
  Preventing Violence in the Healthcare Setting
  https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-issue-45-preventing-violence-in-the-health-care-setting/

Behavioral Health Patients

Behavioral health patients pose risks related to self-harm, violence to staff and elopement. Security staff should be included in situational awareness training and de-escalation training such as MOAB.

Facility design and engineering controls along with administrative security controls warrant consideration when assessing potential BMH environmental hazards and contributing risks. The source below is recommended as a guide facility design when considering the safety and security of behavioral health patients. The guide includes a patient safety risk assessment tool.

Design Guide for Mental Health Facilities

https://www.fgiguidelines.org/wp-content/uploads/2017/03/DesignGuideBH_7.2_1703.pdf

Patient Elopement

When evaluating the needs for security policies related to elopement consideration should be given to differences between elopements, wandering and leaving AMA.

An AHRQ 2007 Spotlight Case slide deck resource entitled ***Elopement*** provides information that defines elopement and separates it from meandering and leaving against therapeutic guidance. In addition to aiding in identifying driving danger components for elopement, the slide deck resource also describes systems for forestalling elopement and ventures for reacting after a patient elopement has been distinguished. It will further help with identifying legitimate dangers connected with elopement.

When developing security policies related to elopement include:

- Definitions of elopements, wandering and leaving AMA
- Elopement Prevention Procedures
- Elopement Response Plans

5 - Weapons & Firearms

Should hospital guards be armed with weapons such as guns or Tasers?

According to **CMS' interpretive guidelines section 482.13(e) of the *State Operations Manual:***

> *CMS does not consider **the use of weapons** in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term "weapon" includes, but is not limited to, pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. **If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement.*** (bold font used in this sentence for emphasis and not as excerpted from the CMS COP)
>
> *Weapons include pepper spray, mace, nightsticks, Tasers, cattle prods, stun guns, pistols, and other similar equipment, according to the interpretive guidelines. Further, handcuffs, manacles, shackles, and other chain-type restraints are considered law enforcement items and aren't appropriate healthcare measures to help staff members to restrain patients.*

The **2014 International Association for Healthcare Security and Safety** (IAHSS) survey revealed that 52% of hospitals said their security response officers carried handguns, while 47% said they carried Tasers—more than double the rates reported in a separate study just three years prior. In spite of the increase in violence in healthcare, many healthcare organizations do not arm their guards. Those that don't, take the position that their response officers are not trained to work in medical settings, and adding weapons to an already tense environment can cause more harm than good.

A Johns Hopkins study examined instances of gun violence at hospitals and other healthcare facilities in the U.S. from 2000 to 2015, and identified the ED as the most common site of hospital gun violence (29%), followed by the parking lot (23%) and patients' rooms (19%).

Readers Respond: Do Armed Guards Make Hospitals Feel Safer?, a *New York Times* February 25, 2016 article written by Elisabeth Rosenthal is worthy of reading. The opinions of doctors and nurses who have worked in emergency rooms, probably the most dangerous place in hospitals, were split regarding as to if security guards with Tasers and guns make hospitals safer for staff members, visitors and patients, and under what circumstances.

A 2016 presentation by the Joint Commission further stated a study of 11 years of data revealed that 23% of hospital shootings occurred in the ED resulting from the perpetrator's taking of a gun from Security Personnel or Police. Although mental health issues are often at

the center of the cases that end in violence, many mental health professionals are opposed to weapons in hospitals.

In summation of this section, when contemplating the use of employed or contracted security response officers healthcare facilities should first conduct a proper risk assessment, and start by asking the following questions:

- Have there been incidents that require security response officers to use weapons?
- Do you believe there will be incidents in which the use of a gun is necessary?
- Are you prepared to handle the consequences if a gun is fired?
- Can you afford to pay for the ongoing costs of training and retaining SROs?
- Should the healthcare facility use security staff as trainers for clinical and non-clinical staff training needs related to security?

Additional Points to Consider

- A level 3 holster should be used at all times (3 separate actions needed to release the weapon from the holster).
- Weapon Retention Training should be conducted on a quarterly basis with one of the quarterly training sessions taking place at the LA State Police Training location.
- If the healthcare facility purchases and owns the weapon, it should also pay for the required maintenance or provide a stipend to cover the related expense.
- Healthcare facilities contemplating the hiring of armed security response officers, whether employed or contracted, should require Louisiana P.O.S.T. training (Peace Officers Standards and Training) as opposed to the minimum requirements of the Louisiana Board of Private Security Examiners Fire Arms Course (L.B.P.S.E.).

