

Preventing Emergency Department Violence

Tips and Tools to Keep Your Facility Safe

Lisa Pryse Terry, CHPA, CPP

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Harrassment Gang Violence Emergency Stressed Argument Victims Outburst Problem Furious Verbal Abuse Conflict Rage Danger Domestic Violence
 Danger Rage Negative Safety Aggression Confront Abuse Upset Domestic Violence Fear Criminal Shout Quarrel Negative Outburst Temper Anxiety
 Emergency Rage Fear Quarrel Domestic Violence Anxiety Danger Stressed Gang Violence Problem Conflict Outburst Criminal Confront Safety Anger
 Safety Violence Aggression Abuse Upset Furious Negative Victims Argument Danger Verbal Abuse Harassment Temper Shout Fear Danger Rage

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Foreword/Dedication/Acknowledgments

From my own work in and with numerous healthcare organizations and from my own experience, I have come to realize that the issue of violence continues to be an industry-wide problem. It remains prevalent in emergency departments, in part due to the exigent nature of the injuries and illnesses treated within the department as well as the open access 24/7. This book is my attempt to share an overview of the culture of violence in healthcare as well as practices and guidelines which I believe to be some of the best in healthcare. From that end, it is my privilege to dedicate this work to all of the everyday heroes—those men and women who serve to provide a safe and secure healthcare environment for all.

I am deeply grateful to so many for their support, dedication, and ingenuity. This book would not have been possible without the hard work and contributions of my healthcare colleagues, my friends, my family, my peers within the Association for Healthcare Security and Safety, and the UNC Hospitals Senior Vice President, Melvin Hurston. I would also like to thank John Palmer, Managing Editor, and the entire HCPro team for their confidence in this project and their continued assistance throughout. I wish to express my deepest gratitude to Rafe Wilkinson, CEO of ODS Security Solutions, who has inspired, supported, and believed in me since day one. Finally, I wish to sincerely thank the driving force on whose shoulders I stand: writer consultant Rhonda Day.

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About the Author

Lisa Pryse Terry, CHPA, CPP

Lisa Pryse Terry, CHPA, CPP, has decades of experience in healthcare security management. She has served as the former Director of Protective Services with Rex Healthcare in Raleigh, North Carolina, Chief of Campus Police and Public Safety with WakeMed Health and Hospitals in Raleigh, North Carolina, and Chief of Police and Public Safety with Eastern Virginia Medical School in Norfolk, Virginia. She has also served as President of Healthcare Security and Chief of Company Police for ODS Security Solutions (ODS) and is currently a consultant to ODS. Lisa has seen violence in the ED and healthcare increase at alarming rates throughout her career as a healthcare security expert. As former president and an active member of IAHSS, and a member of industry-leading organizations, including ASIS International, Southeastern Safety & Security Council, and others, Lisa collaborates with some of the country's greatest minds in healthcare security. She continues her commitment to the industry as the current Director of Hospital Police and Transportation at UNC Hospitals in North Carolina.

The Big Picture of Healthcare Violence

- In January 2014 at Highland Hospital, California, a loaded gun was found on an ED patient, causing panic among the ED staff¹
- The *Washington Times* reported two separate stabbing incidents in Los Angeles hospitals where nurses were stabbed in April 2014, leaving one nurse critically injured²
- A 34-year-old man walked into an emergency room at Valley Hospital in North Logan, Utah, brandishing two guns. Officers shot at him four times after he pointed a gun at one of them³
- A gunman critically injured a doctor at Johns Hopkins Hospital in Baltimore, and later shot himself and his mother⁴
- A man who was dissatisfied with his mother's treatment at a Columbus, Georgia hospital killed one of her nurses and another employee before being shot⁵

It's Not Just a Full Moon on a Friday Night

The emergency room is filled to overflowing, and patients continue to pour through the hospital doors. From traffic injuries and self-inflicted wounds, to domestic assaults and random acts of community violence, the hospital staff is on high alert on this busy night.

