

journal of healthcare
PROTECTION
management

Volume 26, Number 2

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Publication of the International Association for Healthcare Security & Safety

Advancing Excellence in Healthcare Security and Safety Worldwide



The IAHS 2010 crime and security trends survey

Victoria A. Mikow-Porto, PhD and
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According to the findings of this 2010 survey, the overall number of crimes in hospitals reported in 2009 was significantly higher, in most instances, than the number of crimes reported the last time the survey was conducted in 2004. The new survey, funded by the IAHS Foundation, also added new questions to establish baseline data on current and emerging trends in crime-related and other major security issues that challenge security professionals. For the first time, the IAHS survey collected information about patient elopements and forensic and psychiatric patients. The 2010 IAHS survey has now provided baseline data to compare the number of such patients treated in subsequent years to establish trends over time in this critical security area.

(Victoria A. Mikow-Porto, PhD, is principal of the consulting firm of Research & Policy Analytics, Carrboro, NC. She is a former senior project manager of Westat National Research Organization, Durham, NC and Rockville, MD, and Deputy Director for Policy and Research Programs. The James B. Hunt, Jr. Institute for Educational Leadership and Policy, Office of the President, the University of North Carolina, Chapel Hill, NC.

Thomas Smith, CHPA, CPP, is Director of Hospitals Police and Transportation at the University of North Carolina Hospitals, Chapel Hill. He is a past president of IAHS.)

The International Association for Healthcare Security and Safety (IAHS), a non-profit organization with 1867 members representing over 800 hospitals and healthcare facilities, is deeply concerned about safety and security in healthcare settings. At issue is the accurate accrual of information about violence and crime as well as who speaks for security when incidents occur. Providing useful information is critical to the development of reasonable and appropriate preventive programs to mitigate crime.

As a part of its mission to respond to the needs of Association members and healthcare organizations, the IAHS, through its Foundation, underwrote a new research study to collect information on trends in crime since the last IAHS survey on crime was completed in 2004. The 2010 survey included identical questions and definitions of crime taken from the Department of Justice's

Table 1. IAHS Crime Survey 1995-2009

Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2009	Average Number All Facilities
Number Facilities Reporting	221	221	251	222	285	227	295	226	219	192	212	234
Crime												Total Crimes - all years
Homicide	6	2	5	3	2	2	3	0	2	2	3	30
Per Hospital	0.03	0.01	0.02	0.01	0.01	0.01	0.01	0	0.01	0.01	0.01	
Rape/Sexual Assault	67	38	13	54	48	31	54	30	34	42	55	436
Per Hospital	0.3	0.17	0.05	0.24	0.17	0.14	0.18	0.13	0.16	0.22	0.26	
Robbery	165	127	108	53	88	84	245	51	42	25	186	1,610
Per Hospital	0.75	0.57	0.43	0.24	0.31	0.37	0.83	0.23	0.19	0.13	0.88	
Aggravated Assault	NA	NA	NA	273	213	145	228	157	191	123	660	2,176
Per Hospital	1463	1259	604	1410	1595	1444	1389	1486	1418	904	2720	15,692
Simple Assault	6.62	5.7	2.41	6.35	5.6	6.36	4.79	6.58	6.47	4.71	12.83	
Per Hospital	667	488	551	700	501	647	683	612	577	369	1661	7,456
Burglary	3.82	2.12	1.94	2.48	2.46	2.21	2.19	3.0	2.79	3.01	7.83	
Per Hospital	13974	10997	12180	10243	10929	6965	9300	8401	6398	4412	7333	101,132
Larceny	62.23	49.76	48.13	46.13	38.35	30.88	31.53	37.17	29.21	23.0	34.58	
Per Hospital	778	587	601	398	559	404	410	458	429	361	345	4970
Motor Vehicle Theft	3.52	2.66	2.39	1.79	1.96	1.78	1.39	2.03	1.96	1.88	1.63	
Per Hospital	17	27	68	36	20	23	48	12	6	7	132	396
Arson	0.08	0.12	0.27	0.16	0.07	0.1	0.16	0.05	0.03	0.04	0.62	
Per Hospital	2475	2779	2646	2841	2343	1840	2045	1874	1627	1317	1886	23,673
Vandalism	11.2	12.57	10.54	12.8	8.22	8.11	6.93	8.29	7.43	6.86	8.90	
Per Hospital	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5
Kidnapping	19648	16290	16712	15922	16534	11458	14396	13184	10794	7584	14991	157,513
Per Hospital	88.9	73.71	86.58	71.72	57.97	50.47	48.8	58.33	49.29	40.5	70.7	

Uniform Crime Index. The same questions and definitions were used in past IAHS Foundation surveys for the purpose of collecting longitudinal data on crimes. In addition, new questions were added to establish baseline data on current and emerging trends in crime-related and other major security issues that challenge security professionals. Specifically, the survey, funded by the IAHS Foundation, was developed to:

- Assess trends in crimes on hospital campuses from 1995 to 2009
- Collect new information to assess current issues and concerns in safety/security
- Provide information for use by members.

THE SURVEY: REPORTED CRIMES ALMOST DOUBLE IN SIX YEARS

In 2010, the total number of crimes reported by 212 healthcare facilities in the eleven categories of crime was 14,991 crimes, compared to the 7764 crimes reported in 2004 by 192 facilities. This indicates a significant jump in total crimes. Numerically, this represents a total increase of 7227 crimes or nearly twice as many as

were reported in 2004. Four categories of criminal incidents – simple assault, larceny, vandalism and burglary, accounted for 91 percent of all reported crime in 2010.

