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# Emergency Department Workers' Perceptions of Security Officers' Effectiveness During Violent Events

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## Abstract

**Objective:** The emergency department (ED) is among the most at-risk settings for violence by patients and visitors against ED workers. A first response to potential or actual events of workplace violence is often contacting hospital security officers for assistance. The purpose of this study is to describe ED workers' views of security officers' effectiveness during actual events of verbal and/or physical violence.

**Participants:** Healthcare workers (n=31) from an urban pediatric ED in the Midwest United States. Methods: Participants were interviewed regarding their experiences with workplace violence. Verbatim transcripts were qualitatively analyzed.

**Results:** Six themes were identified: (1) a need for security officers, (2) security officers' availability and response, (3) security officers' presence or involvement, (4) security officers' ability to handle violent situations, (5) security officers' role with restraints, and (6) security officers' role with access.

**Conclusions:** It is important that early communication between security officers and ED workers takes place before violent events occur. A uniform understanding of the roles and responsibilities of security officers should be clearly communicated to ED workers. Future research needs to be conducted with hospital-based security officers to describe their perceptions about their role in the prevention and management of workplace violence.

### Keywords

workplace violence; emergency department; security officers; pediatrics

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Workplace violence against emergency department (ED) workers is an international problem with no ED immune. [1–12] Evidence-based interventions to halt this phenomenon are imperative in order to protect the workers who provide care to ED patients around the clock and around the globe. The Occupational Safety and Health Act clearly states in the General Duty Clause that all workers should be free from hazards that may lead to death or serious physical harm (13), including freedom from the hazard of workplace violence. Although several strategies are recommended to curb workplace violence, one strategy that is consistently identified as an integral component for success is the use of security officers. (14–15) While security officers are often involved in violent events that occur in the ED, there is a lack of published research as to the perceived effectiveness of the security officers as an intervention to mediate or moderate the workplace violence that occurs. The purpose of this study is to describe ED workers' views of security officers' effectiveness during actual events of verbal and/or physical violence.

## 1. Background

Security presence has been reported to reduce the incidence of violent events in EDs. [8, 16–20] Lee et al. [19] and Ayranci et al. [2] reported that the odds of a nurse being physically assaulted at work were reduced when there was a security presence. Conversely, an inadequate security presence has been a contributor to the occurrence of workplace violence in the ED. [14, 21] Gates et al. [8] studied workplace violence reported by 242 ED workers in a large health system in the United States. The researchers asked participants to rate their satisfaction with hospital security officers using a Likert scale of 1 to 5. The mean score for participants' satisfaction with security officers was 3.2, indicating no strong viewpoint towards satisfaction or dissatisfaction. Thirty-nine percent of the participants in the study also reported feeling unsafe or only occasionally safe in their work environments. It is possible that the neutral perception of security officers' effectiveness contributed to the participants' feelings of being unsafe. However, it was not clear if the neutral perception was due to a lack of effectiveness of security officers or a lack of enough security officers to prevent and manage workplace violence. A study conducted by Peek-Asa et al. [21] revealed that 66% of the 95 California ED leaders who responded believed that security officers were inadequately prepared to perform their job duties. Reasons for this belief were not reported.

Despite perceptions of ED workers and leaders, security officers will continue to have an essential and specific role regarding workplace violence in the ED. Security officers are consistently among the first persons requested to respond and assist when a patient or visitor becomes violent. [15, 22] Security officers may also perform additional roles related to the safety and security of an ED and for the ED workers. These roles include assisting in the restraint and observation of violent patients, managing visitor access into the main treatment areas of the ED, following-up on violent event reports, and participating in interdisciplinary workplace violence prevention and management training. [15, 21–24]

There are few studies addressing the role of security officers and workplace violence. Even rarer are studies reporting the effectiveness of security officers in an ED. The purpose of this study was to address these gaps in the literature by providing a description of specific roles

performed by hospital security officers and the perceived effectiveness as reported by ED workers.

## 2. Methods

A qualitative descriptive design was used to conduct this study with 31 healthcare workers at an urban pediatric ED in the Midwest United States. Data were collected through individual interviews with the study participants and conducted by the same researcher. The sample included registered nurses, physicians, paramedics, ED technicians, respiratory therapists, and child life specialists who had worked at least six months in the current ED.