6 - Use of Handcuffs

When addressing the use of handcuffs in healthcare facilities we must consider various patient populations individually and separate from one another, i.e. medical patients, substance abuse patients, behavioral health patients, prisoner patients, etc.

In consideration of the variety of patient populations along with rational patient management requiring handcuffs this section will focus on prisoner patients.

The 2018 document ***Violence in Healthcare and the Use of Handcuffs*** by Sarah Henkel and the International Association for Healthcare Security and Safety (IAHSS) encompasses various risk factors when considering the aforementioned patient populations and the use of handcuffs, and should be used as a Best Practices guide when developing policies and procedures for a hospital or healthcare facility.

Per CMS' interpretive guidelines to section 482.13(e) of the *State Operations Manual:*

> *The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule.* ***The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.*** *The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).*

Given the above statement of position from CMS, it is logical for Leadership to want to strive to ensure that healthcare facility security response officers not use any of the aforementioned law enforcement restraint devices when called upon to de-escalate a patient nor should they use such for restraining prisoner patients.

However, from a practical standpoint as voiced by our security expert consultant, Greg Phares, cuffing is the safest and preferred law enforcement practice for ensuring that the combative patient is protected from self-harm and from harming others in the immediate area. By virtue of such, a decision to opt for deviation from CMS standards should be given consideration on a case-by-case basis. When deviation occurs, a root cause analysis type investigation and debriefing should be conducted as soon as possible after the conclusion of the incident.

In the case of prisoner patients, law enforcement officers escorting the prisoner patient into the facility should be responsible for restraining the prisoner patient; however, as stated in the closing statement of the above CMS COP, "*the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).*" Staff should be trained to provide appropriate guidance with respect of restraints used by the custodial law enforcement officers.

Considering the referenced guidelines from CMS, it is imperative that hospitals and other healthcare facilities develop a prisoner patient policy and protocols for appropriate clinical care and patient safety inclusive of:

- Procedures for notifying affected staff upon arrival of prisoner patients
- Designated prisoner patient entry points into the facility
- Appropriately designated treatment rooms
- Protocols for providing relief for law enforcement officers guarding patients
- Monitoring, seclusion, and restraint controls
- Procedure for storage and handling of weapons
- Emergency evacuation related to prisoner patient safety
- Communication with and between security and other staff
- Protocols for food service including disposables and monitoring use of items that could be potential weapons

7 - Body-Worn Cameras

This section will begin by telling you that the U.S. Office of Justice Program's Bureau of Justice Assistance has developed an online toolkit that helps security teams to train on how to use body-worn cameras. Various roles within a security team require different methods for training that are provided in this online website toolkit than can be accessed by clicking **here.**

Risks, concerns, guidance, solutions and professional commentary related to body-worn cameras in a healthcare facility are best addressed in a publication titled ***Body Worn Camera Use in Health Care Facilities*** that was produced by the International Association for Healthcare Security and Safety Foundation (IAHSS Foundation) on August 25, 2015. It also includes an extensive bibliography of related reference and resource materials.

8 - Contracted Off Duty Law Enforcement Officers

When electing to provide security services via contracted off duty law enforcement officers (LEOs), it is of utmost importance that the healthcare facility be the orchestrator of the contracting instrument. General Liability exposure will be of primary concern, consequently the healthcare facility should communicate with the LHA Trust Funds regarding the intent to employ contracted off duty law enforcement officers. Related consultation regarding GL coverage and exclusions should also incorporate dialog with the healthcare facility's legal team.

It is imperative that the healthcare facility's attorney(s) draft the contracting instrument to ensure that the contracted LEOs provide adequate GL coverage and limits, and that responsibilities of both the LEOs and the healthcare facility are clearly communicated while indemnification and hold harmless language favors the healthcare facility and its Board, officers and employees.

Other language favorable to the healthcare facility should include waiver of subrogation, additional insured, owners and contractors protective liability and evidence of workers' compensation insurance.

As stated elsewhere in Section 5 of this publication, healthcare facilities contemplating the hiring of armed security response officers, whether employed or contracted, should require Louisiana P.O.S.T. training (Peace Officers Standards and Training) as opposed to the minimum requirements of the Louisiana Board of Private Security Examiners Fire Arms Course (L.B.P.S.E.).