A simple rate of crimes per hospital was calculated by averaging the total number of crimes reported by the total number of useable cases represented in the survey. Three homicides were reported in 2010. This results in a rate of approximately .016 homicides for all facilities represented in the survey, or a homicide rate of slightly more than one in a hundred hospitals. In 2004, approximately one in a hundred, or .010, healthcare facilities reported homicides. The rate represents a small increase in homicides between 2004 and 2010.

In 2004, forcible rape and sexual assault were reported separately. These categories were combined in 2010 in response to Association member input. There were 55 reported incidents of rape and/or sexual assault in 2010 compared to a total of 42 rapes and sexual assaults in 2004. This represents an increase of 13 rapes and/or sexual assaults in 2010 compared to 2004.

The number of robberies (186) reported in 2010 was significantly

The 2010 IAHS Survey: How the data were collected and analyzed

The 2010 IAHS Survey is a cross-sectional study conducted under the auspices of the International Association for Healthcare Security and Safety Foundation. The study and instrumentation were designed by a lead researcher with advice and input from the leadership of the IAHS Foundation, its Board and IAHS members themselves. It is assumed that the 800 plus hospitals and healthcare facilities are relatively representative of a cross-section of all healthcare facilities.

To facilitate ease of reporting and increase member response rates, the survey was developed to be taken on-line. The 39 item on-line survey gathered information on the number and types of crimes committed on hospital and healthcare properties to facilitate comparison with data previously captured on crimes in IAHS surveys. Standard crime definitions, taken from the Uniform Crime Statistics, the United States Department of Justice, Federal Bureau of Investigation, were used to standardize reporting on crimes. In addition, new information was requested, some of which was captured in text format, about emerging issues and trends seen in hospital security, making the survey both longer and more time consuming than previous IAHS surveys that collected only crime data.

A convenience sampling strategy was used. Solicitation for participation was made on-line in newsletters and in E-alerts from IAHS as well as on the IAHS website itself. All members of IAHS were eligible to participate. However, to avoid duplication of information collected, it was requested that a single senior security member representing each healthcare organization under his/her responsibility provide survey responses. The survey was conducted over a period of about six weeks in early 2010. A total of 212 facilities responded, representing approximately twenty-four percent of the total number of hospitals and healthcare facilities represented by members eligible to participate. This also represents an increase of twenty organizations participating when compared to the number of participating organizations (192) when the previous IAHS crime survey was administered in 2004. IAHS surveys were conducted from 1995–2004 and resumed in 2010.

Data were collected on-line using summary and analytic functions available in Qualtrics. The raw data were then exported to Excel files for statistical management. The data were assumed to be non-normal distributions.

Data Limitations

The nature of convenience or purposive sampling that has been used for this and previous IAHS crime surveys prevents the use of statistical methods associated with random sampling procedures. Therefore, as a caveat, while the results reported are loosely comparative from year to year, it cannot be said with precision that the data are strictly comparable and representative of all hospital and healthcare facilities. As a result, the comparisons must be viewed with caution due to the voluntary nature of participation. The reliability of the interpretations made should be considered

serious, but not definitive. It should be noted, however, that the data and findings in this study are consistent with other studies, including the recent release of information by the Joint Commission (2010).

Further research is needed to determine whether the findings hold for a randomized sample of all member and non-member healthcare organizations and comparisons are needed with national and international healthcare data. Nevertheless, the authors of this study feel confident that the data portray significant finding results for healthcare security providers.

The survey was administered to ensure anonymity and confidentiality of data. Although the survey requested that respondents identify the North American state or international country they represented, the data were aggregated so that individual countries or states cannot be identified or associated with the specific information they provided.

Another caution regarding the survey results is that most IAHS members who represent specific healthcare facilities, primarily private, not-for-profit hospitals, did not participate in the survey. Of those who did participate in the survey, many respondents left large portions of the survey blank or entered non-numeric data where questions called for numeric information. This resulted in a lot of missing data for which simple estimation techniques were used whenever possible.

Results

Thirty-four states in the United States, two Canadian provinces and a Caribbean country participated in the 2010 IAHS Foundation survey. A total of 212 hospitals and healthcare facilities were represented compared to 192 in 2004. This yields an estimated 24 percent of member healthcare facilities. In 2004, approximately 22 percent of member facilities participated in the survey. The total number of facilities represented in surveys since 1995, when IAHS started collecting crime and violence information ranges from a high of 295 in 2001 to a low of 192 in 2004. The average number of facilities represented for all years is 234 organizations.

Analyzing Crime Data

In the past, a single table for reporting crimes was filled out by hand. It included all categories of crimes for which information has been collected by IAHS since 1995. The 2010 IAHS survey included the same categories and the same definitions of crime that was used in the past. However, in the 2010 survey, the on-line section for reporting total number of crimes in each category was one of the last questions asked in the survey. Perhaps due to its new format, answers were not always provided as numerical data, as previously noted. For example, a large number of responses simply contained an X, a percentage or a symbol representing a less than or more than a specific number. In the cases where non-numeric data were entered, an averaging technique was used to replace the non-numeric data. The technique imputed an average value by summing all numeric data and dividing it by

Table 2. Areas of Service Responsibility

	Number	Percent
Security	170	100%
Fire Safety	85	50%
Patient Staff Visitor Safety	125	74%
Emergency Risk Management	80	47%
Communication	41	24%
Parking	143	84%
Transportation (Vehicles)	37	22%
Transportation (Patients)	14	8%
Homeland Security	74	44%
Access Control	156	92%
Visitors	122	72%
Facilities Maintenance Environment	16	9%
Other	46	28%