Interviews were audio-taped and transcribed verbatim. Transcripts were audited for reliability. Employee names mentioned during the interview were replaced with a pseudonym in the transcript prior to data analysis. A modified constant comparative analysis process was used to analyze the data by two researchers who met regularly. During early data analysis, a coding scheme was developed mutually between the researchers and served as a guide for categorizing the units of information. During subsequent meetings to discuss the data analysis, the coding scheme was reviewed and revised as indicated. Data analysis continued until saturation occurred, meaning that no new units of information were identified in the data. A detailed description of the data analysis process was previously published. [22] Institutional Review Board approval was granted prior to participant recruitment and data collection.

## 3. Findings

Data from 31 participants were analyzed. Participants were primarily female (n=28, 90%) and Caucasian (n=29, 94%). Sex and race were reflective of the U.S. nursing population with 94.6% female and 86.6% Caucasian. [25] No comparison data are available for a national physician population. The average age of the participants was 33 years old and ranged from 22 years to 51 years. The majority of the ED workers worked day shift hours from 7 a.m. to 3 p.m. (n=8, 26%) or evening shift from 3 p.m. to 11 p.m. (n=10, 32%). All major occupational groups that interacted with patients and visitors in the treatment rooms were represented in the study sample.

The qualitative data analysis yielded six themes related to the perceptions of hospital employed security officers' effectiveness during violent events. It is important to note that the data were strictly based on the perceptions of ED workers and that security officers were not interviewed to gain their viewpoint on the study findings. The six themes were: (1) a need for security officers, (2) security officers' availability and response, (3) security officers' presence or involvement, (4) security officers' ability to handle violent situations, (5) security officers' role with restraints, and (6) security officers' role with access. A rich description of each theme will be depicted.

### 3. 1. A Need for Security Officers

ED workers made conscious decisions regarding calling or not calling for security officers to aid during a violent situation. While security officers were always present or notified

immediately an event of physical violence occurred, some ED workers elected not to call for security officer assistance believing that they could handle non-physically violent situations. The decision to notify security may have been weighed against a security officer's other responsibilities such as controlling access to the ED or patrolling the parking garages. Jane, a physician, reported that during night shift the security officers were fewer in number. As a result, if security officers were needed in the treatment area of the ED, the security person from the front desk responded leaving no one "… available at the front to let people in …" One participant reported needing a security officer outside of the ED treatment area. Jane asked the security officer to walk her to her car, because she thought that the father who had blocked her in a patient room earlier may have been "… out there somewhere and still angry…"

### 3. 2. Security Officers' Availability and Response

The overwhelming majority of participants reported that security officers were always available and responded within a minute if needed. A few participants believed that there were still situations where security officers should have responded faster and in greater numbers than they did. Competing interests were identified for the availability and response of security officers. Competing interests included monitoring the parking garages and "… clocking people …" for speeding violations. Zoe, a registered nurse, said, "I mean obviously they can't be everywhere." Melinda, a registered nurse, stated that a force of security officers may take several minutes to arrive "… but most of the time the officer from the front desk will come in, if we really need him to."

### 3. 3. Security Officers' Presence or Involvement

Participants reported a variety of experiences with security officers being present or involved in the violent event. While security officers were effective in de-escalating the violent event in some situations, there was no effect on escalation of violence in other situations.

**3. 3. 1. Involvement that led to an escalation of violence.—**Participants shared that perpetrators may have perceived that adding a security officer presence was the ED workers way of "… putting our foot down and saying you're going to do it our way." The perception of the participants was also described as "… raising the price of poker …" and "… adding gasoline to a fire." Fiona, a paramedic, described how the interactions of security officers with perpetrators may have led to a perpetrator's escalation. Fiona said:

> I honestly think [security] made it worse because they yelled at him … Um, they were just mean. I mean they were nasty to him—you know shouting orders, throwing him on the ground. I mean, it just, it's—more than necessary.

**3. 3. 2. No effect with security presence.—**Six participants reported that there were instances where a security officer presence had no effect on the occurrence of violence. Francis, a registered nurse, had her face struck by a patient while "… security was actually right outside the door. I mean, it was so quick that none of us really could do anything." Lizzy, a respiratory therapist, offered a reason for other circumstances where the presence

of security officers had no effect on pediatric patient perpetrators. Lizzy said, “They’ve been around the block enough they know a security guard can’t do anything to them.”

**3. 3. 3. Positive effect with security presence.—**A far greater number of participants reported that the presence of security officers wearing their uniforms reduced workplace violence. Lolita, a child life specialist, said, “There’s, there is something about having someone in a uniform that looks like they’re there to control the situation. Um, it’s a little psychological help in many situations.” The effect was most noticed with younger patients who perceived the security officers as intimidating. An additional attribute of security officers was their ability to talk with families and “… help them calm down.”

