Modern Healthcare

Security lapses

Critics urge execs to take safety issues more seriously

By Joe Carlson | October 17, 2011

New rules now help inspectors assess the safety of hospitals. Officials, above, at Johns Hopkins Hospital hold a news conference in 2010 after Paul Warren Pardus shot and killed his mother in her hospital room.

When Jeaux Rinehart boarded the bus home from his Seattle emergency department one summer night in 2010, jangled nerves at the end of his shift finally forced the realization that his 32-year career as an ER nurse was at an end.

Back in 2008, Rinehart had been hit by a billy-club-wielding heroin user while working in the ER. The following year brought the death of a close friend following a violent struggle in the ER of a different hospital to the south. Then, that night in July 2010, an intoxicated patient spit on him, escaped wrist restraints, tried punching him in the face, and then threatened to kill him, according to a King County probable cause affidavit.

"I got on the bus and started thinking, if someone started calling me names and spitting on me here, I wouldn't take it. But at work, I have to," Rinehart said in an interview. "And I remember thinking, this is insane. … You wouldn't take it at home, you wouldn't take it at the mall, or on the bus, or anywhere. But at work you are supposed to take it?"

Not long afterward, Rinehart, who asked that his hospital not be named, received a follow-up call about a job prospect and finally did what other ER nurses all over the nation privately mull—he walked away from a long career in nursing because of the tide of workplace violence and the persistent fear for his personal safety.

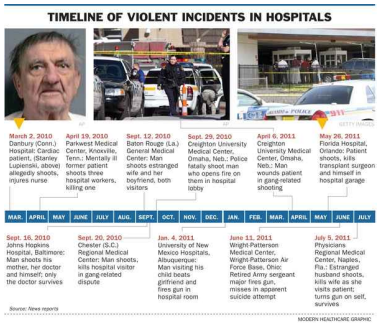
The Occupational Safety and Health Administration has long identified violence as an occupational hazard for doctors, nurses and other healthcare workers. Just last month the federal agency unveiled new rules to help local inspectors assess the safety of hospitals and healthcare facilities following incidents of violence.

Looking at the statistics, it's not hard to see why.

The average American worker stands a 1.7-in-10,000 chance of being assaulted on the job, but for registered nurses in hospitals the risk is more than tripled, at 6.1 per 10,000—higher chances of assault than faced by taxi-cabdrivers or bartenders, according to the Bureau of Labor Statistics' data from 2009, the most recent available.

Already, 2011 is shaping up as a violent year in U.S. hospitals.

The Joint Commission, which investigates violent incidents in hospitals and long-term-care facilities as part of its role in accrediting healthcare providers, tracked 23 violent incidents in the first half of 2011. At that pace, this year would exceed the record set in 2008, with 42 such reports.



The Joint Commission already mandates that its accredited hospitals perform risk assessments and have plans in place for security of staff and patients, but experts say going beyond the minimum requirements has been shown to reduce violence measurably.

A survey of members of the Emergency Nurses Association provided to Modern Healthcare ahead of its planned November release shows that the presence of zero-tolerance policies for patient or visitor violence and affirmative support of staff who report violence are correlated with fewer incidents against staff.

“Above all, we've got to have the C-suite and leadership take a supportive role of what needs to be done,” said Russell Colling, a security consultant and a founder of the International Association for Healthcare Security and Safety. “What we constantly hear is, ‘We're busy taking care of patients.' And security is put on the back burner.”

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Another commonly cited explanation for executive inaction is the widespread belief that at least some mild violence is simply part of a nurse's job. Dr. Mike Wilson, a clinical research fellow at 535-bed University of California San Diego Medical Center specializing in psychiatric emergency medicine, said advocates for healthcare-worker safety still confront that outmoded attitude.

“If you're standing on a street corner and you strike a nurse, we put you in jail,” Wilson said. “When you're in a hospital and you strike a nurse, we give you a series of drugs and get you out as soon as possible. That's not right.”

