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Is your hospital prepared if a crime should occur on your campus?

Sentinel Event Alert focuses on violence in health care settings

A couple enters the emergency department — the wife with a black eye and fresh bruises on her arm. She tells registration she fell down the stairs. A man hooked on drugs comes to the emergency department with a gunshot wound; he clearly is still "under the influence" and is showing signs of aggression and paranoia. A woman delivering her baby at the hospital seems afraid that her boyfriend may visit her. Such situations could, and should, signal at least the possibility of a situation that could escalate into violence or other crime. All hospital staff should be able to spot "red flags" and alert the organization's security department. Identification is the first step in mitigating or de-escalating violence in health care settings, says **Joe Bellino**, CHPA, HEM, president of the International Association for Healthcare Security & Safety (IAHSS) and system executive, security at Memorial Hermann in Houston, TX.

According to The Joint Commission's latest Sentinel Event Alert, violence in hospitals is on the rise, and due to under-reporting, the only data the organization has on such occurrences may not reflect the true numbers of crimes committed. *(To read the entire alert, go to http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_45.htm for the entire alert.)*

The alert — "Preventing violence in the health care setting" — focuses on assault, rape, and homicide of patients and visitors at the hands of staff, visitors, other patients, and "intruders to the institution." Including those three categories of crime, The Joint Commission's Sentinel Event Database holds 256 reports since 1995, with a caveat that those numbers "are believed to be significantly below the actual number of incidents due to the belief that there is significant under-reporting of violent crimes in health care institutions."

Michael R. Parks, director of security at Mercy Medical Center in Baltimore, says he was not surprised by the issuance of the alert. "I'm not surprised at all. In fact we, those of us who are in the business of security for health care organizations, have seen an increase in the years of violent acts being committed in the hospital settings and health care settings. This is not news to us," he says.

"I don't know where [The Joint Commission has] been for so long," says Bellino, in response to the alert.

"OSHA addressed this issue with workplace violence standards back in

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the 90s, [which] was promulgated by health care workers in California being assaulted and killed. So they put the workplace violence standard into place and then we, for lack of better terms, jumped on the bandwagon to address it," he says.

He says he and his peers were disappointed when The Joint Commission "18 months ago merged the safety chapter and the security chapter... Many of us felt they should have never combined it, because I feel it diminished security. Although I do agree that safety and security go hand in hand."

He does fear that the alert makes the problem seem more rampant than it is. "There's always crime, don't get me wrong. But it's not as bad as other areas of industry and business; we do have competent, highly professional security people and security officers doing their jobs," he says.

He points to the data provided in the alert: "Since 2004, the Sentinel Event Database indicates significant increases in reports of assault, rape, and homicide, with the greatest number of reports in the last three years: 36 incidents in 2007, 41 in 2008, and 33 in 2009."

"I think about the millions and millions of people that are being treated every day. One could argue that one [criminal incident] is too many, and I agree with that philosophy. I never want to have any of that happen at any of my facilities or any other hospital facilities," he says. "But 36 events over a three-year period out of [about 6,000 hospitals in the United States] doesn't indicate to me a rampant, aggressive-type crime spree. It's bad; don't get me wrong. I'm not saying it's not bad. But we have to deal with it, and I think we are. I think we're doing a very good job at it."

Ken Kizer, MD, MPH, consultant, has a unique perspective. Founding president of the National Quality Forum and responsible for introducing the first "never event" in 2001, Kizer sees a parallel between the recognition of violence in the health care setting to the beginnings of the patient safety movement in the mid-1990s. Kizer, who has researched and written about serial murders committed in health care settings *(see story on page 80)*, says, "By and large, I think many hospital administrators — not just directors, but the whole management team — do not know and just don't understand that these events do occur, even though as we pointed out [in the articles I have written] that there's been dozens of them over recent years. When they read about them, they, or at least the response I've gotten from them and colleagues, is 'Well that's there. That couldn't happen here.'

"I think, one, there's a lot of lack of knowledge or awareness that these events occur, and I think among those who may have read about it or heard about it, there is a lot of resistance to accepting the idea that it is significant," he says.

Kizer says health care had the same response — "Those things happen, but not at our hospital" — when the patient safety movement, and issues such as medication errors and wrong-site surgeries, started about a decade ago. "The first thing is for people

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just to understand that these events occur, and they can occur anywhere. Just to have that mindset, being open to the possibility, as disturbing as that might be, but just to recognize that it can happen."

Joint Commission requirements

Identifying and mitigating or preventing violence from occurring is a hospital's duty; just as a hospital is responsible for treating its patients, it is responsible for keeping those patients and its staff safe.

Parks says to fulfill Joint Commission standards a hospital should:

- "identify safety and security risks associated with the environment of care, and these are risks that are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analyses, results of annual proactive risk assessments of high-risk processes, and also from credible external sources such as Sentinel Event Alerts and from law enforcement";
- take "actions to minimize or eliminate identified safety and security risks in the physical environment";
- identify "individuals entering its facilities... and determine which of those individuals would actually require identification";
- control "access to and from areas it identifies as security-sensitive";
- implement "written procedures to follow in the event of a security incident including infant abductions or pediatric abductions";
- follow identified procedures when a security incident occurs.

"A strong and robust security management plan is absolutely paramount, and that plan needs to be an ongoing process where we keep trying to determine whether or not that plan meets the needs of the organization at that time. And if not, then we need to make adjustments. But then annually we review that plan for its effectiveness to make sure it's doing as we anticipated it to be doing," Parks says. In that plan, you want to define access control policies, workplace violence practices, and police presence in your facilities. *(See story, page 79.)*

The first step in creating a plan and corresponding policies is identifying the crime trends in your locale, he says. Experts agree that the most notable areas for risk of criminal activity include: the emergency department; pediatric units or hospitals; labor and delivery and any units that house mother and baby; and the pharmacy. To understand local crime trends, it's crucial you build a relationship with your local police department or sheriff's office and include them in your annual risk assessment or vulnerability analysis.

Kristen Kenst, JD, MBA, manager of risk services at Community Mercy Health Partners in Springfield, OH, says one method to assess crime rates and statistics is to use the hospital's mortality and morbidity committee to review incidents that happen within the hospital. Last year, along with her manager of security, she met with the chief of police and members of the county sheriff's department "on the ways we could further the relationship we had with them." Being new to the area, she wanted to get a better sense of the trends in the community "and how we could best prepare to handle that from a hospital risk standpoint."

Following that conversation, a policeman came to the facility to hold a nonviolent crime intervention training program for staff in security, the ED, and the birthing center. After training, one hospital conducted a "code silver" drill, simulating a hostage situation to gauge the training's effectiveness.

For Community Mercy, the local police department's special operations team participated in the code silver drill. Now, almost a year later, Kenst is preparing to do another drill "to again assess the current state of our community, see what's changed over the last year, determine whether or not we need to consider new or additional resources, and then see if there's any opportunities that we can explore that will further strengthen our relationship with local law enforcement."

One trend the team uncovered from conversations with police was an uptick in drug-related crimes and break-ins resulting from the down economy. For drug-related crimes, understanding how to treat those patients became an initiative, Kenst says.

"It's about equipping the emergency department with the tools it needs — for example, the nonviolent crisis intervention training — to be able to handle those patients who come in and are coming down [from a drug] or still on a high, to work with them and create a safe environment, not only for the patient but for the other people [in the ED] as well." Drug-related crimes also present other situations that could easily escalate. For example, often a perpetrator or a victim will come into the hospital with the police who are doing an investigation. The family of the opposing side often comes into the ED to hear what is said in the conversation with police. Mitigating situations like these became priority. To address the increase in break-ins, the organization stepped up security guard rounding in the hospital and its parking lots.

Bellino recalls working at a hospital that was seeing a number of break-ins. Security ultimately caught the perpetrators. "The word on the street was, 'Don't go that hospital. They have a good security department. They have cameras everywhere. You'll get caught. You'll go to jail.'

"Our crime rate went down exponentially. You want to publicize your successes. A lot of people are afraid to do that, but I think when you can use security as a marketing tool — you have a safe and secure environment that has a great balance between customer service and the enforcement model of security — you really can use that to your advantage."

Bellino also suggests using websites that will report all the crimes committed in your area, such as www.spotcrime.com, and following guidelines, such as ones developed by IAHSS. *(See page 77.)*

Engaging staff housewide

Parks says it's also essential to communicate information about trends to staff. For example, he says, crime numbers tend to increase in the winter, especially around Christmas. "You should alert your staff about the potential of becoming a victim of an assault or worse, and things that they can do to reduce their chances of becoming a victim. You alert them either through crime prevention bulletins or by becoming involved in a patient safety fair at your hospital."

Bellino suggests talking to staff about de-escalating situations that could result in violence. "Everywhere I've been where we've worked with the psychiatric staff, nursing, security, we've decreased violence."

Executive director, security and parking, at UPMC Presbyterian Shadyside and Magee-Womens Hospital of UPMC, **Don Charley**, says he runs an annual computer-based training session with staff, as well as alerting them through in-house newsletters about security matters they should be aware of.

At Mercy Medical, Parks says four staff employees are certified instructors in a program offered by the Crime Prevention Institute. "We're training a cross-section of security emergency room clinical staff, receptionists who deal with patients and visitors coming in, the people who work in the field of registration, and social work on how to deal with preventing and intervening in crisis situations," Parks says. The program is held at least twice a year by the Crisis Prevention Institute "to help our staff identify when someone is in crisis and then how to minimize the risk of that escalating and then it becoming an act of violence. That's been very helpful for us."

He also communicates regularly with risk managers and senior leadership because they "can make recommendations about changes to our environment" and perhaps get financial help to fund such changes. Bellino says in every institution he has worked throughout his career, he has built a strong relationship with the quality improvement directors and has sat on the quality council, where he can speak to board members. He encourages his staff to familiarize themselves with all staff members. The philosophy that security is the security department's problem is a broken one, he says. "Security is everybody's issue."

How can you work with and help your security director? Charley says his hospitals' quality improvement team has helped him understand how the patient population is changing. For example, one hospital in the multi-hospital system closed, and another facility was handling the majority of the overflow in its ED. QI, he says, "helps us understand that trending, those kinds of statistics, how things are changing."

Parks recommends networking with other hospitals in building your security management plan. "Why reinvent the wheel if there are other plans out there that will fit your needs? You just have to tweak it to your specific campus."

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Common threats and how to deal with them

Assault, domestic violence, prisoner patients

Experts *Hospital Peer Review* spoke with say some of the most common criminal activity in hospitals involves assaults by patients on other patients or staff; patients in psychiatric units; patients on drugs; prisoner patients; acts prompted by domestic violence; patients on drugs; and gang members or VIP patients. All present unique challenges.

Assaults, sexual crimes

Don Charley, executive director, security and parking at UPMC Presbyterian Shadyside and Magee-Womens Hospital of UPMC, says, "I think assaults

Guidelines from the International Association for Healthcare Security and Safety (IAHSS)

Program Management
Violence in Healthcare
STATEMENT: Healthcare Facilities (HCF's) will implement an interdisciplinary protocol addressing workplace violence prevention and response.
INTENT:

a. The protocol should elaborate on the five main components of an effective safety and security program, whose components also apply to preventing workplace violence:
   1) Management commitment and employee involvement
   2) Worksite analysis
   3) Hazard reduction and response
   4) Training
   5) Record keeping and program evaluation
b. A multidisciplinary team should be appointed to develop and maintain the workplace violence program. The team should have express support of the facility's CEO along with authority for the program.
c. Security should have a clearly defined role in the HCF's workplace violence program. Security often takes the lead role in coordinating the team. The team should receive orientation and training in evaluating and responding.
d. Each HCF should establish a system such as patient record flags, electronic warnings, chart tags, log books, or verbal census reports that identify patients and clients who may present assaultive or threatening behavioral challenges.
e. Each HCF should establish policies and procedures prohibiting the carrying of firearms and other weapons onto the facility with the exception of authorized law enforcement officers, weapons carried by the facility's security, and others specifically authorized, such as armored car personnel.
f. Each HCF is encouraged to post 'No Weapons' type signage at entrances to the facility.
g. Each HCF should incorporate Targeted Violence protocols (written in accordance with IAHSS Guideline 02.02.01-Targeted Violence) into its Violence in the Workplace policy or create a separate policy for preventing and responding to targeted violence (including domestic violence).

REFERENCES:

— Violence Occupational Hazards in Hospitals, DHHS (NIOSH) Publication No. 2002-101, April 2002
— Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, U.S. Department of Labor Occupational Safety and Health Administration OSHA 3148-01 R 2004
— Workplace Violence Prevention and Response Guideline, ASIS International, ASIS GDL WPV 09 2005

Program Management
Violence in Healthcare
Targeted Violence
STATEMENT: Healthcare Facilities (HCF's) will provide responses to manage targeted violence.
INTENT:

a. Definition: Targeted Violence — a situation where an individual, individuals or groups are identified at risk of violence, usually from another specific individual such as in cases involving domestic violence. Often the perpetrator and target are known prior to an incident.
b. The three major functions of a threat assessment are: identification of a potential perpetrator, assessment of the risks of violence posed by a given perpetrator at a given time, and management of both the subject and the risks that he or she presents to a given target. The level of threat will determine the scope and timing of the response.
c. The HCF policy should identify responsibility of staff to report a risk of targeted violence as quickly as possible so that the threat can be assessed and preventative measures can be initiated as required.
d. Mechanisms should be in place to encourage reporting of threats where personal safety may be at risk.
e. All identified threats of targeted violence should be treated seriously and assessed through a process that analyzes the threat and recommends the appropriate level or type of intervention to be initiated.
f. Security should play a lead role in the threat assessment process and design of any safety plan.
g. HCF staff involved in the process of assessing the threat to determine the appropriate level and type of intervention required should receive training for this role.
h. Where warranted by risk in specific circumstances, HCF's should employ preventative measures to protect the potential target. Measures should include:
   1) Placing a no information/privacy block on patient information system or, if a worker, protecting information related to work location
   2) Communicating with security to provide updated information
   3) Information to be shared with workers or other individuals in the area as appropriate
   4) Involvement of staff or family members for support as necessary
   5) Consideration of moving the person at risk to another care area or another site
   6) Restriction on visitors or access to the potential target, including lockdown of the area if required.
   7) In appropriate circumstances notify law enforcement
   8) Document risk and preventative measures initiated
i. The safety of the potential victim should be of paramount concern at all times.