### 3. 4. Security Officers’ Ability to Handle Violent Situations

Participants were divided in their opinion as to the ability of security officers to handle violent situations. While some participants reported that security officers were not physically able to manage violent perpetrators, Emily, a physician, stated that when a violent perpetrator escalated to the point that when security officers became involved in the event “… security couldn’t even take over.” The situations then required as many as 15 additional workers to manage the event.

Security’s ability to handle a violent situation was limited. Papa Giorgio, a paramedic, said that security officers “… have no jurisdiction as far as arresting powers …” or there were hospital policies that limited security officers’ ability to handle violent situations. Despite these limitations, security officers were able to try limit setting to control perpetrators’ behaviors. When limit setting was not effective, some security officers progressed to physically hold and later remove family perpetrators from the campus. Zoe, a registered nurse, stated that security officers had been dealing with a grandmother who refused to let the ED workers into the patient room. Zoe provided a description of security’s involvement with the event:

> And then security said, “This is IT! You know, you’ve had plenty of time. We want you to go.” So they were kind of escorting her out …. As they were escorting her out, there was some type of a struggle … she was down on the ground and security was on top of her and the police came …

A few participants’ comments mirrored the outcome that Zoe reported. When physical violence with patients’ family members progressed beyond the security officers’ ability to safely escort the perpetrators off campus, the local police department was called.

### 3. 5. Security Officers’ Role with Restraints

It was perceived that security officers were not allowed to touch patients unless they were involved with the application of leather restraints. Fiona, a paramedic, said that a lot of security officers didn’t know how to apply leather restraints. However, most participants reported that security officers were knowledgeable with restraint application and did so safely and humanely. In fact, Phoebe, a paramedic, reported that security officers were experts when dealing with restraint application. Phoebe said, “[Security officers] were able

to show techniques that we did not know as far as restraining her without harming her…. They were beneficial there."

### 3. 6. Security Officers' Role with Access

Security officers were responsible for preventing or granting access of patients and visitors into the treatment areas of the ED. Hannah, a child life specialist, reported that the security officer at the waiting room security desk kept a parent from gaining access to the ED treatment area, because the parent didn't have a visitor's pass. Shortly before the father was denied access, someone had been letting the father and multiple other family members into the trauma bay to visit the patient; not limiting the number of visitors nor requiring anyone to have a visitor badge. Melinda, a registered nurse, believed that security officers let too many people into the ED's treatment areas. However, Jane, a physician, reported that a security officer required another parent to show proof that he was a patient's father before they would let the father into the treatment area. It's important to note that all of the hospital-based security officers rotated through the ED; there were no consistently ED assigned security officers.

## 4. Discussion

The perceptions of the ED workers varied in relation to the effectiveness of security officers in maintaining a safe ED work environment; however, the participants overall valued and respected the security officers with whom they worked. Consistent with findings reported in other studies, the participants overwhelmingly agreed that security officers are a vital part of an ED's workforce in the management of violent patients and/or visitors. [14–15]

As described in the study findings, security officers were routinely consulted or present for violent events. However, there were times when the ED workers had to decide if the need for security outweighed the need for security to perform other hospital-based roles such as monitoring a parking lot or garage. This decision reflects a need for an increased security force to allow workers' possessions (e.g., motor vehicles) to be protected while simultaneously protecting the workers themselves. When ED workers do determine that a security officer presence is required, it was important to the ED workers that security officers respond quickly. In addition, they wanted multiple security officers to respond. This desire will be a major barrier for hospitals that may only employ one security officer during the nighttime hours even though workplace violence is more likely to occur during the night when the security officer is not based in the ED. [4, 26]

Some participants clearly stated that they did not contact security even though they believed an event of workplace violence was pending. This decision may be due to the contradiction identified with the presence of security officers. While some participants reported that the presence of a security officer in his or her uniform de-escalated violence, other participants reported that the violence escalated. An implication for practice based on this contradiction is the need for an algorithm-based policy that identifies when security should be put on alert, asked to be in close proximity, or respond immediately to assist.

Bliss et al. [27] found that a reason for violence in high school students was school discipline not being enforced. Teenagers knowing that “rules were made to be broken” may help explain why a security presence could de-escalate younger patients but typically had no effect on the teenage patients. Webster-Stratton and Taylor [28] reported a relationship between children that received harsh or ineffective parenting during early childhood and enacting violence as a teenager. This may serve as yet another explanation for why a security presence de-escalated violence in younger patients but was ineffective in adolescents. After years of ineffective parenting the teen may no longer respect persons of authority including security officers resulting in defiance or continued acting out. Another explanation was provided by Leary, Brennan, and Briggs. [29] The researchers studied 200 African-American teenage males and found that incarcerated youths associated the need to enact violence when they thought they were not receiving adequate respect. Several participants in the current study described how the interactions between the adolescent patients and security officers seemed “harsh.” The patient perpetrators may have been responding to what Drury [30] describes as a perceived lack of respect from the security officers even when the security officers were treating them with respect and trying to talk with them.

