Violence in the ER

BY ALAN R. COWEN,
CSFA EMS COMMITTEE CHAIR

There is a false sense of security at this Los Angeles area emergency room. The sign notwithstanding, the door opens automatically for anyone.

It was April 15, 1991 in a small community hospital in San Diego when an upset family member entered the emergency room and shot nurse Debbie Burke, killing her. An EMT student was also killed in the attack. The shooter also wounded the emergency department physician and another patient's father. Not a single person who was shot had anything to do with the care of the gunman's father, who died in surgery the previous day of a ruptured abdominal aortic aneurysm. This act of violence cost to EMS professionals their lives.

All across California violence was on the increase with assaults being perpetrated upon the very hands of those entrusted to render care. It didn't seem to make sense.

As a result, Califomia's Emergency Nurses Association, Government Affairs Committee conducted a survey to deten-nine the extent to which violence against emergency nurses was occurring. Additionally, the committee reviewed the practices in effect to deal with aggressive and hostile behavior and security practices within hospitals to combat the problem. Nurse managers in five metropolitan areas were surveyed; these included Los Angeles, San Diego, San Francisco, Sacramento and Fresno. In all, 103 nurse managers were surveyed.

Since most reported violence occurs in urban settings, those hospitals were particularly relied upon for data. Personal contact was accomplished by committee members with few questionnaires were mailed. Respondents were from inner city (10 percent), urban (60 percent) and rural (30 percent) hospitals. 70 percent of respondents were from private hospitals, while 30 percent were from public hospitals. 35 percent of the respondents indicated a predominance of drug and gang activity within the area served by their facility. It is noteworthy that conductors of the study felt that nurse managers were minimizing or down playing the violence they encountered. Some interviewers felt that nurse managers may have felt that negative public relations might result from negative data collected.

Some very interesting observations were obtained. First, interviewers were surprised that some hospitals with considerable violence in their emergency department had little or no gang or drug activity in the area the hospital served. Secondly, although most reported incidents were threats of violence, verbal and physical (no weapon), actual acts of violence were indeed occurring. Most of the violence was specifically directed at staff members resulting in only minor injures, yet necessitating days off from work. Severe injuries were noted in several instances.

Another important element of the study was the recognition that current emergency room measures to protect employees were varied. Some ER's had policies and procedures while others had none. Many hospitals had procedures in place on paper, but employees lacked training in recognizing dangerous or potentially dangerous persons. As one might expect, violence is primarily associated with substance abuse, psychiatric illness, patient anger and prolonged waiting times.

Some hospitals did have some preventive measures to protect the ER staff, the two most common being the ability to lock up a unit and security officers. Concerning hospital security officers, nurse managers were of the opinion that officers were lacking training and not able to respond adequately. Conversely, some hospitals did have "panic buttons" to activate law enforcement. The question, of course, is how long will it take to have local law enforcement officers respond to the ER.

An amazing find of the study was that more than 50 percent of all surveyed hospitals reported that incidents occurred involving weapons brought into the ER by patients or visitors. Most commonly, it was knives and loaded guns. Even when violent or hostile patients are recognized, few are searched.

An increase in hospital violence has occurred since the survey was conducted in late 1990. There have been shoot-outs in the emergency department, many attacks against ER personnel and the brandishing of weapons.

Another incident

It was a routine day on Monday, February 8, 1993 at Los Angeles County USC County Medical Center - the busiest emergency room in our country. The 2,045 bed institution, serves as many as 15,000 patients daily, and is the largest of the county's six public hospitals; the linchpin of the county's trauma care network.

Damacio Ibarra Torres of Los Angeles was heavily armed when he entered the emergency department at about 12:20 pm, critically wounded three physicians and holding two staff members hostage upwards of five hours before surrendering. His actions resulted in a standstill of the emergency room bringing emergency care to a complete halt for the majority of the afternoon and evening.