REFERENCES:

— Canada, Department of Justice, "Criminal Harassment: A Handbook for Police and Crown Prosecutors."
— US Department of Justice, National Institute of Justice, "Threat Assessment: An Approach To Prevent Targeted Violence."

are probably one of the largest categories, both physical and, particularly, verbal assaults (patient visitor to health care worker) seem to be where we spend a lot of our time... The thing that I've noticed in my career is that there's factions of families that have never gotten along and they have a loved one in common. The hospital can bring all those factions together, and a lot of those old grievances play out in this setting, and that's certainly another area we deal with a lot."

Beatrice Yorker, JD, RN, MS, FAAN, dean of the college of health and human services at California State University Los Angeles, says, "When I saw [The Joint Commission's Sentinel Event Alert on violence in hospitals] I was very, very pleased to see that they recognize crimes by health care workers because I have expanded my topic when I give presentations, and I talk about the sort of slew of sexual assaults, particularly in pediatric hospitals or an area in where the patients are compromised — developmentally delayed or comatose — things like a nurse's aide taking photographs of a patient's genitals on their cell phone and then distributing it on the internet."

Another situation she sees, which she says is too often minimized, is "when patients sexually assault other patients, like in psychiatric hospitals." She recalls one case of a 13-year-old female patient placed in a co-ed inpatient psychiatric unit. Two 16-year-old males entered her room and sexually assaulted her. "The nurse punishes all three of them for sexually acting out, never reporting it as a sexual assault until a couple of days later when in therapy the girl is clearly traumatized," Yorker says. In another, similar case, the female patient was taken to the rape crisis center but the case was never reported as an incident.

Domestic abuse

Michael R. Parks, director of security at Mercy Medical Center in Baltimore, says the hospital "has a very robust workplace violence policy. Security works very closely with the human resource department to identify those employees who are victims of domestic violence or whether or not there's an employee act of violence, be it a relationship that's gone bad or just heatedness between one coworker and another. So we do everything we can to identify if there's a chance for those types of incidents to find themselves on our campus."

If there is a domestic abuse situation and the offender is not an employee, the security team asks the employee:

- Has the offender been on the campus before?
- Does the offender knows where exactly the employee works?
- Does the offender have a criminal record or a criminal history?
- Are there weapons in the home?
- Does the employee believe the offender would come to the campus?

Security alerts other staff about the situation and tries to obtain a photograph of the offender, even though it's kept confidential. "We wouldn't want all the hospital employees to know that Mary Jane has a domestic issue. We do alert our staff and have these photographs posted in security locations so that in the event that we think that that person may come through, we can make a quick identification and call law enforcement."

To encourage staff to come forward with the issue, security includes discussions of domestic violence in the hospital's new employee orientation. It also has a domestic violence unit on campus, and the director presents to all new employees. "I give a similar presentation encouraging employees that if they're the victim of abuse or if they overhear an employee who's talking about an abuse and they believe that violence or abuse could find its way on our campus to call us," Parks says. Patients are also asked at registration whether they are victims of domestic abuse and whether they believe their abuser may come to the campus.

Domestic violence or paternity/financial issues can also present problems in mother/baby units, Parks says. **Joe Bellino**, CHPA, HEM, president of the International Association for Healthcare Security & Safety and system executive, security at Memorial Hermann in Houston, TX, suggests staff also look for instances of domestic abuse — for instance, if a couple walks in and the wife is bloodied and bruised.

Prisoner patients

With more than 700 prisoner patients coming through its facilities each year, Mercy Medical has implemented a number of policies to address this population. Parks says the problem is one many hospitals have to consider. "Many, many hospitals across the country deal with the issue of prisoner patients, or forensic patients, because there have been a number of documented cases where a prisoner patient has escaped or attempted to escape from a hospital setting, taken an officer's weapon, and either killed the officer that was guarding them or shot someone during their escape," he says. "You really need to have a very strong prisoner-patient policy in place and communicate with the leadership of those various law enforcement agencies that bring

prisoners to you and what your expectations [are]."