Erkol, Gökdoğan, Erkol, and Boz [5] discussed the need for trained security personnel to provide protection in the ED. This was mentioned by several of the participants in the current study; participants specifically mentioned police training being essential. Gates et al. [15] reported that ED workers desire to not only have security officers with additional training and equipment to mitigate violence, but also participate in interdisciplinary ED-based training focused on the prevention and mitigation of workplace violence. The International Association for Healthcare Security and Safety (IAHSS) also advocates for interdisciplinary training for the effective prevention of workplace violence. [31] Ultimately, the security officers need to be involved with the solution thinking process to reduce the violence. [14–15, 31] Allowing a core group of security officers to work in the ED would provide continuity and increase the working relationship between security officers and ED workers. In addition, the experience of the security officers in preventing and managing workplace violence could significantly increase.

Even if security officers received police officer training, hospital policies may still limit the ability of security officers to perform their roles in maintaining safety. Participants in the current study stated that security officers were not allowed to detain or touch perpetrators unless leather restraints were going to be applied. Hospital policies for restraint application indicated that only trained persons should be involved in the leather restraint application process; a practice consistent with the recommendations of the IAHSS. [31] No policy was found that identified if security officers routinely received restraint application training. A potential solution to this contradiction of hospital policy and security officer ability may be employing a security officer director with a police officer background (Blando et al., in press). The director would have organizational leadership authority to drive the fundamental changes needed to enact a zero tolerance policy as requested by the participants in the study by Gates et al. [15]

An important contradiction identified was the specific job roles of the security officers. Participants reported that some security officers assisted with the application of leather

restraints for violent patients while others did not. The job description of security officer ability in the prevention and management of workplace violence was not clear to the study participants. This reinforces the need to have interdisciplinary training in conjunction with ED workers and security officers on violence management. [15] While there is no single training program attended by all security officers or ED workers in the United States, the IAHSS recommends a model workplace violence employee training program where education is focused on the organization's workplace violence prevention policy, definitions of violence, risk factors for violence, warning signs for violence, techniques to prevent violence, the reporting process, knowing how to respond during a violent event, procedures to follow related to violence, being supportive of employee victims, and providing physical and emotional assistance to victims. [31] Training should also include a clear description of when security officers need to be contacted for the anticipation of a violent event, the role of each person responding to a violent event, the function of security officers during violent events, the limitations of security officers (e.g., inability to detain and arrest perpetrators), and when police officers are to be contacted for assistance. [14–15, 22] To address the problem of role limitations perceived by the study participants, the training program can be delivered as a large group discussion focused on problem-based learning. The program should be co-facilitated by both a security officer and an employee of the ED (e.g., nurse, physician) to reflect the collaboration needed during violent events. Attendees to the program should be interdisciplinary as well with at least one representative from security, nursing, medicine, and unlicensed assistive personnel (e.g., registration, patient are assistant). Functioning as a team, attendees can discuss how to work as a team to prevent, manage, and recover from problem-based scenarios of workplace violence. During the training sessions, the facilitators should emphasize the roles, responsibilities, and any limitations of the disciplines that respond to workplace violence events.

### 4. 1. Limitations

The sample excluded security officers, chaplains, registration personnel, and hospital unit coordinators who also experience workplace violence. Data from these groups could contradict the findings reported in this study. Data collection was limited to one pediatric setting. Policies and training practices were not reviewed to verify healthcare workers' perception. Publically paid police officers in the ED may be perceived in a different manner.

## 5. Conclusion

There is a need for dedicated security officers to the ED who can provide an immediate response to events of workplace violence. It is imperative that the security officers participate as a member of interdisciplinary team meetings aimed at reducing workplace violence, train alongside ED workers for violence prevention and mitigation, relate their roles and limitations to ED workers with respect to violent perpetrators, and establish a rapport with their fellow ED workers. Ultimately, the trusting relationship between ED workers and security officers will be established allowing for the safer, more effective prevention and management of violent events. Further research needs to be done to describe the views of security officers about their role and support with managing violent events in both adult and pediatric EDs.

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