Consideration should also be given to incorporating the Cooper Test Age and Gender Based Standards for Law Enforcement. This is a test of physical fitness that was designed by Dr. Kenneth S. Cooper in 1968 for US military use. It is of strength and endurance that provides an objective way to measure fitness and set goals for the future.

9 - Security Staffing Guidelines

Factors to consider when determining how to staff the healthcare facility security department:

- Designation of trauma center
- High volume ED
- Facilities with psychiatric-specific ED
- Facilities with Labor and Delivery / Nursery Unit
- Facilities with pharmacies or pharmacy distribution center
- Facilities with school of nursing or other institution of higher education
- Facilities with 24/7 schedule.
- Local police response is more than 3 minutes
- Significant workplace violence recorded incidents
- Facilities with “At Risk” patient populations
- Level of existing physical security measures

Written job descriptions should be developed after conducting a job safety analysis for each level of security staff. Each job description should include essential functions that reflect related skill set(s), well defined performance expectations and key competencies.

10 - Security Response Officer Training

Training in any area is never a one-time event. On-going training is necessary for the purpose of addressing changes in the environment, to learn, improve and further develop professional skills. Related training records should include:

- Subject matter
- Time
- Date
- Duration of the training
- Instructor's name and affiliation
- Competency verification

Consider the following points when building the training program for the healthcare facility security team:

- Laws, Statues and Principles
- Crisis Management Training
- Effective Communication
- Application of Force
- Subject Restraint and Restraint Systems
- Intermediate Weapons (Batons)
- Sharp-Edge Weapon Training

Appendix G of the ***Security Toolkit Resource Manual*** further details the above bullet point listing.

In addition to the above, training for new security response officers should also include a knowledge-based foundation in these areas:

- Protection
- Customer Service
- Public Relations
- Response to Calls
- Documentation of Security-Related Events

To further aid in the development of a training program for security response officers, refer to Appendix H in the ***Security Toolkit Resource Manual.*** That Appendix offers a sample security guard training checklist for healthcare facilities. The list includes the subject item and required frequency of related training.

Weapons training is addressed in Section 5 of this publication.

11 - Healthcare Security Program (A Security Management Plan)

The healthcare facility's Security Management Plan should be thought of as a living document that is adjusted periodically. It is a document that should include organizational goals, best practices and security risks that require mitigation.

Conducting a facility-wide comprehensive security risk assessment is a pre-cursor to developing the Security Program / Security Management Plan. The security risk assessment should include the campus and parking areas.

The Program Plan should include these core tenets at a minimum:

- Purpose
- Objectives
- Scope
- Definitions
- Roles, Responsibilities, Authority to Act
- Departmental Org Chart as a subset of Master Org Chart
- Communication
- Training
- Risk Assessment Tools
- Incident Reporting and Response
- Program Evaluation and Plan for Improvement

Additional guidance for developing the written Program Plan can be found in Appendix B of the ***Security Toolkit Resource Manual*.**

12 - Best Practices Guidance When Considering the Use of Employed Armed Security

The Best Practices found herewith in this publication are further supported by a September 27, 2018 writing ***Armed Law Enforcement in the Emergency Department: Risk Management Considerations.***

Healthcare facilities contemplating the hiring of armed security officers, whether employed or contracted, should require Louisiana P.O.S.T. training (Peace Officers Standards and Training) as opposed to the minimum requirements of the Louisiana Board of Private Security Examiners Fire Arms Course (L.B.P.S.E.).

Hiring

- Certified, sworn or accredited law enforcement officers are preferred over private security officers or armed clinical staff due to the assurance of extended training and certification.
- Adequate review of prior employment experience, disciplinary issues, behavior and conduct, especially in confrontations or conflicts, should be conducted as part of the hiring process. This should include a review of prior disciplinary incidents or allegations occurring in other security or police roles.