But it's not a Friday night and there is no full moon. The myth that "it's a full moon on a Friday night" is clearly debunked.⁶ To determine if there is any effect of the full moon on emergency department (ED) activity, an ED of a suburban community hospital conducted a retrospective analysis of all patients seen in the ED during a four-year period. A full moon occurred 49 times during the study period. No significant differences were found to a monitored unit on days of the full moon. The conclusion was an occurrence of a full moon has no effect on ED patient volume, ambulance runs, admissions, or admissions to a monitored unit.

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The frenzied pace for healthcare professionals does not simply escalate based on the lunar effect. For years, many people believed there was a correlation between full moons and critical events.

But EDs do not just fill up on a full moon—and a full moon does not cause more mental health or psychological problems. The lunar cycle cannot account for increased rates of trauma, suicide, seizures, crime, aggression, accidents, and violence. People who believe this lunar myth are simply seeking to maintain an illusion of control over an uncontrollable situation.

Although there are many difficult, stressful, and even violent events in the ED on nights with a full moon, these same types of incidents occur any night of the week and regardless of the phase of the moon. Finding any semblance of consistency in the randomness of violent incidents in the ED is a futile attempt at explaining it away.

But one thing is for sure and is certainly not a myth. Violence in healthcare is random and it occurs in the hospital—and especially in the ED—on any night throughout the lunar cycle. Sadly, many nurses and hospital staff believe that violence is to be tolerated as a hazard of the profession.

Some have put up with dysfunctional behaviors for so long that they do not even recognize it as workplace violence. “The culture is such that it does not get addressed in fear of retaliation,” said one nursing officer in Temple, Texas, speaking only on condition of anonymity. “For those that don’t admit it happens, I feel they are walking around with blinders on.”⁷

A culture of tolerance

According to the *Online Journal of Issues in Nursing*, “Workplace violence is one of the most complex and dangerous occupational hazards facing nurses working in today’s healthcare environment.”⁸

More than 53% of nurses reported experiencing verbal abuse at work. Thirteen percent reported experiencing physical violence in the past seven days. The study results come from the Emergency Nurses’ Association (ENA), which surveyed more than 7,000 emergency room nurses nationwide regarding their experiences from 2010 to 2011.⁹

According to the Bureau of Labor Statistics (BLS):

*In healthcare and social assistance, musculoskeletal disorders (MSDs) made up 42 percent of cases and had a rate of 55 cases per 10,000 full-time workers. This rate was 56 percent higher than the rate for all private industries and second only to the transportation and warehousing industry. The incidence rate for violence and other injuries (15 cases per 10,000 full-time workers) in this industry sector was more than three times greater than the rate for all private industries.*¹⁰

Unfortunately, many doctors and nurses see violence in the workplace as an accepted hazard of the occupation. They perceive a culture of tolerance relative to violent individuals. According to the

2010–11 ENA survey results, 66% of nurses who were physically assaulted never formally filed a report.¹¹

Violent crimes in hospitals continue to create serious concern. According to *Campus Safety* magazine, “The rate of violent crime, assaults, and disorderly conduct incidents at U.S. hospitals in 2013 was significantly higher compared to the previous year, according to research released by the IHSS Foundation at the International Association for Healthcare Security and Safety (IAHSS) 46th Annual General Membership meeting held May 18–21 [2014] in San Diego.”¹²

Crime surveys and studies

Workplace violence is divided into four separate categories based on the FBI’s workplace violence typology:

- **Type 1:** Violent acts by criminals, who have no other connection with the workplace, but enter to commit robbery or another crime.
- **Type 2:** Violence directed at employees by customers, clients, patients, students, inmates, or any others receiving services by the hospital/organization.
- **Type 3:** Violence against coworkers, supervisors, and 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, such as an abusive spouse or domestic partner.¹³

The majority of violence against hospital staff is inflicted by patients or distressed family members, which corresponds to Type 2 violence.¹⁴

The International Healthcare Security and Safety Foundation (IHSSF) is the philanthropic arm of the International Association for Healthcare Security & Safety (IAHSS). The 2014 IHSSF Crime Survey provides healthcare security professionals with an understanding of crimes that impact hospitals and the frequency of those crimes.