A security officer with a canine visits each prisoner patient admitted. Mercy's policy requires that all prisoner patients be accompanied by two officers throughout their stay. "We deliberately go to that patient care room and engage these folks in conversation and let that prisoner patient see that dog, and I think it just sends a very subtle message that if that prisoner patient is contemplating an escape attempt that maybe he may not want to do that. Because they never know where that dog is going to be. We find that very helpful," he says.

He says Mercy is the only hospital in Baltimore to require prisoners have two police escorts. "Mercy had an incident here a couple of years ago where we just said to all the agencies that bring prisoners here, 'Effective immediately, you must have two guards with every prisoner patient,' and we haven't deviated from that in the last several years." ■

Access policies: A hard or soft approach?

Assessing your hospital's threats should help you address what type of police or security presence you should have. And just as crimes vary by community, security presence differs by institution.

"I'm an advocate for a strong access control policy to be able to identify those areas where folks cannot get in unless they have the proper electronic badge access to get into these areas," says **Michael R. Parks**, director of security at Mercy Medical Center in Baltimore.

"For example, if there's an incident of potential workplace violence where one employee may work behind a closed area, a sensitive area, you certainly wouldn't want somebody to be able to walk into that area to carry out an act of violence." That area, he says, should be protected so that only workers with a specific level of access can enter.

The facility also require visitors to have passes and to identify upon entering the facility which patient they are coming to see so the hospital can verify that patient is in-house. "A security officer is also there at the elevators to make sure that those who are accessing patient care floors have gone through step one and had identified the fact that there is a patient here," he says.

"Some of the other things that we do, specifically as it relates to the mother/baby delivery area, we've required folks to give their photo ID before they're given access to go to those floors."

The hospital happens to be going through the process of crendentialing vendors with direct patient contact. "It's very easy to have these companies out there do all that homework for the hospital," by checking that the individuals who come to the facility fit "all the requirements that need to be in place before they're allowed to visit patient care areas," he says. "You have to have a robust visitor access plan in place, specifically as it relates to clinical contractors or vendors as it relates to patient care. So you just don't have everyone willy-nilly going to patient care floors because they want to sell a product or they're trying to get the ear or attention of a particular physician or what have you," he says.

"Mercy has something unique that the majority of hospitals do not have. And that's a canine unit. We actually have authorized five teams of handlers and dogs, and these dogs are trained in explosive detection, crowd control, obedience, handler protection, etc.," he says. They commonly round in the ED. "The mere presence of that dog seems to have a very calming affect on people who are acting out. We don't make it a point to call attention to that patient with this dog. We just happen to walk through. It has reduced criminal activity and incidences of assault. I'm confident of that," Parks says.

"Personally, I like a uniformed security officer," says **Joe Bellino**, CHPA, HEM, president of the International Association for Healthcare Security & Safety and system executive, security at Memorial Hermann in Houston, TX. "I think they present a high level of visibility and professionalism. They're what we call 'squared away,' and you keep them moving. Then what happens is you develop a perception, whether real or not, that there's a heavy security presence and you can do that by keeping your people moving."

Flexing security staff in the future is going to be a big focus, he says. "I keep my shifts pretty well rounded because they're all very busy. What helps at night is to have a better screening system. I know most hospitals are open during the day, but at night you start to concentrically close down so that you have one point of entry at night and you can screen people and keep the bad element out," he says. "Don't leave your doors wide open at night. At night, a hospital is like a hotel with sick people, and we can't lock patient rooms, so we have to do a better job at the front room."

Kristen Kenst, JD, MBA, manager of risk services at Community Mercy Health Partners in Springfield, OH, says her facility limits access by having only two access points — the main entrance and the ED. For employee-only areas,

one must have a key. At the critical access hospital in the system, doors are locked at night.

"Right now we don't have metal detectors or wands. We do have security guards who are present 24/7, more than one on a shift, who do frequent rounds in the emergency department, but I wouldn't say that we necessarily block access. We don't have visiting hours so family are free to come anytime of the day or night, but we do maintain a security presence all the time as well," she says.

"We try to have kind of a mix of both [a hard and soft presence]. On our perimeters we like to have our officers dressed in more of a hard uniform; they usually use the LAPD blue uniform," says **Don Charley**, executive director of security and parking at UPMC Presbyterian Shadyside and Magee-Womens Hospital of UPMC. In the hospitals' ED, officers are in a "harder-style uniform."

"And then officers on the patient units are dressed more in a soft uniform with a blazer and tie," he says, adding that it's important to "strike that balance of a warm and welcoming presence for our visitors, but at the same time having a security presence."

