Violence in Healthcare and the Use of Handcuffs

by Sarah Henkel

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INTRODUCTION

Violence in the healthcare setting has been escalating for the past several years across the globe. As early as the 1990's, researchers were trying to verify the data and propose strategies to address this disturbing trend.[1] According to the US Department of Labor, the rate of serious workplace violence incidents over a ten year period was more than four times greater in healthcare than in other sectors of private industry. In fact, healthcare accounts for nearly as many serious violent injuries as all other industries combined. It is likely that many more minor assaults, threats or verbal abuse go unreported.[2]

The Occupational Safety and Health Administration (OSHA) has taken a much stronger stance in recent years, requiring healthcare facilities to have workplace violence programs to protect staff and leveraging hefty fines against those who do not. However, protecting staff by using weapons, which includes handcuffs, may be construed as a direct violation of the Centers for Medicare and Medicaid (CMS) conditions of participation which direct the allowable treatment of patients. This contradiction puts healthcare facilities, and especially security officers who are on the front lines, in a precarious situation to try to meet the requirements of both federal agencies while providing a safe environment for staff, patients and visitors.

This article will explore:

- The prevalence of handcuffs as a tool in healthcare
- The regulatory environment that governs the security officer's right to detain, the patient rights related to handcuffs, and staff's right to protection from violence
- Patient management including prisoner patients, medical patients and substance abuse/behavioral patients
- Best practices to prevent situations requiring handcuffs and respond when they are unavoidable

PRESENT STATE

Healthcare security officers employ a variety of tools to help promote a safe environment. These tools may include handguns, K9s, conducted electrical weapons (CEW; such as a

[1] Beech, Bernard and Phil Leather. "Workplace violence in the health care sector: A review of staff training and integration of training evaluation models." *Aggression and Violent Behavior*, vol. 11, August 2005, pp. 27-43. Elsevier, doi:10.1016/j.avb.2005.05.004.

[2] Occupational Safety and Health Administration. "Preventing Workplace Violence in Healthcare." Retrieved September 9, 2018 from https://www.osha.gov/dsg/hospitals/workplace_violence.html

Taser®), Oleoresin Capsicum (OC or pepper) spray, batons and handcuffs. There is heated debate presently regarding these tools and whether they have any place in the healthcare setting. The most controversial is firearms for which there are many documented cases of unarmed patients being shot by officers or patients gaining control of a firearm worn by a police or security officer and then causing harm to themselves or others.[3,4,5] Handcuffs are somewhat less controversial and are commonly available in the healthcare setting. A 2014 survey of 340 hospitals found that 96 percent of these facilities had security departments that carried handcuffs, with approximately two thirds reporting security personnel had the authority to restrain patients.[6]

The term "handcuffs" can be used to describe a variety of forensic restraints including handcuffs, hinge cuffs, rigid cuffs, thumb cuffs, shackles, manacles, flex cuffs, zip ties and other similar devices. The Merriam Webster definition is "a metal fastening that can be locked around a wrist and is usually connected by a chain or bar with another such fastening – usually used in plural."[7]

The principle reason for handcuffing a person is to maintain control of the individual and to minimize the possibility of a situation escalating to a point that would necessitate using a higher level of force.[8] However, in the healthcare setting, there are many unique circumstances to consider in evaluating whether their use is necessary or appropriate and what is reasonable. In addition, handcuffs themselves can cause injury when they are excessively tightened or are applied to a person who has been injured.[8] For these reasons, utmost caution should be used in considering their use.

REGULATORY ENVIRONMENT

States

If a health care facility employs certified peace officers, they are typically governed by the laws affecting all law enforcement officers in the state. In most cases, they would be permitted to handcuff any individual whom they are arresting. The legality of a private

[3] Kelen, Gabor D., et al. "Hospital-Based Shootings in the United States: 2000 to 2011." *Annals of Emergency Medicine*, vol. 60, no. 6, 2012, pp. 790–798 e1. DOI: https://doi.org/10.1016/j.annemergmed.2012.08.012

[4] Lord, Steve. "Geneva hospital standoff ends with jail inmate dead: Officials." *Chicago Tribune*. May 13, 2017. http://www.chicagotribune.com/suburbs/aurora-beacon-news/ct-geneva-delnor-hospital-police-standoff-20170513-story.html