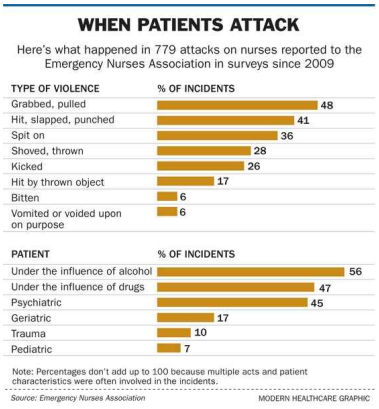
It's not only the executives who think violence is part of the job.

AnnMarie Papa, president of the Emergency Nurses Association and clinical director of emergency nursing at two Philadelphia hospitals, said nurses themselves need to be reminded not to rank their own personal safety behind all other considerations. She said nurses should borrow techniques from other professionals such as paramedics and firefighters.

“The first thing that they do, before they do anything, is they assess the scene for

safety and they assure that things seem safe before they go in," Papa said. "Because they know that if something happens to them, then that's just another casualty that they will have to fix, and that's not helping anyone. We in healthcare need to take a page out of that book, and learn how to assure that a scene is safe, and (ask) where are our risks?"

Detecting trouble



Many factors bring violence into hospitals.

Jim Stankevich, the president of IAHSS, said hospitals attract individuals who are mentally unstable, whether because of underlying psychiatric conditions or the abuse of alcohol or drugs. They are open 24 hours, seven days a week, many times through multiple building entrances. And hospital waiting rooms are frequent sites for emotional outbursts, as overcrowding and the triage system of seeing the most acute patients first can cause long delays.

Dr. Ana Pujols-McKee, executive vice president and chief medical officer for the Joint Commission, said the enhanced level of stress in society at large may also be playing out in high rates of hospital violence, driven by high unemployment and depressed wages from the unending economic downturn.

The stories stream out of the media regularly. In July, authorities say a man went to 70-bed Physicians Regional Medical Center-Pine Ridge in Naples, Fla., and fatally gunned down his estranged wife before turning the gun on himself. The wife had been at the hospital visiting a patient.

In April, police say two known gang members carried a feud into the lobby of 334-bed Creighton University Medical Center, Omaha, Neb., where one man shot the other and triggered the hospital's second violence-related lockdown in six months.

In September 2010, police say a man went to 918-bed Johns Hopkins Hospital in Baltimore, apparently despairing over a poor medical outcome his mother had received during cancer care. The perpetrator shot and killed his 84-year-old mother in her hospital room, shot her physician (who survived the attack), and then committed suicide.

The Johns Hopkins shooter—Paul Warren Pardus—lived in Virginia, was 50 years old, and had a license to carry a gun, according to news accounts.

Like most of the 10 hospitals contacted by Modern Healthcare for interviews after incidents of violence, officials with Johns Hopkins declined to be interviewed.

David Banks, CEO of the 1,067-bed Florida Hospital in Orlando, described feelings of failure and vulnerability after a patient specifically targeted Dr. Dmitriy Nikitin for assassination on the sprawling hospital campus, killing the transplant surgeon in a parking garage.

“Even though you see it on the news and you have your security in place, you just don't think it's going to happen to you,” Banks said. “I think we'd all be better served to give a little more forethought to what you would do if that kind of event takes place.”

After the shooting, the hospital stepped up its use of video monitoring and security personnel, both uniformed and undercover, Banks said.

But in the wake of publicity about hospital violence, news accounts show that the public often clamors for visible signs of safety precautions, particularly metal detectors, though hospital officials have mixed opinions on that topic.

A 2008 article in the journal Academic Emergency Medicine found that about 14% of respondents said their hospitals used metal detectors to screen for weapons.

Dr. Melissa Barton said concerns about public image did not hurt her push for more metal detectors at her hospital in Detroit, the 316-bed Sinai-Grace Hospital, which she said has the distinction of being the closest trauma center to Detroit's infamous 8 Mile area.

The hospital already had metal detectors at the emergency department entrance, but Barton said she was one of the people who successfully pushed to have them installed at the hospital's front door as well.

“It's a balance between having patients and facilities and visitors feel welcome and that we want them to come and see their loved ones, versus also offering safety and a feeling of security for those same people,” she said.

The security enhancement also included more training for security officers and the development of a no-tolerance policy for violent behavior in the hospital.