Table 3. FTEs employed in Security Services

	Number	Percent
1-10 FTEs	39	23%
11-30 FTEs	82	48%
31-60 FTEs	33	19%
61-100 FTEs	10	6%
101-150 FTEs	5	3%
More than 150 FTEs	1	1%

Table 4. Average number of Days spent on Services in 2009

	Average number of days in 2009
Patient Interventions (Assists, Standbys, and/or Escorts)	994 Days
Patient seclusions/restraints	121 Days
Forensic/Prisoner Patients	14 Days
Emergency Department Responses	114 Days
Motor Vehicle Assists	59 Days
Workplace Violence	22 Days
Other	1 Day

the actual number of responses for that question. In the cases where a percentage was reported, a data estimation technique was used by averaging the total number of crimes reported numerically in that category and assigning an average value based on the percentage reported. For example, if 100 percent was reported in a particular category, the average value of the numerical data in that category of crime was used. For any category less than 100 percent, a proportional value of the average (e.g., 50% of the average value, if 50% was reported in the category) was used.

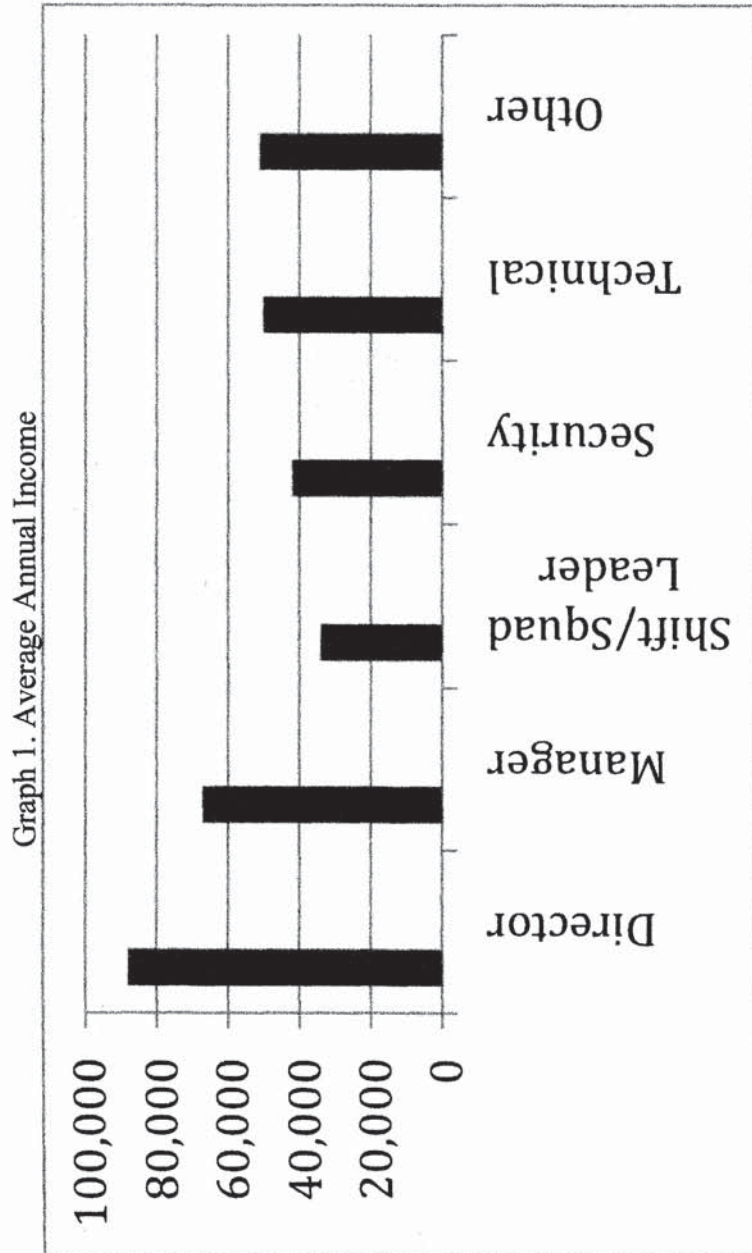
More serious was the variation in reporting crimes in sub-categories and in the totals requested for each crime reported. Specifically, some data was entered in the category of crimes committed inside or outside a facility while the total number of crimes was left blank. Additionally, there were serious inconsistencies with the data that required, as a part of the data cleaning process, an examination of each line of data, row by row and column by column, until all data entered were reconciled. After cleaning the data and eliminating the number of cases in which no data were reported and using the estimation techniques cited above, 183 usable cases were reported. It should be noted overall, that the total number of crimes varies from year to year but indicated a declining trend in crimes until 2010.

higher than the 25 reported in 2004. In 2010, 660 incidents of aggravated assault were reported, compared to 123 in 2004; a sharp rise. It should be noted that the number of aggravated assaults have varied from year to year, but significantly increased in 2010. The total number of larcenies increased in 2010, but overall the trend has been decreasing over time. Similarly, the number of motor vehicle thefts has varied from year to year, but shows an overall decline across survey years. Prior to 2010, data were not collected on kidnappings/abductions, but in 2010, five kidnappings/abductions were reported.