According to the 2014 IHSSF Crime Survey relative to hospital violence:

- Assault cases rose from 10.7 to 11.1 per 100 beds from 2012 to 2013.
- Disorderly conduct rates per 100 beds rose from 28.0 in 2012 to 39.2 in 2013.
- The number of violent incidents involving hospital workers jumped 37% in the past three years, according to a recent study by IAHSS.¹⁵

A 2013 study by the *International Journal of Nursing Studies* found that:

- 33% of nurses worldwide had been exposed to physical violence and bullying in the workplace
- 66% reported nonphysical violence (verbal, nonverbal, intimidation, other)
- Physical violence was most prevalent in emergency departments and psychiatric facilities¹⁶

Rewind

My understanding of violence in healthcare began many years ago. I was initially exposed to the healthcare environment when things were very different than they are today. While many things improve over time, hospital violence is not one of them.

My fascination with healthcare security began as an early teen. It started with a summer job in the hospital emergency department. As a high school senior in 1977, I secured a part-time position as an emergency department admitting clerk in a small community hospital. Little did I know that the experience within the hospital environment would fuel my passion as a hospital security leader in the future.

I worked as an admitting clerk throughout high school and college, filling shifts whenever possible. Since I was a part-time employee and student, I was available to work nights, weekends, and holidays, which gave me a firsthand look at hospital operations 24/7.

My observations gave me a real-life immersion into behaviors of aggressive, inebriated, mentally ill, and traumatically injured patients presenting to the ED. I also experienced the particular challenges and concerns triggered throughout the environment when forensic patients presented at the ED.

Those were early years in a healthcare environment. The hospital's protocol was very clear: The policy required staff to call for the charge nurse and the chaplain when high-risk patients or grief-stricken and upset families became agitated. Without fail, the experienced charge nurse and/or chaplain were always successful in containing the situation and bringing it to a calm and appropriate level. Quite frankly, I didn't imagine a need for a security presence in the ED at that point in my career. And I certainly did not consider it a dangerous environment that harbored a culture of tolerance for violence.

In May 1982, immediately after graduating with a Bachelor of Science degree in political science/criminal justice, I headed to the city to begin my career as a city police officer. I did not think a lot about my job in the hospital—except for the occasional visit to the hospital's trauma center with an individual in custody who needed medical treatment.

In 1987, the trauma center advertised for a security director. My combined years of experience as an ED admitting clerk and law enforcement officer made me highly qualified as a healthcare security director. Or so I thought.

I knew firsthand that there was no "real" crime committed in a hospital. I never considered it a dangerous occupation. At least that was my perception at the time. After all, I had five years of experience as a police officer with the North Carolina University of Public Safety in Raleigh, N.C. I was just 27 years old with five years of part-time emergency department admitting experience and five years

of experience as a police officer when I became the new hospital security director. What more was necessary?

Over the next few months, I observed many adverse events and recognized that the hospital environment was like no other. It did not take me long to realize that this was only the tip of the iceberg regarding violence in healthcare—and especially within the emergency department. The landscape was changing and violence in the ED was becoming a whole new challenge for the healthcare environment.

Fast-forward

The weight of assuming responsibility as the organization's security director drove me to delve more into hospital security and managing violent patient behavior. I knew it was critical to appropriately respond, reduce, and hopefully eliminate the violence.