At its flagship hospital, UPMC Presbyterian, there is a metal detector at the ED entrance, and "that's one of the areas we have a hard presence in terms of our uniform and style. On the weekends we do employ off-duty armed police officers to supplement our security force."

He characterizes the access control system as "extensive." "Our philosophy is trying to divide our facility into public space and private space. The public space is where people can come and go. As we get more in certain areas of the facility, we start tightening it down. Like our trauma units are access-controlled for the most part." For that unit, each patient is given two passes a day, which he or she or the primary care physician can give to family members. There's also a camera on the buzz-released door so if people try to enter without an access card, staff can talk with them and make the decision whether to allow them to enter. "We have some restrictions like that in our OB areas as well and our postpartum and labor and delivery," he says. ■

Serial murders in health care settings

The case of Charles Cullen is one of the most egregious cases of serial murder in health care settings, according to **Beatrice Yorker**, JD, RN, MS, FAAN, dean of the college of health and human services at California State University Los Angeles, who has researched and published in the field of forensic nursing. Cullen, formerly a nurse, murdered between 35 to 45 patients while working in 10 hospitals and ultimately received 11 life sentences.

Cullen's story was "just mind boggling. That really seemed to trigger a lot of response. But again, not enough response. They treated it as though he were the only one." That was the impetus of the article, "Serial Murder by Healthcare Professionals,"[1] Yorker co-wrote with **Ken Kizer**, MD, MPH, consultant and founding president of the National Quality Forum. The two also recently published another article on the topic.[2] *(To see more stories on serial-type murders in health care, visit http://www.trutv.com/library/crime/notorious_murders/angels/male_nurses/index.html or http://www.trutv.com/library/crime/notorious_murders/angels/female_nurses/index.html.)*

"That's what really prompted us to write our article, to say, 'Look, this is a huge problem.' The body count is probably larger than the garden-variety serial murder, like the Green River Killer, or the guys who go out and stalk women. They only get away with maybe eight to nine victims. Whereas the hospital serial killers, some of them have over 200."

The health care setting, she says, is a psychopath's dream. "First of all, you expect people to die. Second of all, you never treat it like a crime scene. Third of all, you don't do enough autopsies on death. The whole idea is when you're in a hospital, it is so normalized," she says. Often, nighttime or weekend shifts in hospitals, or in nursing homes that may have only one vocational nurse per unit for those shifts, are ripe for criminal action for these individuals because of less supervision and fewer personnel in-house, Yorker says.

Often these perpetrators go unnoticed, moving from one facility to another. Very few have a criminal background, so no one would be alerted when per usual protocol the human resource department conducts criminal background checks.

One of the only clues these types leave behind, Yorker says, is fabricating details about their lives — for instance, whether they were married or divorced or whether they were involved with any civil legal proceedings. The markers of the personality is they often are "crisis creators," and the problem with detecting an employee with psychopathic tendencies is "right now in health care you can't screen for whether you have a psychopath like you can in law enforcement and in the FBI and places like that. In health care, so far, that would violate people's civil rights. It's not done. But as soon as you have some hint that a health care provider has psychopathic ten-

dencies, particularly as it comes to falsifying credentials, that should be a huge red flag," she says.

Many hospitals and their counsels provide references believing that they are allowed only to offer dates of service. The belief is "'If we give a bad reference we could be sued.' Well, true. But only if it's an untrue reference and only if there were damages, and the damages tend to be in the $30,000 range. But if you give a truthful reference that when this nurse worked in your hospital, adverse patient outcomes increased threefold or something like that, first of all, that's not libelous or slanderous. It's true. And second of all, if you don't give that, you're looking at damages in the $8-$20 million range," she says.

Hospital legal counsels need to balance the risks and the benefits, she says. There was a case of a hospital worker who had eight "fire/do not rehire" notes in his files, but only one hospital released that information. He worked at about 20 facilities and patients died in his care every time he was on a shift, Yorker says.

"There's now case law that supports or that shows that facilities can be at risk for civil penalties if they don't provide this information, although I think the preponderance of concern among the risk management folks is that if they do provide the information they will be sued for libel," Kizer says.

Kizer says serial murders in health care settings often occur in smaller communities. "And often, in some of these smaller communities, it's maybe even easier to get away with it."

Yorker favors video surveillance systems to uncover these types of events. Kizer says in most cases that are discovered, colleagues had suspicions.

So in the absence of a criminal background and full reports from resources, what are clues to look for? "The things that jump out are obviously deaths or codes. Some of those codes are going to be successfully resuscitated. So those are two clear types of events that should be monitored on a regular basis, and they really should be monitored on a unit-by-unit basis. And someone should be looking at that," Kizer says.