Table 1 lists the number of crimes reported since 1995 when the surveys were first implemented. As can be seen in Table 1, the data show a large increase in total incidents in crimes when compared to 2004 although there are fewer crimes overall when compared to 1995, the first year of survey administration. The increase in crimes in 2010 firmly supports current reports (e.g., the Joint Commission, 2010).

NEW FACTS ON HEALTHCARE SECURITY PROFESSIONALS

The field of healthcare security has expanded rapidly in recent



years (Colling & York, 2009). Yet there are gaps in what is known about the profession. To further inform the public in general and healthcare security professionals in particular, the 2010 IAHS Survey collected new information about issues and trends in hospital and healthcare security and safety that members had indicated, through a variety of venues, an interest in and need for more data. Several categories of information were collected: demographic, security leadership information, and hospital and patient characteristics. A final category of data information collected was about the kinds of information that IAHS members would like more information about in future IAHS surveys. The findings are summarized in the following sections.

Who Security Leaders Report To

The vast majority of security leaders of hospital and healthcare facilities reported they are designated as either Security Directors or Managers (92%). Other job titles included: Director of Facilities, Chief of Security Services and Director of Support Services. Most security leaders report to a Senior

Vice President of the healthcare organization (46%) while fifteen percent report to a CEO/COO/CFO, twenty percent report to another senior hospital administrator and nineteen percent report to other administrators such as Director of Operations.

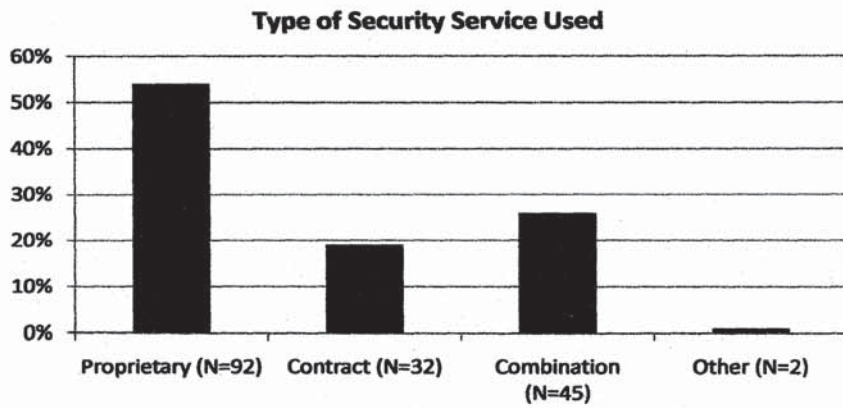
Areas of Responsibility

The 2010 IAHS Survey collected information about the areas of responsibility that security leaders are responsible for in healthcare settings. While there is some variability, there are five primary areas of responsibility. They include; 1) providing security (100%); 2) access control (92%); 3) Parking (84%); 4) Patient, staff, and visitor safety (74%); and, 5) Visitor control (72%). Table 2 provides information about services responsibility.

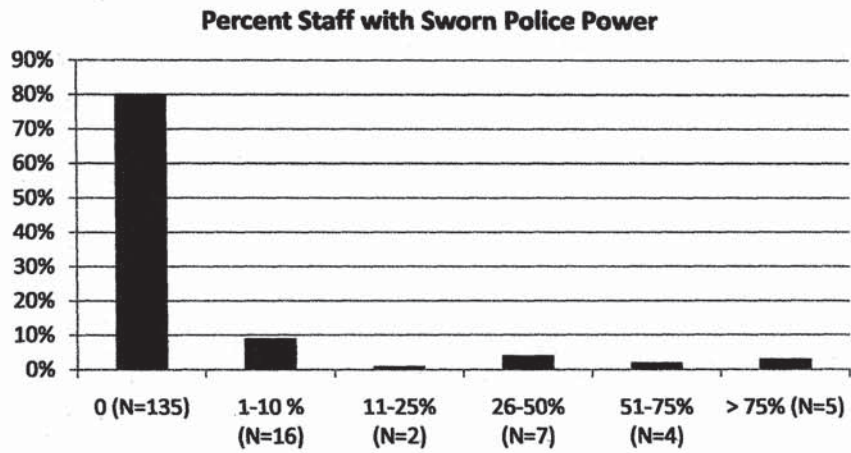
Number of Full Time Employee Equivalents

The number of employees in healthcare facilities security departments provides valuable insight into the size of most offices. As can be seen from the Table 3, nearly ninety percent of full-time staff equivalents (FTEs) range from one

Graph 2. Types of Security Services



Graph 3. Percent Staff With Sworn Police Power



to sixty staff employed in security services. Table 3 depicts the number and range of FTEs reported.

Annual Salary

In order to provide baseline information to the healthcare security profession, for the first time the 2010 IAHS Survey requested average annual income data on security leaders and staff. The information is intended to help inform the profession about the range of salaries associated with the healthcare security profession. Graph 1 presents that information.

Types of Security Services Used

Healthcare facilities must have secure environments. To provide safety and security at a reasonable level, healthcare facilities employ security personnel through their own departments or through hiring outside security services. The study sought information about the types of security services used. Graph 2 presents the information. As can be seen from Graph 2, the majority of hospitals reported using proprietary security services.