The gunman was aptly described as a "disgruntled former patient" who was upset over what he perceived to be poor medical treatment. The hospital later reported that the gunman did not know the doctors that he shot nor the two hospital employees he held hostage.

The three physicians, Richard May, Paul Kazubowski and Glen Roger were immediately

CONTINUED ON NEXT PAGE

CONTINUED FROM PREVIOUS PAGE

treated at the same hospital that they themselves had treated thousands of patients. May sustained gunshot wounds in the abdomen and head, Kazubowski in the right arm and scalp and Roger in the upper torso resulting in a collapsed lung.

As he was being led handcuffed to a patrol unit, Torres shouted to a TV cameral, "I feel like I'm a victim of a medical conspiracy," "They refused me treatment for 10 years, I'm in ill health, I don't give a damn. Where can I go? All I can do is go to jail."

Torres's head was shaved, his camouflage jacket concealing three loaded weapons and a knife. Witnesses stated Torres had been pacing for about 10 minutes amidst a crowd of over 100 people waiting to be treated at the ambulatory care unit.

This unit had three physicians who interview patients and separate those with less serious illnesses (triage) from people in need of emergency care. Many of the patients are poor and uninsured; they take a number and then begin the wait for their turn to be treated.

Torres, according to witnesses, became more and more agitated as he waited to be seen He was heard to yell out, "Goddamn, give me something for pain!" He then promptly walked up to the physicians and opened fire. An eyewitness reported to police that he never said a word, just started shooting. Many feared that the gunman would shoot everyone, but it soon became evident, according to one witness, that he just wanted to shoot the doctors.

Hospital security guards pursued the gunman from the ER area to the X-Ray room, but not before Torres took two hostages - a 54 year old receptionist and a 32 year old female physician.

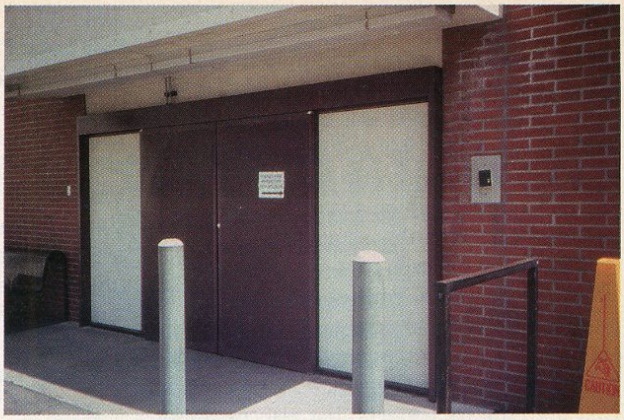
Torres talked to LA Police Department SWAT officers throughout the afternoon from his location. At a little past 5:00 pm Torres released his two hostages who were unharmed and minutes later gave up. Police confiscated a .44 caliber magnum revolver, a .38 caliber automatic pistol, a sawed-off rifle and a hunting knife.

This incident totally disrupted the care for thousands of the county's neediest patients and brought the ER to a standstill. Healthcare workers reported that the shooting was yet another example of the tide of rising violence that has spilled over into the nation's urban emergency rooms.

Marshal Morgan, Chief of Emergency Medicine at the time at UCLA said, "We are an open front door to whatever society has to offer, and some of these patients are not the best people." Officials at the LA County - USC said it was unclear how an armed man could have made it into the emergency room, which is monitored by security guards. Many hospital officials expressed shock at how this could happen.

But, patients and hospital employees dis-

CONTINUED ON NEXT PAGE



Physical barriers protect ER doors. Note one-way viewing from inside only. This allows observation of parking/ambulance docking area. TV monitoring device is also in operation, making this ER secure.

CONTINUED FROM PREVIOUS PAGE

agreed. Bob McCloskey, at the time an official of the county nurses union, said inadequate security at County USC was a major issue in strikes by nurses in 1989 and 1991. The county has since beefed up security budgets at all its hospitals by $1.1 million a year, but the union considers the measures inadequate.