"The benefit of doing that is less to pick up criminal activity than a standard-of-care problem. It might be harder to justify it if you were just looking for criminal events. But the reality is, if you look for it you're going to find all kinds of things. So there's lots of benefit there," he says. "Now what's harder to pick up would be events that aren't fatal. Codes are kind of that transition. Assaults are often harder to access and track, and they aren't often as clear-cut."

Most cases are committed by woman, partly because the vast majority of hospital workers are women, Yorker says. "As a matter of fact, men are overrepresented in our data, especially when you look at the nursing because only 7% or 8% of nurses are male and yet 38% of the nurse murderers are male." She says society "has ignored or has not paid attention to feminine forms of violence and murder. We are very well versed and we're very opposed to male forms of violence. That's bludgeoning, that's gun shots, that's strangling, that's beating. What we are not as aware of, and much more tolerant of, is feminine forms of violence, which is poisoning, smothering, sort of killing in the context of caretaking."

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ACCREDITATION
Field Report

Pain assessment, documentation TJC focus

With its latest survey, beginning May 25, 2010, and ending May 27, Holy Family Memorial had the most surveyors it ever had — seven — and its first life safety survey. **Mary M. Schilder**, quality management, accreditation/CME coordinator, and privacy specialist, says the surveyors, who visited "every single clinic and department," were "very educational."

"They gave us a lot of different forms that they downloaded for us to be able to drill down into data... They say that the survey agenda is negotiable. It truly is. There were no times listed on it. We could go ahead and work with them on the first day as to when we wanted to do things," she adds.

Prior to the survey, TJC sent an agenda, but if a particular person was unavailable at a certain time, she says, the surveyors were amenable to shifting things around. "If our CEO was busy in the morning, they would move something to the afternoon," she says.

But unlike past surveys, she says the surveyors didn't focus on the National Patient Safety Goals. She says it was truly based on tracer activity. "Everything was done by tracer," she says. "So if there was a

National Patient Safety Goal involved in that patient tracer, of course they looked at it, but they didn't go in looking for compliance on the National Patient Safety Goal. They would pick our patient and they would basically work from that point backwards until the entry into our system and looked at every single department and person and order, etc."

With an electronic medical record system for both the inpatient and outpatient side, she says the survey flowed much better. "What we found was really helpful is, we had two experts for the surveyors to go along and be able to pull up things on those records very quickly. And that they really liked. They liked our ambulatory electronic record. They thought that we were light years ahead on that." It also eased other staff to have experts available to locate information on the EMR system, as it is still fairly new. The surveyors also praised how the systems for outpatient and inpatient care "talk to each other on multiple levels."

As part of the survey agenda, Schilder says, The Joint Commission sent a sheet detailing everything that would be needed as part of the survey. "We made sure that was all up to date and ready to go, and this is twice now we've done that, and both teams of surveyors have been very complimentary on that — that they didn't have to keep asking for things. We made sure they were in there and updated. You feel like at least you're starting off on the right foot," she says.

One thing the surveyors not only complimented the system on but asked if they could take with them to offer as an example of a best practice was Holy Memorial's admission assessment for its home care/hospice program. Schilder says as part of the hospital's work with Lean and Six Sigma processes, it found it needed to improve the admission piece. One nurse, she says, took it upon herself to do that, working with other organizations that had a good policies in place. The policy includes "everything from the social assessment to the physical assessment to medications, fall risks, etc. But then we took it one step further and, depending on who this patient was going to need from the community, we contacted them to see what would be helpful on that assessment form or if we needed to send it to them for assistance" she says. The policy addresses two central, and often problematic issues, for hospitals: continuity of care and handoffs.

She says pain assessment was a big focus in the survey, as well as documentation of education including patient education. "Those were two really, really big things. Our inpatient pain assessment is really well done. Of course, we have a lot of outpatient clinics, so now our goal is to get them in that mix to be able to do it as well as the inpatient. It's not that they're assessing pain. Oftentimes it's the documentation of it. And then what happens after you document it," she says.

She says the hospital is using the Lean process in developing its own pain assessment scale. "It really has to be a template," she says, not simply asking: What is your pain level and are you taking something for that pain? She says it should include:

• What level was your pain before you took your meds?

CNE QUESTIONS

1. Including assault, rape, and homicide, how many incidents since 1995 does The Joint Commission's Sentinel Event Database report include?

A. 156
B. 256
C. 324
D. 424

2. Identifying local crime trends is critical in developing a security management plan.

A. True
B. False

3. At UPMC Presbyterian, patients in the trauma unit are given how many passes a day for visitors?

A. 1
B. 2
C. 3
D. 4

4. Most perpetrators of serial murder in health care settings falsify personal information when they are hired.

A. True
B. False

Answer Key: 1. B; 2. A; 3. B; 4. A.