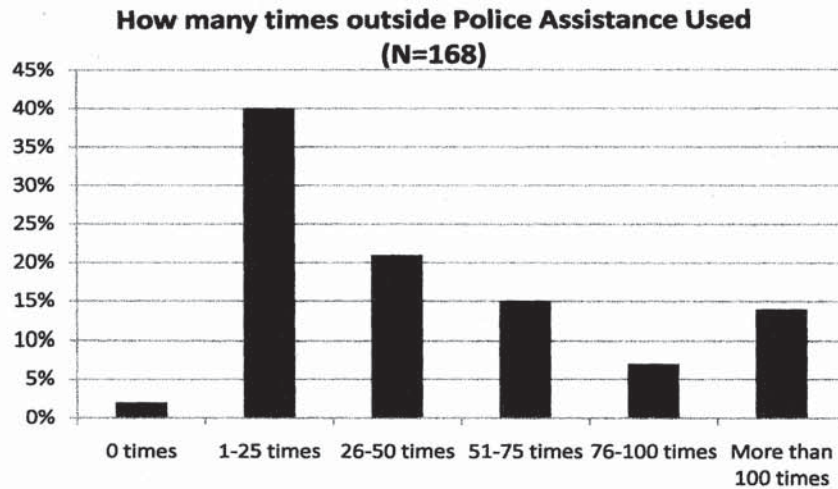
Sworn Police Power

Many hospitals and other healthcare providers do not have security staff with sworn police power, though they may have citizens' arrest power. This may impact the ways in which violent and aggressive patients, staff and visitors are handled and/or detained. Graph 3 shows that 80 percent of healthcare facilities participating in this study do not have sworn police power.

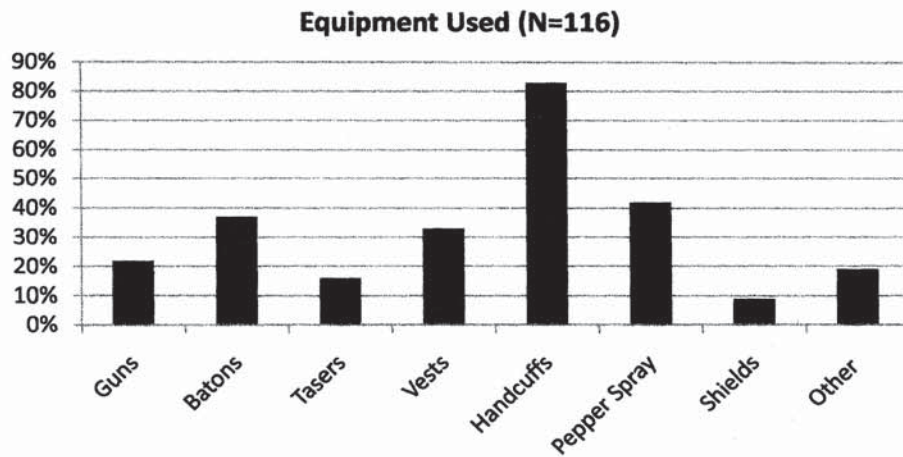
Calls to Outside Police

There is limited information and research about the circumstances associated with the need for local police assistance. The need for outside assistance from local police is likely to be associated with the capability for sworn police power. This may be an important area to gather more information. Graph 4 depicts the frequency with which outside police are called in. As can be seen, the majority (61%) of healthcare facilities participating in the survey reported using outside police assistance one to fifty times in 2009 while 86 percent reported using outside police one to seventy-five times in the past

Graph 4. Times Outside Assistance Required



Graph 5. Equipment Used



year. It is important to note that 14 percent of healthcare facilities reported using outside police assistance more than one hundred times in 2009.

Equipment Used

The increasing levels of violence and aggression in healthcare settings has resulted in increased demand for security equipment that can be used when patients, staff or visitors are at risk. The 2010 study asked about the types of equipment security staff use for the first time. Listed in Graph 5 are the types of equipment used by the healthcare security staff in 2009.

Total Days spent on Service Provision

In an attempt to determine how personnel resources are being used in areas that are emerging as critical hospital needs that, simultaneously, increase demands on security staff, a question was included in the 2010 IAHS survey about the average number of days spent of the provision of services in particular areas. Table 4 lists the amount of time, in days, spent on services in 2009.

As can be seen from Table 4, the majority of days are spent on patient interventions that include assistance, standbys and/or escorts. However, a significant number of days are spent on patient seclusion and restraints (121 days) and emergency department responses (114 days). Since this is the first year that this question was asked, comparative data are not yet available. Nevertheless, the findings are consistent with other research (e.g., Gacki-Smith, J., Juarez, A., Boyette, L., Robinson, L. and MacLean, 2009).

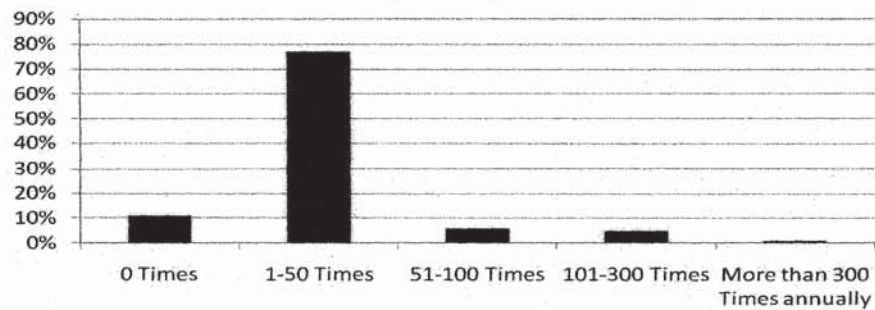
Patient Elopements

Patient Elopements (when a patient who is incapable of adequately protecting him/herself and who departs the healthcare facility unsupervised and unprotected) are serious challenges for security personnel. In Graph 6, information is presented about the number of patient elopements that occurred in 2009. The graph shows that nearly eighty percent of hospital facilities reported patient elopements occurred 1–50 times in 2009 while only 11 percent of healthcare facilities reported that no