This author has seen a lot of unruly patients in emergency rooms. Patients spit, are high on drugs and alcohol, and some are extremely difficult to control. Nurses have been pushed, shoved, slapped and verbally abused for years. And not only by patients, but also by angry family members frustrated by long waits. Chronic overcrowding leads to increased tempers, which in turn is the spark that sets them off. People get mad after long waits and sometimes are still not seen.

Strangely, witnesses interviewed after the shooting said they understood the rage and intense frustration felt by the gunman.

Could it happen again? The question is not if, but when...

If we look at recent years we can see a pattern of violence in emergency rooms across the country.

1991

Los Angeles: While four nurses ate breakfast in the cafeteria at County-USC, a panhandler plunger a pair of scissors deep into one nurse's neck.

Salt Lake City: A 39-year-old Utah man, angry because doctors had performed sterilization surgery on his wife, stormed a suburban hospital, armed with dynamite and two guns. He killed a nurse and held eight people hostage before surrendering.

Costa Mesa: A painter at Fairview Developmental Center, who was angry with administrators for ignoring tensions in his division shot and killed a facilities supervisor and injured two others.

Los Angeles: Gang gunfire ripped through the windows of White Memorial Hospital in Boyle Heights, and shot gun pellets struck a pregnant women in the face.

1990

San Diego: A man distraught over the death of his father walked into Mission Bay Memorial Hospital in San Diego and fired a barrage of bullets that killed a nurse and a hospital trainee and wounded a doctor and a visitor.

Los Angeles: A gun-wielding assailant killed one woman and shot another several times at the UCLA Medical Center.

Los Angeles: An 18-year-old gain member was shot in the face during an altercation involving about 20 youths who were visiting patients at County-USC.

1989

New York: At Bellevue Hospital Center, a 23-year-old homeless man with a history of psychiatric problems who had been living for weeks in a closet and roaming the hallways in a stolen lab coat, was charged with the rape and strangulation murder of a woman doctor.

1988

Los Angeles: Five carloads of gang members put Martin Luther King Jr./Drew Medical Center in Watts under virtual siege, converging on the lobby of the emergency room and terrorizing people in the waiting room.

1985

Chicago: A 32-year-old food service supervisor at Rush-Presbyterian-St. Luke's Medical Center was assaulted and left bound and gagged on the hospital stairwell.

1984

Los Angeles: A patient at County-USC Medical Center was shot to death by a security guard in the emergency room after he allegedly reached up from his gurney, grabbed another guard's gun and opened fire.

1982

Chicago: A woman being treated at the University of Chicago Medical Center in Hyde Park was raped in her hospital room.

Chicago: A security guard was found beaten to death in a hallway of the Loyola University Medical Center near Maywood.

CONTINUED ON NEXT PAGE

More statistics

Another study in 1988 conducted by Frank LaVoie, M.D., and Associates at the Department of Emergency Room Medicine, University of Louisville School of Medicine. The study concerned ER violence and security issues. They contacted 170 teaching hospitals in the United States relative to security issues in their emergency department. Seventy five percent of the hospitals responded (127 hospitals); their answers revealed an indication of the then growing problem of violence in emergency departments. The study found:

80 percent of the responding hospitals had a staff member injured in the ER.

57 percent had at least one threat against a staff member where a weapon was involved.

46 percent had at least one physical attack on a staff member each month.

32 percent had at least one verbal threat each day.

7 percent had an act of violence resulting in a death.

Today's physicians, nurses, and emergency room personnel are demanding a greater protection and security by the hospitals for which they work. Resolutions by medical associations have been passed, studies and polls have been conducted, and nurses groups have enacted a resolution to increase safety and security of emergency department healthcare workers.

The resolution called for collaboration and liaison with other organizations to develop security and safety protocols, education, as well as minimal safety standards for personnel and for the physical plant.

Security: How much is enough?