[5] Rosenthal, Elisabeth. "When the Hospital Fires the First Bullet." *The New York Times*. February 12, 2016. https://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html?_r=0

[6] Schoenfisch, Ashley L., and Lisa A. Pompeii. "Security Personnel Practices and Policies in U.S. Hospitals." *Workplace Health & Safety*, vol. 64, no. 11, 2016, pp. 531–542. https://doi.org/10.1177/2165079916653971

[7] https://www.merriam-webster.com/dictionary/handcuff

[8] "Civil Liability for the Use of Handcuffs: Part I – Handcuffs as Excessive Force." *AELE Monthly Law Journal*, Civil Liability Law Section, October 2008. Retrieved on September 9, 2018 from http://www.aele.org/law/2008LROCT/2008-10MLJ101.pdf

security officer using handcuffs to detain a person or detaining a person at all is more complex. Rules, statutes and case law vary by state, but in most cases, a private security officer is seen as a private citizen with the right to affect a citizen's arrest. A citizen's arrest is defined as "an arrest made by a private individual who has witnessed, or has reasonable belief that the detained person has committed a crime."[9] For the purpose of this article, the terms arrest and detain will be used interchangeably.

The use of handcuffs is considered a use of restraint and force, subject to the constitutional objective reasonableness standard of the Fourth Amendment. Even if a hospital uses security officers, as opposed to certified peace officers, it is likely it would be held to this standard from a civil perspective in evaluating the appropriate application of handcuffs.[8]

In many states, an individual may be detained by citizen's arrest for a felony, by force if necessary, which would include the use of handcuffs, regardless if the crime occurred in the presence of the arresting individual. In most states, lesser offenses such as misdemeanors or disrupting the peace must occur in the presence of the person making the arrest or are not subject to citizen's arrest at all. Actions that may be considered disrupting the peace could include fighting in public and shouting or yelling for an excessive period of time. In nearly all states, a proprietor of goods may detain and arrest individuals suspected of shoplifting, though the specific rules vary.

The following table was compiled using data from four sources and independent research by the author of this article.[10, 11, 12, 13] Specific statutes vary. This table is intended to be a starting point for additional research and may not be comprehensive.

State	Statues/Case Law Citizen Right to Detain/Arrest	Statues Right to Detain Shoplifting
Alabama	AL Code § 15-10-7	AL Code §15-10-14
Alaska	AS 12.25.030	AS 11.46.220
Arizona	AZ Rev Stat § 13-3884	AZ Rev Stat § 13-1805
Arkansas	Ark. Code Ann. § 16-81-106(c)	§ 5-36-116
California	CA Penal Code § 834	CA Penal Code § 490.5

[9] "Citizen's Arrest." Legal Dictionary. https://legaldictionary.net/citizens-arrest/

[10] "Scope of Legal Authority of Private Security Personnel" *US Department of Justice/National Institute of Justice Private Security Advisory Council*, report 146908, 1976, pp. i-C-1. Retrieved August 2, 2018 from https://www.ncjrs.gov/pdffiles1/Digitization/146908NCJRS.pdf

[11] Robbins, Ira P. "Vilifying the Vigilante: A Narrowed Scope of Citizen's Arrest." *Cornell Journal of Law and Public Policy*, vol. 2 5, 2016, pp. 57-599. https://digitalcommons.wcl.american.edu/facsch_lawrev/545

[12] "Legal Authority of the Security Officer." *Thomas Protective Services, Inc*. Retrieved September 22, 2018 from http://thomasprotective.com/userfiles/files/oct2016_LegalAuthSecOfcr.pdf

[13] "Shoplifting Law: Constitutional Ramifications of Merchant Detention Statutes," *Hofstra Law Review*, vol. 1, iss. 1, article 18, 1973. Retrieved September 28, 2018 from: http://scholarlycommons.law.hofstra.edu/hlr/vol1/iss1/18