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

• Are you taking your meds?
• When was the last time you took your meds?
• Is it helping you?

"And then that needs to close the loop by going back to the physician with the report. I believe we're doing that. It's the documentation part of it [that we're working on]. We're going to have to build something into our ambulatory electronic record," she says.

On H&P timing and dating, an oft-cited standard for hospitals, she says Holy Memorial has improved by automating and requiring those fields be filled in the EMR.

Post-survey, she says, the hospital is reviewing some of its environment-of-care plans. "They wanted just a little bit more on the data things in there. We are looking at our emergency management plan. They really liked our emergency management plan, but one of the things that was missing or they thought wasn't addressed enough was what resources do we have to get our hospital and network back to normal after an event. Do we have the resources? Do we have the people? How are we going to let our people who've worked through all this get rest? Are there people to replace them?"

Another area, this one in life safety, the hospital is going to be looking at is its durable medical equipment service. Surveyors wanted that service to have its own disaster drill and also found some things that were outdated, such as sutures. "They probably haven't done sutures in that clinic since they were outdated. But because of that, we're going to have a policy in place. It's going to talk about a stop-gap so if there is an outdate that it's checked before use on the patient just so we have it as part of our standard work. So there's a stop-gap there."

As part of the hospital's falls program, the surveyors asked if it could further categorize risks. So, for example, she says, in the mother-child unit, surveyors "talked about changing that falls assessment from low risk until [the mother] can get up and ambulate because maybe she's still on some pain medications to change that up into a higher risk. And that was being done but again not documented. So we're going to have to put some kind of a flag on that in our system."

Her suggestion to other facilities preparing for their survey: Give surveyors their space. "Remember to be respectful of them and get out of their space and let them prepare for the day and just wait. That's all you can do."

(For more information contact: Mary M. Schilder. E-mail: mschilder@hfmhealth.org.) ■

Now live: Interim staffing effectiveness standards

As of July 1, The Joint Commission's interim staffing effectiveness requirements are in effect for hospital and long-term care organizations, as it continues to research the issues associated with the standards.

The previous standard was "onerous," says **Kurt Patton**, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission. In the previous versions, TJC "required all kinds of graphical analyses and different types of statistical analysis, and organizations kept saying that, 'No matter how much we analyze it, we're not seeing the numbers correlate to staffing issues."

"Really, most organizations pulled out that data when The Joint Commission surveyor was around and other than that it was fairly useless," says **Susan W. Hendrickson**, MHRD/OD, RN, CPHQ,

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

COMING IN FUTURE MONTHS

■ What is a world-class medical facility?

■ Building a pain assessment policy

■ Getting Joint Commission-certified for chronic kidney disease

■ Revisiting your med rec policy

FACHE, director of clinical quality and patient safety at Via Christi Wichita (KS) Health Network.

Patton says "the interim standards are actually a very positive change from the former standards. The key thing that I advise folks on is that this is a much easier requirement to fulfill — not something to get all worked up about."

The interim standards, he says, simply require that when a hospital has an adverse event, that it analyze the "potential effects" staffing had, looking at the number of staff and their qualifications.

He says to make your yearly report as simple as possible. First identify how many sentinel events occurred. Then look at the root-cause analysis done to analyze the impact staffing might have had. Look "at the numbers of staff, their experience in that work site, their competency in doing those particular jobs, and then whether or not they see anything that might have facilitated some of those adverse events from occurring," he says.

"And that is a narrative-type report. It just needs to show that you've tabulated how many incidents occurred and that you can summarize what the role of staffing, if any, was in each of those events, and then if you can draw some conclusions from it, that's great," Patton says.

"The idea is rather than trying to look at this data and find a correlation [with staffing] it's try to figure out if there are trends in these process failures that may or may not be related to staffing," Hendrickson says.

You're required, she says, to evaluate staffing with any untoward event. "For instance, let's say you get a fall, one of the things you look at as part of your analysis of that fall is who was working that day, how many people were working, what was their shift, what was their patient load, what was their competency, which is something I think we've all looked at for a long time and it makes sense," she says.

Let's say, though, that you see a large number of falls. You might discover you don't have a good method of evaluating the risks of patients falling. "So you would determine, maybe I need to put in a scoring system and maybe I need to train my staff on that. So you're still looking at the effectiveness of your staff, but instead of looking at it strictly in numbers — how many people did we have when these people fell — it's digging into it and doing more of an analysis of what's really going on with this staff," she says.

Multiple things can affect staffing effectiveness — orientation, training, supervision, work flow. "Your analysis is expected to show whether any of those processes had any effect on the event," she says. ■

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