I immediately set out to better understand the unique environment by working toward a master's degree in Healthcare Administration. I also initiated research on the origins of violence within the hospital where I worked to ascertain what drove the events. I devoured resources to learn more about violent individuals and what drove their behaviors. Not surprisingly, much of what I learned was garnered through observation and hands-on experience in the ED, where violence erupted frequently. It didn't take long for me to discover that the majority of violence in the ED resulted under very specific conditions, and primarily emanated from identifiable individuals, including:

- Drug- and alcohol-impaired patients and visitors
- Victims of gunshot wounds and the circumstances surrounding those situations
- “High acuity” behavioral health patients who perceived the ED as the only treatment option due to the elimination of or decrease of mental health inpatient and outpatient community treatment alternatives
- Gang members transferring violence to the hospital environment from the surrounding perimeters of the facility
- Perpetrators of domestic violence who may follow their victims through the ED doors
- Indigent patients experiencing unpredictable overcrowding accompanied by stress, anxiety, and ultimately violence
- Forensic patients entering the ED under the supervision of law enforcement or Department of Corrections officials

Other causes of ED violence also emerged and permeated from within the walls of the hospital:

- Unrealistic expectations by emergency department patients/families who expect immediate and individualized treatment with no understanding of triage protocol

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- Hospital staff expectations that ED patients are cooperative and adherent—and that all patients understand the triage process based on severity of a patient’s condition
- Communication problems when patients perceive they are being ignored by staff as a result of triage protocol
- Additional communication challenges with non-English speaking patients or families who often feel their concerns are not well understood or are ignored
- Ethnic diversity and not clearly understanding the differences and customs
- Long waits in the ED due to lack of hospital beds for behavioral health patients, which has become increasingly more problematic over time

These drivers of violence were just the beginning of a national epidemic in our country’s healthcare institutions. Over time, we have learned that patient acuity, staffing shortages, patient surge due to natural disasters, risks of terrorism, and acts of violence generate major security risks in today’s hospital environment.

Increasing risks of violence are documented today through rising healthcare security events. The 2012 Crime and Security Trends Survey reported a significant increase in healthcare crimes over a two-year period:

A survey found that the number of healthcare crimes increased by nearly 37 percent in just two years from just under 15,000 in 2010 to more than 20,500 in 2012. The 2012 Crime and Security Trends Survey was underwritten by the Foundation of the International Association for Healthcare Security and Safety (IAHSS).¹⁶

The very nature of an immediate and unplanned ED visit sets the stage for overwhelming stress levels for patients and families. Emergency department staff, patients, and visitors are vulnerable to violent behavior stemming from a variety of sources.

My experience over several decades has immersed me in the world of healthcare security that focuses on safety and security for everyone involved. Positive patient engagement, innovative security solutions, and adherence to regulatory controls that support the volatile ED environment are all keys to success.

You will find strategies, tactics, and solutions in this book that will help you create a safer and more secure ED and overall safer facility. The recommendations and strategies consistently incorporate patient engagement strategies, respect, privacy, and protection into every human interaction.

The War against ED violence

As I reflect on my early days in the ED and law enforcement, it is obvious that much has changed. But one thing remains constant: Hospital security is most successful when it involves security leadership supported by well-trained officers, clinicians, ancillary staff, hospital management, and hospital leaders.

Collaboration is one of our most valuable weapons in the war against violence in healthcare. It is a valuable tool in our arsenal as we learn to respectfully manage the violent individual. It's essential to utilize innovative, creative strategies and tactics to underpin successful security programs, as described throughout this book.

But first, we must further understand behaviors and what drives a person to violent aggression.

And it's not just a full moon on a Friday night.

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Preventing Emergency Department Violence

Tips and Tools to Keep Your Facility Safe

Lisa Pryse Terry, CHPA, CPP

This book provides hospital security departments with guidance on how to deal with violent patients and visitors, active shooters, uncooperative behavioral health patients, and disruptive prisoners; recognizing signs of violence; training options; and sample response protocols in the healthcare setting. Author Lisa Pryse Terry, CHPA, CPP, offers real-life examples and tools such as training options, sample response protocols, and ER design ideas to help readers develop plans and make improvements in their own facilities.

This resource gives readers the following:

- Real-life examples of incidents with violent patients from national experts
- Tips to train healthcare professionals to detect signs of anxious or potentially violent patients
- Strategies for working as a team to assess threats in the facility, share information, and develop a plan to defuse violence
- Customizable tools including training options, sample response protocols, and ED design ideas

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