  Greg Phares, our security expert consultant, recommends that this be done by the facility's Chief Security Office or Head of Security, not by HR Staff or HR Managers. Consider engaging the resources of an outside security expert consultant to participate in the applicant background checks.
- Comprehensive assessment during the conditional hire and training phase should be conducted by a licensed psychologist and in accordance with accepted standards for law enforcement officer assessment and which addresses the specific nature of work in a healthcare setting. Careful attention to pertinent professional assessment standards will be needed to avoid possible Americans with Disabilities Act (ADA) liability.
- Officers with demonstrated experience in community policing or clinical work may be preferable over private security or less experienced officers.
- Consider incorporating the MMPI test (Minnesota Multiphasic Personality Inventory) in the hiring/pre-employment phase. In addition to looking at personality traits, this psychological exam also looks at a candidate's psychopathology determine if he has mental health issues. For more information about MMPI testing visit https://www.betterhelp.com/advice/general/what-is-the-mmpi-test-and-what-does-it-say-about-you/

Training

- Armed security staff should receive training in recognizing and managing behavioral emergencies and agitation with an emphasis on verbal de-escalation and use of force, such as MOAB training.
- Ongoing training and supervision to support the use of verbal de-escalation and less lethal interventions should be standard for all security or law enforcement staff.
- Law enforcement officers based in clinical setting should have ready access to cross training and peer support with local law enforcement to support ongoing development and to mitigate the risks of isolation and burn-out.

Policies and Procedures

- Hospital leaders should carefully weigh and memorialize their facility's distinct needs and the relevant and foreseeable risks and benefits justifying the creation of an armed security or law enforcement team. Armed or sworn officers should not be considered as a default arrangement but as a variation from unarmed, non-sworn officers.
- Policies, practices and culture should place primary responsibility and leadership for managing behavioral emergencies with clinical staff.
- Policies should expressly address use of force standards, rules of engagement, including identifying when intervention by law enforcement or security staff may occur without clinical staff input, i.e., imminent lethal risk situations.
- There should be integration of security and clinical staff and leadership in developing other appropriate policies and practices and in problem-solving potential issues.
- Processes should be in place to assure routine monitoring of process and outcomes for armed security staff and heightened scrutiny for outlier and high risk/sentinel events. This should involve clinical and security leadership alongside quality and risk management.
- Processes should be in place to assure appropriate education of security or police personnel to other pertinent hospital policies, especially for externally contracted staff or moonlighting officer.

Action Requirements

- Develop and enforce comprehensive policies and procedures against workplace violence.
- Evaluate objective measures of violence to identify risks and risk level.
- Train staff to recognize the warning signs of violent behavior and respond proactively.
- Establish comprehensive workplace violence prevention program.
- Encourage all employees and other staff to report incidents of violence or any perceived threats of violence.
- Ensure appropriate follow-up to violent events, including communication, post-incident support, and investigation.

- Ensure that the violence prevention program addresses the possibility of gun violence, including active shooters.
- Cross reference and ensure compliance with CMS guidelines.
- Be familiar with and ensure compliance with **42 CFR 482.13; CMS *Guidance on Federal Requirements for Providing Services to Justice Involved Individuals* (reference: S & C: 16-21-ALL, revised 12/23/2016).**

13 - Miscellaneous References, Resources and Tools

NCMEC - *Guidelines on Prevention of and Response to Infant Abductions*

Emergency Nurses Association Position Statement,
Violence and Its Impact on the Emergency Nurse
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/violenceintheemergencycaresetting.pdf

Emergency Nurses Association and American Organizatin of Nurse Executives
Toolkit for Mitigating Violence in the Workplace

American College of Emergency Physicians (2018)
Violence in the Emergency Department: Resources for a Safer Workplace
https://www.acep.org/administration/violence-in-the-emergency-department-resources-for-a-safer-workplace/

TJC Sentinel Event Alert, Issue 45, June 3, 2010
Preventing Violence in the Healthcare Setting
https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-issue-45-preventing-violence-in-the-health-care-setting/

Design Guide for Mental Health Facilities
https://www.fgiguidelines.org/wp-content/uploads/2017/03/DesignGuideBH_7.2_1703.pdf

Elopement
http://www.presentica.com/ppt-presentation/spotlight-case-december-2007

New York Times February 25, 2016, Elisabeth Rosenthal
Readers Respond: Do Armed Guards Make Hospitals Safer?
https://www.nytimes.com/2016/02/26/us/readers-respond-do-armed-guards-make-hospitals-feel-safer.html

Armed Law Enforcement in the Emergency Department: Risk Management Considerations

U.S. Office of Justice Program's Bureau of Justice Assistance
Body-Worn Camera Toolkit
https://www.bja.gov/bwc/topics-gettingstarted.html

MMPI Testing
https://www.betterhelp.com/advice/general/what-is-the-mmpi-test-and-what-does-it-say-about-you/

42 CFR 482.13
CMS *Guidance on Federal Requirements for Providing Services to Justice Involved Individuals* (reference: S & C: 16-21-ALL, revised 12/23/2016).
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf