Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings

Executive Summary

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INTRODUCTION

Health care workers, especially those providing emergency and psychiatric care, have long been recognized as having a high risk of work-related assault. In order to respond to high rates of violence, many hospitals have implemented violence prevention programs that include such approaches as administrative policies, physical security, and employee training.

Several efforts to require such programs are in place. For example, hospitals must show a written security plan that includes violence prevention when reviewed by the Joint Council on Accreditation of Healthcare Organizations (JCAHO). California, in particular, has been at the forefront of efforts to reduce healthcare facility violence. In 1993, the California Occupational Safety and Health Administration (Cal/OSHA) released "Guidelines for Security and Safety of Health Care and Community Service Workers," which was the first statewide effort to control violence in the health care setting. These guidelines are supported by the California requirement that all businesses have an Injury and Illness Prevention Program (IIPP) (Title 8 Section 3203) that requires all businesses to take steps to reduce known workplace hazards, including violence. In addition, California passed the Hospital Security Act (AB508-Speier) in 1993 that required all hospitals to conduct a security assessment and implement a violence prevention program by July 1, 1995.

Despite efforts to decrease hospital violence, no systematic studies have been conducted to identify the security program elements implemented by different hospitals. The goal of this report is to describe the violence prevention and security programs in hospitals, and to identify gaps that could improve the effectiveness of these programs.

METHODS

The sample of participating hospitals included 135 from California and 54 from New Jersey. Information about the violence prevention and security programs were collected from Emergency Departments and Psychiatric Units and Facilities. Information about hospital security programs was obtained from interviews with several key informants, an on-site walk-through, and from printed documents provided by the hospital. Key informants included, for each unit, the unit nurse manager, the hospital's

Risk Assessment Director or Security Director, and one or two staff members on the unit. Documents requested from each hospital included training materials for medical and security staff, written policies, and forms for reporting violent events.

RECOMMENDATIONS

We found that almost every hospital had taken some steps to reduce violence. Although many hospitals had comprehensive programs, many other programs were severely deficient. Based on our findings, we have several recommendations:

- Hospitals could benefit greatly from improved surveillance and reporting. Many hospitals had no ongoing methods to track and learn from reported violent events. Other hospitals had multiple, nonoverlapping reporting systems that could not provide an overall picture of the violent events that had occurred. Ongoing examination of reported violent events is the best method to develop evidence-based and tailored programs that work well in each specific hospital environment.

- Enhanced efforts should be made to encourage coordination between health care and security staff. Medical and security staff rarely reported training together, and medical staff often reported dissatisfaction with security staff. The few hospitals that had coordination between medical and security staff reported very high satisfaction rates.

- Training programs need to be tailored to the specific hospital environment. Specifically, they should include a review of trends in violent events and information on hospital policies, procedures, and security equipment. While most programs addressed the major issues in violence prevention and response, the information was predominantly from an outside source with no integration with specific hospital information. We recommend that systematic evaluations of these training programs be evaluated to identify the most effective and efficient methods to deliver workplace violence training, including training content, length, modality, and trainer fidelity.

- Although all hospitals trained the majority of personnel in the ED and Psychiatric units, no hospitals trained all employees regularly stationed in the unit (for California hospitals, this is specified in the law). The most common omissions from training were physicians and contract employees of all job categories.

- Workplace violence training often occurred on a recurring schedule, and sometimes only once per year. Employees hired just after one of the scheduled training sessions may work in the unit for a very long time before receiving any formal training.

- All hospitals had installed security equipment and made attempts to control the physical environment. While some of these efforts were highly sophisticated, some were uncoordinated and insufficient to protect the unit. We recommend that security equipment be installed in response to specific hazard assessments conducted by trained security personnel in conjunction with their unit staff, and that scientific evaluations be conducted to identify the most effective equipment within different hospital settings.

- Few hospitals had effective systems to communicate about the presence of violent patients. The most common system used a tag within the chart, which is not accessible to non-medical personnel, including security guards.

- In general, security programs were less complete in Psychiatric Units than in Emergency Departments. Psychiatric facilities were less likely to rely on security equipment and security guards, and had less rigorous training programs. They also had higher rates of reported violence.

- Many of the facilities were not aware of existing sources of information about reducing violence, such as Cal/OSHA or OSHA Guidelines. Security and Risk Assessment personnel were more likely to be aware and to use them. Reference to these initiatives were not present in the printed materials provided for policies or training.