Graph 6

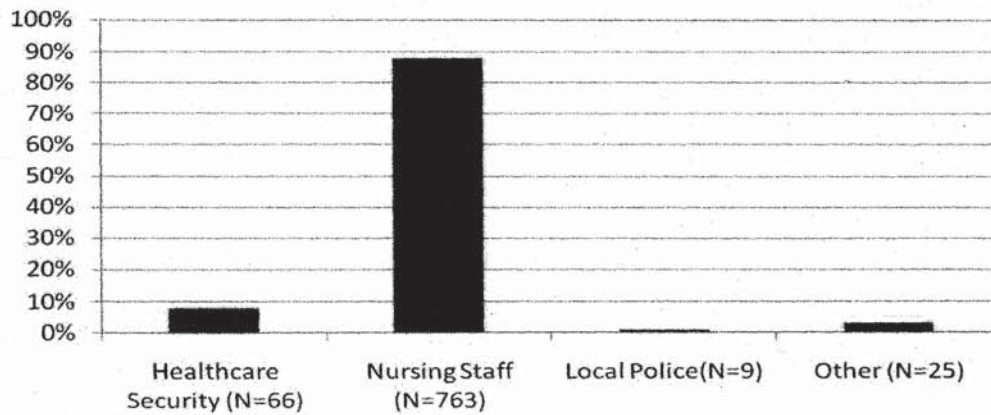
2010 IAHS Survey

How Many Times did Patients Elope in 2009? (N=166)



Graph 7

Of Patients who Eloped, who had Custody?



patients eloped. This is a serious and time/resource consuming issue for security personnel.

Custody of Eloped Patients

When patients elope, it is the responsibility of security staff to find and return patients. To further inform this issue, a question was included to determine who had custody of patients at the time that they eloped. Graph 7 provides information about patient elopement and custody. As Graph 7 shows, the largest proportion of patients was in the custody of the nursing staff when elopement occurred. This suggests that nursing staff may need additional assistance and resources from security staff to prevent elopement.

Improvement of Security

Participants in the survey were asked whether security has improved or declined in the last five years. Eighty-four percent responded that security and safety has improved, 6 percent said that it has declined, and 10 percent said that it has stayed the same.

When respondents who answered that security had

improved over the past five years, a drop-down text box asked them to fill in the reasons why it had improved. Reviewing and summarizing the text data showed that respondents cited the following reasons for improvement:

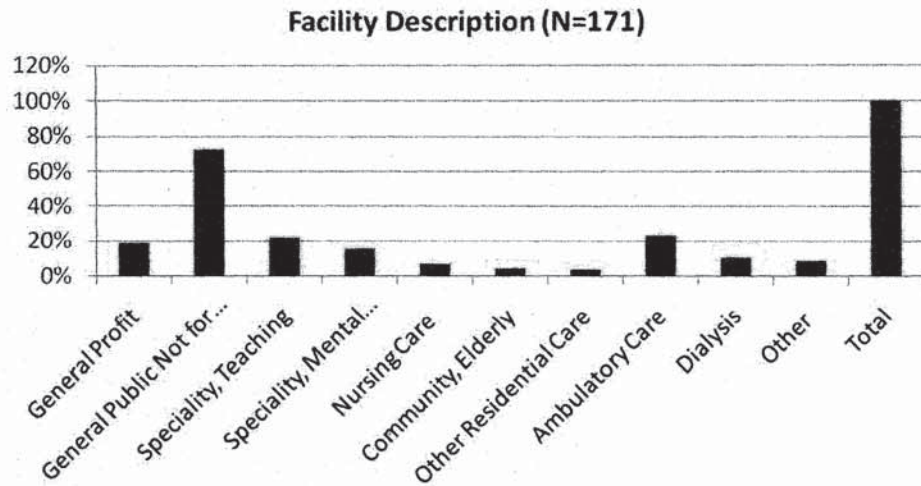
- Better Leadership
- An increased focus on security duties and training
- Physical security upgrades
- Locking down the hospital at night
- Better training
- IAHS training improved security
- Additional staff hires
- Alarm and CCTV system upgrades
- Improved reporting procedures and mechanisms for reporting crime and violence
- Moving from contracted to proprietary security services
- Improvement in contracted security services

For those who believed that security services had declined, the majority cited staff reductions as the primary reason.

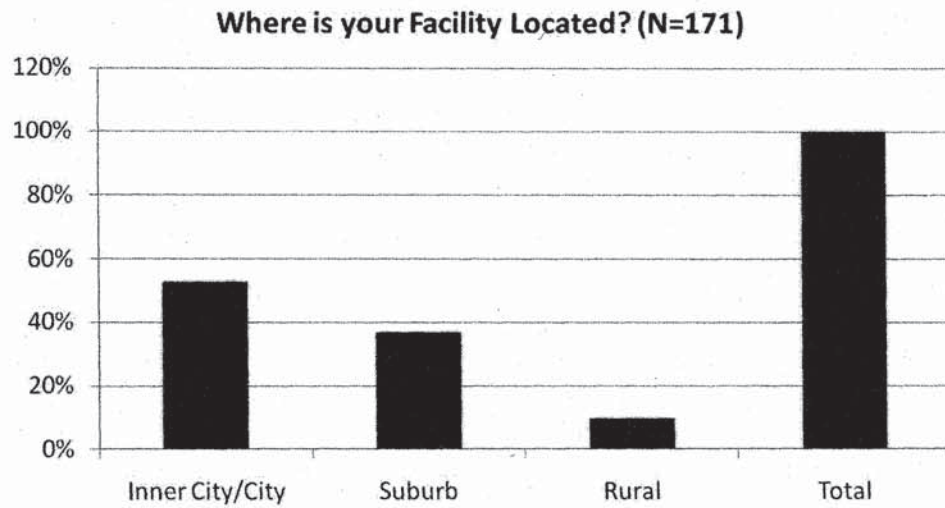
HEALTHCARE FACILITY CHARACTERISTICS

General demographic questions about healthcare facilities were

Graph 8



Graph 9



added to the 2010 IAHSS survey in order to provide information about the types of facilities represented in the survey. Previous surveys have not included such information.