Each hospital must assess its own specific need to maintain a safe and secure environment. Some ER's can function with periodic security patrols, while others must have officers actually present near or adjacent to the ER. Some need it during nighttime hours, others 24 hours a day. Above all, minimal standards are a must to ensure safety.

Needs to accomplish safety: Access Control

Controls on access to patient, visitors and staff are essential. The ability to vary the degree in access must be part of the system. Time of day/night, weekends, etc., must be built into the system.

The ambulance entrance should open to some sort of station wherein a key, keycard, or pushbutton lock will enable the crew access. An electric release at a nurse's station can be used to accommodate entry for others as needed. A clearly marked communications center with direct visual observation or a closed circuit TV system is needed to manage the system. Additionally, someone must be assigned to observe the TV system at all times.

Most ambulatory entrance points are not locked, although they should be. This is a most vulnerable area where angry, hostile people can enter. In most facilities the first person encountered upon entering the emergency department is a receptionist or triage nurse. It is essential that this area be staffed at all times to meet visitors who enter. The triage nurse should be in a protected, controlled booth in such a way that it would be very difficult for someone to grab the nurse or receptionist. Vulnerability should be assessed with resultant safeguards taken.

The entire philosophy of controlled areas is essential within the concept. Separated and controlled areas should be: Visitor waiting area, triage area, treatment area, and Quiet room.

Visitors in the ER Waiting Area

Visitors may include family members, friends or even the person(s) who assaulted the patient. It is not infrequent that security incidents involve visitors within the waiting area.

Waiting areas should have at their disposal restrooms, vending machines, telephones and music. Long waits and angry, tense visitors is a recipe for big trouble if not managed carefully. Lack of information or visits to the family by hospital personnel to keep visitors informed is negatively perceived and will spawn negative events. All hospitals that provide emergency care must be organized and staffed to facilitate communication with visitors.

Metal detectors

Very few emergency departments utilize metal detectors similar to

CONTINUED ON NEXT PAGE

airports. One of the first to use them was Henry Ford Hospital in Detroit. During the initial six months of their operation, 33 handguns, 1,324 knives and 97 chemical spray instruments were detected and confiscated. Complaints that were thought to occur did not pan out, and ER staff indicated a high level of satisfaction with the increased level of security. Strong hospital administration support is needed and the units are costly; they are highly effective, however.

ER Security Officers

The provision for security officers within the ER is an administrative decision. Some ER's have only one officer during the nighttime hours while others have them 24 hours a day. Uniformed officers seem to achieve maximum results, but most are unarmed. The issue of arming security officers is complex and involves significant legal issues.

ER security officers should be considered "team members" of the emergency room staff and be included in meetings that related to security and safety. Some hospital ER's utilize off-duty police officers, and while some administrators think this is not a good idea, others do. Indeed the training of police officers is different than hospital security officers, when the going really gets though (serious violent incidents); police officers are quite adept at handling these. Sometimes their no-nonsense approach is the only way to quell an incident. The question of whether police officers will escalate an incident, rather than use conflict resolution is as old as the dinosaur. Modern police academies teach non-verbal judo and common sense conflict resolution techniques. Sometimes it will necessitate the need for several officers to resolve a conflict, those that require physical restraint.

Officer Training

By the nature of their job duties and responsibilities, ER security officers require extensive training. Part of such training should include verbal and non-verbal interventions skills, early signs of disruptive/arrogant behavior, stress sign/symptoms, ER protocols, physical restraint application and appropriate takedown procedures. Being in top physical condition should be an essential part of their job; the ability to be physically fit and mentally alert a must.

Established Protocols

Security personnel within the framework of an ER must have guidelines/established protocols governing their actions. If not, conflict between ER personnel and officers will result. While each specific situation may differ, the overall manner in which security personnel perform their job duties and responsibilities must be clearly and specifically laid out in a manual of operation. Solidly thought out roles for different scenarios will minimize dissatisfaction between medical and non-medical employees and achieve a higher level of service.