But neither the Joint Commission nor professional associations for emergency nurses or emergency physicians specifically recommends metal detectors, saying each hospital's needs and communities are different. Critics say that in addition to the cost of labor to staff the detectors, the equipment is powerless against the more common type of patient who is violent without using a weapon that would be detected and confiscated at the door.

Too drunk for jail

Last June, a new law in Kentucky took effect forbidding police from jailing people who commit misdemeanors and don't appear to pose any immediate threat as a way to save jail space for the most dangerous criminal suspects.

The change, it turned out, had a dramatic effect for medical centers such as Lexington's 156-bed UK Good Samaritan Hospital, which found itself a dumping ground for extremely drunken, disruptive and often-homeless patients who otherwise would have been in jail.

Dr. Ryan Stanton, medical director of the emergency room at Good Samaritan, said it's not uncommon for the hospital to hold these “too drunk for jail” patients for 10, 12 or even 14 hours at a stretch, after which police often don't return to issue citations. In the hospital, the patients can become not only physically abusive, but verbally as well—something that wears on front-line providers.

“The potential of them getting injured is the most important, but the verbal assaults are important to me too,” Stanton said. “This is their job. I don't want them to be verbally assaulted when they come to work. But what we are trying to do is get a handle on the physical assaults.”

Hospital administrators quickly acted on the situation, implementing an institution-wide risk assessment and adding more security officers.

Meanwhile, Stanton said the hospital is exploring other options, such as segregating the disruptive patients in specific parts of the hospital “to provide the medical coverage they need but at the same time not expose this high-risk population to our other folks or our staff.” Hospital officials are also working with local authorities to see whether hospital staff could help provide manpower to an existing medical area of the Lexington city jail.

In a move following a national trend, Stanton said Kentucky lawmakers are scheduled in January to take up new changes in laws that would specifically protect healthcare workers.

States across the country have established a patchwork system of enhanced legal protections for healthcare workers. A 2-year-old national assessment by the Emergency Nurses Association found that at least 26 states had laws declaring that violent acts against healthcare workers were felonies, and several states have passed new laws or strengthened existing ones since then.

Planning for violence

Administrators with the University of Tennessee Medical Center in Knoxville recently found out what would happen if they had an active-shooter situation on their campus: early confusion.

As part of violence-prevention efforts, a long-standing multidisciplinary team at the 489-bed hospital staged a mock shooting event to learn how staff and local law enforcement would and should deal with an emergency situation.

The hospital had an established incident command system that includes a phone tree to notify managers and executives, and a designated on-site command center to coordinate events. But one of the first lessons administrators learned from the drill was that they needed a better system for communicating that command had been moved off-site, said Gary Thomas, vice president of compliance and administration and a member of the hospital's incident command team.

“When you have an event like this, you can't use your routine command center, because it's inside the hospital and you don't know where the event is happening,” Thomas said. “We had to extend the command to an external center.” Thomas said the hospital also actively addresses day-to-day violence against staff by maintaining a staff of armed security guards and an Internet-based system where workers can internally report incidents.

Wilson, the clinical research fellow at UC San Diego, said research has found the single most important step that executives can take is to encourage staff to report such incidents and file charges when that's warranted.

“When you think security in a broad sense, you start thinking about metal detectors and security officers,” Wilson said. But “the biggest change CEOs can make is that when patients strike a staff member, that should be considered a criminal offense.”

Brent Lemonds, an RN and the administrative director of emergency services at 815-bed Vanderbilt University Medical Center in Nashville, said that in addition to having an ER metal detector and prosecuting offenses against workers, the hospital provides regular daylong training sessions for its entire emergency department staff.

The sessions consist of four hours of verbal de-escalation techniques and four hours of physical self-defense tactics, taught by two staff members who were trained by one of the several consulting firms around the country that specialize in that service.

Lemonds said the metal detectors, armed ER guards and training hours do not come cheaply, but he's convinced that they have had a real effect.

“It's not inexpensive, but we have been blessed to be able to protect ourselves from some of these incidents of violence you've seen across the country,” he said. “If we hadn't spent the money and put the security measures in place, we would be part of the headlines.”

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