Type of Hospital

Graph 8 illustrates the types of facilities represented in the sample. The majority of healthcare facilities represented in this survey were general public not-for-profit hospitals (73%) followed by ambulatory healthcare facilities, and specialty teaching hospitals. It is interesting to note that for-profit general hospital facilities were least likely to participate in the 2010 survey.

Location

Where healthcare facilities are located often contributes to security challenges. Healthcare facilities that are located in the inner city are generally more likely to have a higher incidence of all types of crimes. In this sample, the majority of facilities were located in the inner city or city (53%) followed by suburban healthcare facilities (37%) and rural hospitals (10%). Graph 9

illustrates the distribution of hospitals in this sample.

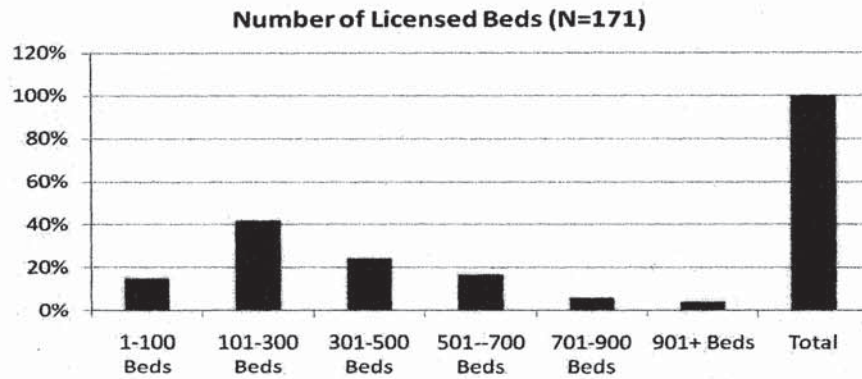
Number of Beds

The number of hospital beds is an indicator of the size of the hospital. Graph 10 indicates that sixty-eight percent of hospitals/healthcare facilities were medium-sized with 101–300 beds. Only 15 percent were small with 1–100 beds. In addition, 20 percent of the sample reported the number of beds at 501- to over 901, clearly demonstrating that these were very large hospitals.

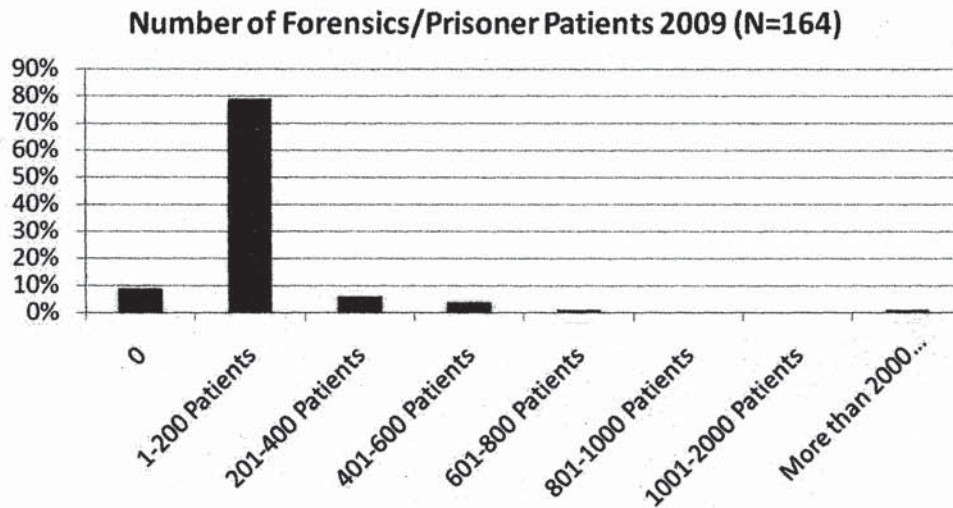
NUMBER OF AND TYPES OF FORENSIC AND PSYCHIATRIC PATIENTS SEEN IN THE EMERGENCY DEPARTMENT IN 2009

A growing concern among security professionals involves the number of forensic/prisoner and psychiatric patients treated in healthcare facilities. These patients tend to carry higher risk in terms of potential violence and danger to staff. Research studies, previously cited, report that the emergency department is often the scene of violence and aggression against staff, visitors and patients.

Graph 10



Graph 11



Respondents were asked to provide summary information on how many forensic and psychiatric patients, on average, were seen in the emergency department in 2009. Graph 11 provides that information.

Types of Patients seen

Tables 5–8 present additional information about the number of forensic and psychiatric patients seen in 2009. Since this is the first time that the question has been asked, it is not known whether this represents an increase or decrease although national data suggest that all emergency departments are experiencing a substantial increase in the number of annual visits to emergency departments. In following surveys, IAHSs will establish and track trends associated with these particular types of patients.

