Think carefully before using security officers to monitor high-risk patients

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As CMS, The Joint Commission and other accrediting organizations continue their focus on preventing suicide risk, some facilities are turning to their security department for help.

If your hospital is considering using its security officers or police as sitters for patients at high risk of self-harm, make sure the conversation includes the need for resources to ensure the officers are trained and can show competency in CMS requirements regarding appropriate seclusion and restraint (S/R). They also should fully understand their role as a one-on-one observer.

Probably the best practice, however, is not to use them at all, say experts.

If your hospital does decide to use officers in one-on-one observation, explain to your C-suite that they must invest in the training and continuous oversight of those officers. CMS is calling out hospitals when officers use inappropriate S/R methods or when they are used as observers because other staff were not available (for examples, see p. xyxyxXYxyy).

Your hospital must also maintain the integrity of overall hospital security when a security officer is otherwise assigned, says a new policy guideline, "Security Role in High-Risk Patient Watches," made available in June by the International Association for Healthcare Security & Safety (IAHSS).

"The Healthcare Facility (HCF) should establish policy and procedures to provide guidance for the constant observation of patients, including the use of security in a patient watch role. The long-term use of security as sitters or in patient watch situations should be avoided unless dedicated security staffing resources have been allocated for this specific purpose," according to the guideline's opening statement.

Among other key points leading the guidelines, "If on-site security resources are used for patient watch, the overall posture of safety on campus should be maintained to the largest degree possible. In general, on-site security should be used in defined circumstances to supplement and not replace clinical staff members."

Officers have different duties

The IAHSS is not alone in its concerns about regularly using officers as sitters for at-risk patients. "Police and/or security officers should not be used as one-to-one observers unless they have had significant training in behavioral health disorders and are trained on the purpose of these tasks. Police are trained to protect the public, not a patient with mental illness," says **Kevin Ann Huckshorn, PhD, MSN, RN, CADC, ICRC**, a national behavioral health consultant with years of experience in hospital settings and now the director of evidence-based practices and programs for Wellpath Recovery Solutions.

In her previous service as director of the Office of Technical Assistance for the National Association of State Mental Health Program Directors (NASMHPD) and the National Coordinating Center for Seclusion and Restraint Reduction, she led the development of an evidence-based model to prevent violence and the use of S/R, called "Six Core Strategies to Prevent Conflicts and Violence in Inpatient Settings©."

Close observation of high-risk patients is always a challenge, notes Huckshorn. Determining when a patient must be in close observation is "generally a nursing and psychiatry decision based on a number of risk factors that are identified on admission or sometime during the individual's admission as risk factors often change. The most common risk factors looked for are suicidal intent, self-harm, or aggression toward others."

Training for the staff asked to do close observation is crucial.

"Since these are human interventions, there are often situations where the direct care staff tasked to do these jobs are either poorly trained or just inattentive. Frankly, being assigned to one-to-one duties without a clear understanding of why or how to perform these duties can be mind-numbingly boring for staff assigned," says Huckshorn. "That is why most hospitals limit this work to two hours, for staff involved, and have supervisors round consistently to be sure these duties are being done competently."

CMS, The Joint Commission (TJC), and other accrediting organizations have increased scrutiny on suicide prevention and mitigating ligature risk. When the physical environment cannot be minimized to remove elements patients might use to harm themselves, hospitals have been instructed to use constant visual observation.

"For patients identified as high risk for suicide, constant 1:1 visual observation should be implemented (in which a qualified staff member is assigned to observe only one patient at all times) that would allow the staff member to immediately intervene should the patient attempt self-harm," reads one frequently asked question (FAQ) TJC recently highlighted online. "The use of video monitoring or 'electronic-sitters' would not be acceptable in this situation because staff would not be immediately available to intervene. The use of video monitoring would only be acceptable as a compliment to the 1:1 monitoring, and not acceptable as a stand-alone intervention."

Ensure staff qualified for role

TJC also has emphasized that the monitor must be a qualified staff member.

In another FAQ about patients in the emergency room, TJC stated that "only patients with serious suicidal ideation (that is, those with a plan and intent) must be placed under demonstrably reliable monitoring. Most importantly, the monitoring must be linked to immediate intervention by a qualified staff member when called for."

One-to-one observers should be well trained in safety and "know what to look for related to effects of mental illness on behavior, safety to the patient and others, and on how to 'get to know and engage' the patient," advises Huckshorn. "Close observations should not be seen as a punishment or a criminal or legal action."

Such monitoring is to keep the patient and others in the environment safe. The only time police or security should be used is in emergency departments when there are absolutely no other staff available or "for individuals with very serious criminal charges and," Huckshorn emphasizes, "who might be able to hurt a staff person or others in that location."

Huckshorn warns that using uniformed police or security staff as a monitor could actually aggravate or "escalate the individual in care. That is not the outcome or point of close observations."

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