Tasers as something to be used as a deterrent, as opposed to something that would be used as a common weapon.

"Tasers are always a last resort," he says. "Just because a patient doesn't get back in bed doesn't mean you can pull a Taser out on them. But as soon as you pull the Taser they are much more likely to comply. They understand there is a violent option. If they've been tased before, they realize, 'This will get my attention and I don't want any part of that.'"

(See this month's **Healthcare Security Alert** insert for a case study about how Tasers are used in a North Carolina health system.)

There may come a time when a security guard may have to use a Taser on a patient if he or she poses a real threat to ER staff, Smith says.

"If you allow them to carry, they say they'll never use it on a patient, but if a patient is committing a crime, they become a criminal and are no longer a patient," he says, adding that hospitals may have a tough time convincing regulatory agencies that using a weapon is justified.

"According to CMS rules, you can't use those devices on a patient, but on the other hand if you don't use it and someone gets hurt, you are at risk for liability. It depends on which way you want to be sued."

Guest column: Should ER docs carry weapons?

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In July, a patient shot and killed his case worker and wounded a physician at Mercy Wellness Center in Darby, Pennsylvania. The wounded physician then pulled a gun and shot the gun-wielding patient who was then subdued by other staff members in the clinic. That same week video was released from an incident that had occurred earlier this year in an ED in North Logan, Utah. In this incident, a patient entered the ED waiting room, pulled two guns, and demanded to see his doctor saying that, "Someone is going to die today." This patient was shot four times by law enforcement staff that happened to be on site for something unrelated.

After having been responsible for security operations in healthcare facilities since 1981, I could not help but analyze the police and security response, physical security measures (or lack of) emergency responders, public relations staff, and then the gun control and gun proponents during the news cycle or two after the incident.

The answer to the title queswtion is, of course, no. But what should hospitals do to reduce the potential for these incidents and to effectively respond when they do occur?

Violent crime is on the rise in healthcare facilities (HCF) across the country. Regulatory agencies have recognized this in recent years and The Joint Commission (TJC), and OSHA have published additional guidance on workplace violence incidents for surveyors and HCFs. Healthcare workers, particularly those that work in emergency and mental health settings are at higher risk of assault than almost any other employee population (think police, prison guards, and taxi drivers). Professional associations such as the International Association for Healthcare Security and Safety (IAHSS), Emergency Nurses Association, American College of Emergency Physicians, and others have all developed position statements and guidelines for assisting HCFs in mitigating violence.

The cause of this seeming increased level of violence in our HCFs are many and varied, but here are the generally recognized factors that contribute to violent incidents:

- Increased wait times in our EDs
- Unrestricted movement of the public in clinics and hospitals. Many HCFs have moved to "open visitation," meaning friends and family may visit anytime of the day or night. Some facilities are taking this to mean no limits on who or when persons may enter their facilities. I have no argument about the need for people to visit here, but there must be reasonable checks and balances

to limit risks to patients, visitors, and staff.

- Reduced inpatient "institutional" mental health beds for high acuity patients
- A general increase in patient acuity upon arrival in our EDs and clinics. Many acute and chronic mentally ill patients are being released from hospitals without follow-up care. These patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others
- Increasing use of hospitals by police and the criminal justice system for the care of acutely disturbed, violent individuals or as an alternative to already overcrowded jails.

So what can and should hospitals do? Each HCF should at a minimum take the following six actions to assess risk and implement measures to reduce the likelihood of an adverse incident and provide an effective response if one does occur.

1. Conduct a comprehensive evaluation of your security program. Reducing the likelihood of a serious incident involves a layered approach involving many aspects of security including policies, procedures, and training as well as physical security, design, and other factors.

A competent hospital security professional should lead this effort using a multidisciplinary team. Competent means someone with hospital experience and credentials (CHPA and/or CPP). The local PD may have some resources, but you want someone that understands healthcare.

2. Conduct workplace violence policy assessment. Evaluate your policy and make sure it has senior leadership support. There are several excellent resources to assist in this process including OSHA's "Guidelines for Preventing Workplace Violence for Health Care and Social Services Workers," and the ASIS Workplace Violence Prevention and Intervention Standard.

3. Assemble a threat management team. A threat assessment team will be part of any decent workplace violence program. Establish this team (usually composed of representatives from Legal, Security, Human Resources, Psychiatry, local law enforcement, and others depending on the resources readily available in your HCF). Train the team and use them for threats. This group gets better with experiences as with most teams.

4. Implement flag systems in electronic medical record. Develop policies and procedures for identifying threatening patients and family members, and patients with violent criminal records.

Patients and family members that have previously threatened and or assaulted staff in the past should be identified and flagged so staff members that encounter them in the future have the benefit of the previous experiences. This then allows them to take appropriate measures to protect themselves and others. The best predictor of future behavior is past behavior.

5. Design security into new construction and renovation projects. In the next decade there will be billions of dollars spent on new construction and renovation projects. This is a major opportunity to build security into each project. The IAHSS has developed security design guidelines for healthcare facilities. HCFs and healthcare systems should consider these guidelines and develop systems security requirements that each design project implements as a required part of any new project.

6. Training. Train staff in security sensitive areas on crisis intervention and security policies and procedures. Evaluate your current crisis training and consider if it meets your needs given this new era of violence toward healthcare and human service workers.

This is a call to action. It is easy to become complacent and think these things don't happen here. Every healthcare organization should consider the risks and take action to make sure you have reasonable, appropriate, risk-based security programs in place.

There could be some wiggle room for certain situations where a staff member may be allowed to carry a firearm. During the risk assessment process, each HCF should consider whether it needs an armed capability on its campus to be able to quickly respond to an active shooter situation.

A professionally trained and managed security department has many other benefits in addition to improved capability when responding to emergency situations. Staff and patient opinion scores are positively affected when there is a positive sense of security provided by the organization. These questions need to be considered as a part of the overall risk assessment. H