Routinely, nurses and physicians generally handle incidents involving patients, while security officers deal with visitors outside the treatment areas. Visitors within the treatment area are in the "middle zone," but are usually handled by the medical personnel.

Security officers are just as their name implies; present to maintain the peace and security, a safe area. Security officers should not be relied upon to be caregivers.

Occasionally, security officers are asked to "watch" a patient. Perhaps a nurse or physician feels uneasy or unsafe. Incidents of violence can be avoided if this practice was done more frequently. Veteran medical personnel develop almost a third eye toward behavior of patients and can tell when someone is nearing the breaking point. The goal of a "watch" is to ensure a safe environment for everyone in the ER, including the patient.

Emergency Signals

Every ER should maintain and frequently test their system of "quick alerts" for situations requiring immediate action. This can include panic buttons, or other activation devises.

Quiet Rooms

"Quiet Rooms" offer alternatives to restraints and are less disruptive to the overall environment of the emergency department. This is a room for detaining patients and to minimize injuries that patients could inflict upon themselves. Observations of patients can be accomplished through a viewing window or closed circuit TV system. New legislation requires frequent personal contact with the healthcare team.

Security Room

In most large emergency rooms, a separate location within the ER or closely nearby allows for security personnel to do reports, taking statement etc.

ER's are conducive to violence. People with extremely physical and mental problems show up here. Acute psychiatric manifestations, drug and alcohol abuse, and a mix of patient's, family and visitors congregate here. Chaotic circumstances evolve to produce a potentially hostile environment. In fact, disruptive behavior is not only predictable; ER staff's should expect it. But we can plan for it and hopefully minimize it.

In a nutshell

The nature of emergency rooms is conducive to violence. ER's are open 24 hours every day, seven days a week to everyone and anyone. The physical environment is full of activity that promulgates unrest, and restlessness. Normally non-violent people may become fearful when scared and in pain. In many cases, patients in the emergency room being treated are victims of violence itself.

Hospital Strategies

In today's atmosphere, hospitals are active in security solutions. Strategies to address safety are frequently looked into by administrations as well as committees. Facilities should maintain an up-to-date security assessment plan identifying potential problems.

Security Plan - Location of a facility/unit
Number of reported incidents
Unit violence of patients
Physical barriers

Detailed analysis of problem types (i.e., number of weapons, drugs, removed by staff from patients)

Staff Education

1. Situations can be prevented when staff is trained.
2. Training should focus on how to identify the potential for violence, recognition of drug, alcohol and mental impairment.
3. Establish appropriate response strategies.
4. Training should address cultural difference.
5. Training should include emergency room staff and security assigned.

Facility Changes

1. Sufficient, comfortable setting.
2. Distractions such as TV, music, magazines, etc.
3. Access to refreshments
4. Frequent patient/family/staff communications; keep family/friends informed on patient's condition.
5. Designation of a "quiet room" or seclusion room for patient being hospitalized because they are believed to present a threat to themselves or others.
6. Placement of signs giving general information regarding the emergency department. This can diffuse a potentially violent situation.

Health care workers often follow the same routine each day. Do you? This makes them easy targets for disgruntled or deranged people who may stalk them. Workers should be encouraged to vary their routines as much as possible.

Report all Incidents

All employees should be encouraged to report all aggressive behavior, verbal or physical incidents.

Final Comment

1. Health Care Reform is the cure for this serious ailment.
2. Long waits and overcrowding is the culprit.
3. The call for action is now.

Shootings can happen anywhere, anytime, in any emergency room or hospital. The shooting of the three physicians at LA County/USC Medical Center is the tip of the iceberg. Hospital violence is on the increase.

Over the last 10 years violence in our society has sharply increased. One third of all Americans are victimized by crime each year. The number of assaults per hospital nearly doubled from 3.24 percent in 1987 to 5.9 percent in 1990.

Remember, be careful out there.