TYPES OF INFORMATION NEEDED FROM IAHSs

A number of questions that allowed for text responses were asked in the 2010 survey. These questions elicited rich information and varied responses. In the final question, input was solicited from respondents about what kinds of

information they would like to see the IAHSs Foundation collect to assist members in improving their healthcare security departments. Association members' responses fell into two broad categories: more information about workplace violence; and, best practices and exemplary policies in healthcare security.

Workplace Violence and Related Issues

Most respondents indicated that they would like more data and general information on workplace violence including:

- Incidence rates and the number of security staff injured or killed in the line of duty
- Use of weapons by security staff
- The number of hospitals using metal detectors and their effectiveness in preventing crime
- How to better secure healthcare facilities
- Ways to improve access control
- Managing aggressive or substance abusing patients
- Information about satellite facility security and vulnerability assessments
- Comparisons on the quality and effectiveness of training provided

Table 5. Number of Forensic/prisoner in-patients seen in 2009

	Number	Percent
0 patients	14	9%
1-200 patients	129	79%
201-400 patients	10	6%
401-600 patients	7	4%
601-800 patients	2	1%
801-1000 patients	0	0%
1001-2000 patients	0	0%
More than 2000 patients	2	1%

Table 6. Number of Forensic/prisoner out-patients seen in 2009

	Number	Percent
0 patients	14	9%
1-300 patients	125	77%
301-600 patients	10	6%
601-900 patients	7	4%
901-1200 patients	1	1%
1201-1500 patients	1	1%
1501-3000 patients	2	1%
3001-5000 patients	2	1%
More than 5000 patients	1	1%

- by private contract services versus proprietary security
- Recommended competencies for all security staff
- Ways to reduce violence and staff time/resources in Emergency Departments

Best Practices and Exemplary Policies

A great deal of interest was expressed in the area of exemplary policies and best practices. Respondents requested that studies be conducted and publications be disseminated about:

- Remediating and de-escalating violence
- Procedures used to prevent infant/child abductions or other kidnappings
- Ways to standardize report forms
- Standardized evaluations, policies and procedures so that all healthcare facilities are collecting the same information
- Information about exemplary practices, policies and procedures for dealing with local police
- Information about the best ways to use technology in security practices
- Publications detailing best practices for handling all major security problems

- Publications offering methods for obtaining additional resources and hiring new staff
- Collecting information about exemplary procedures for handling psychiatric patients

Several specific recommendations were made for the Association that included convening hospital administrators to educate them about security issues and changing IAHS accreditation to include new and emerging trends in healthcare security to ensure that security professionals remain on the cutting edge.

DISCUSSION

Respondents to this survey predominantly represented general public, not-for-profit hospitals. Although the specific reason for this finding is unknown, it may be that public hospitals are less reluctant to share information because they are often required to provide information to government agencies.

According to the findings of this study, the overall number the crimes reported in 2009 was significantly higher, in most instances, than the number of crimes reported in 2004. This supports other recent research reporting higher rates of

Psychiatric Outpatients

Table 7. Number of Psychiatric outpatients seen in 2009

	Number	Percent
0 patients	14	9%
1-500 patients	64	40%
501-1000 patients	24	15%
1001-3000 patients	14	9%
3001-5000 patients	4	3%
5001-8000 patients	4	3%
8001-10,000 patients	4	3%
10,001-15,000 patients	4	3%
15,001-20,000 patients	0	0%
20,001-30,000 patients	3	2%
30,001-50,000 patients	2	1%
More than 50,000 patients	2	1%

Psychiatric In-Patients

Table 8. Number of Psychiatric in-patients seen in 2009

	Number	Percent
0 patients	38	24%
1-500 patients	67	42%
501-1000 patients	19	12%
1001-5000 patients	26	16%
5001-10,000 patients	7	4%
10,001-50,000 patients	1	1%
50,001-100,000 patients	0	0%
More than 100,000 patients	0	0%

crime in healthcare settings. Specifically, the incidence of simple and aggravated assault reflects similar findings reported in the literature. The number of aggravated and simple assaults reported in 2009 is significantly higher than in 2004. The number of actual incidents of aggravated assault was more than two times greater than in 2004. Similarly, the number of reported cases of simple assault was nearly twice as many as reported in 2004. These findings are particularly significant in light of national trends. The rate of reported homicides has remained steady, but is likely to be under-reported when compared to recently published findings.

The findings indicate that there are areas of security in need of improvement. For the first time, the 2010 IAHS survey collected information about patient elopements. The actual number of patients who eloped was high with nearly eighty percent of healthcare facilities reporting that patients eloped one to fifty times in 2009. Since this is the first year that this question was asked, it is not known whether the total represents an overall increase in patient elopements, but the sheer number of elopements suggests this is important area that security

professionals may want to examine in light of personnel resource allocations and staff training, particularly among nursing staff.

Another series of questions were asked for the first time in the 2010 IAHS survey: how many forensic and psychiatric patients were treated in healthcare settings. These patients tend to carry the highest risks of violence and aggression when compared to the general patient population. Anecdotally, it has been suggested that the number of psychiatric and prisoner/forensic patients treated in healthcare settings, especially in Emergency Departments, has significantly increased in the wake of deinstitutionalization of psychiatric patients and the closing of prison-based healthcare facilities. The 2010 IAHS survey has now provided baseline data to compare the number of such patients treated in subsequent years to establish trends over time in this critical security area.

Citations

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