	CA Penal Code § 837	
Colorado	CO Rev Stat § 16-3-201	CO Rev Stat § 18-4-407
Connecticut	*Malley v. Lane*, 97 Conn. 133 (1921); *State v. Ghiloni*, 35 Conn. Sup. 570 (1978); *Wrexford v. Smith*, 2 Root 171 (1795) Connecticut Code § 53(a)-22(f)	Connecticut Code § 53a-119
Delaware	11 DE Code § 2514	11 DE Code § 840
Florida	FL Stat § 941.14	FL Stat § 812.015
Georgia	O.C.G.A. § 17-4-60	O.C.G.A. § 51-7-60
Hawaii	HI Rev Stat § 803-3	HI Rev Stat § 663-2
Idaho	I.C. § 19-604	I.C. § 18-4626
Illinois	725 ILCS § 5/107-3	720 ILCS § 5/16-26
Indiana	IC 35-41-3-3; IC 35-33-1-4	IC 35-33-6-2
Iowa	IA Code § 804.9	IA Code § 808.12
Kansas	KS Stat § 22-2403	KS Stat § 21-5411
Kentucky	KRS § 431.005(6)	KRS § 433.236
Louisiana	LA Code Crim Pro § 214	LA Code Crim Pro § 215
Maine	17-A ME Rev Stat § 16	17 ME Rev Stat § 3521
Maryland	*Great Atlantic & Pacific Tea Co. v. Paul*, 256 Md. 643, 261 A.2d 731 (1970); *Stevenson v. State*, 413 A.2d 1340 Md	Maryland Code, Courts and Judicial Proceedings § 5-402
Massachusetts	*Commonwealth v. Lussier*, 128 N.E.2d 569	MA Gen L Ch 231 § 94B
Michigan	MI Comp L § 764.16 *In Michigan a single code covers citizen's arrest and shoplifting*	
Minnesota	Minn Stat § 629.37	Minn Stat § 629.366
Mississippi	MS Code § 99-3-7	MS Code § 97-23-95
Missouri	*State v. Morris*, 680 S.W.2d 315 Mo. App; *State v. Gay*, 629 S.W.2d 470 MO Rev Stat § 563.051	MO Rev Stat § 537.125
Montana	MT Code § 46-6-502	MT Code § 46-6-506
Nebraska	NE Code § 29-402	NE Code § 29-402.01
Nevada	NRS § 171.126	NRS § 597.850
New Hampshire	Common law: *Moebus*, 62A. 170 N.H. NH Rev Stat § 627:4	NH Rev Stat § 627:8-a
New Jersey	N.J. Rev. Stat. § 2A:169-3	NJ Rev Stat § 2C:20-11
New Mexico	*State v. Johnson*, NMSC-075, 22 N.M. 696, 930 P.2d 1148	NM Stat § 30-16-19
New York	NY Crim Pro L § 140.30	NY Gen Bus L § 218
North Carolina	NC Gen Stat § 15A-404	NC Gen Stat § 14-72.1
North Dakota	ND § 29- 06-20	ND § 12.1-23-14
Ohio	ORC § 2935.04	ORC § 2935.041
Oklahoma	22 OK Stat § 22-202	22 OK Stat § 22-1343
Oregon	OR Rev Stat § 133.225	OR Rev Stat § 131.655
Pennsylvania	*Commonwealth v. Chermansky*, 242 A.2d 237, 239–40 (Pa. 1968); *Commonwealth v. Corley*, 462 A.2d 1374 (Pa. 1983); *Samuel v. Blackwell*, 76 Pa. Super. 540, 547 (1921)	18 Pa Code § 3929
Rhode Island	*Monteiro v. Howard*, 334 F.Supp. 411-D.C. R.I.	*Staples v. Schmid*, 18 R.I. 224, 26 A. 193, 19 L.R.A. 824 (1893).

South Carolina	SC Code § 17-13-10	SC Code § 16-13-140
South Dakota	SD Codified L § 23A-3-3	SD Codified L § 22-30A-19.2
Tennessee	Tenn. Code Ann. § 40-7-109	Tenn. Code Ann. § 40-7-116
Texas	TX Crim Pro § 14.01	TX Civil Prac. & Rem. § 6-124
Utah	Utah Code § 77-7-3	Utah Code § 77-7-12
Vermont	*State v. Barber*, 596 A.2d 237 Vt	13 V.S.A. § 2576
Virginia	*Moore v. Oliver*, 347 F.Supp. 1313 Va.; *Tharp v. Commonwealth*, 270 S.E.2d 752; *United States v. Mullen*, 278 F.Supp. 410; *Lima v. Lawler*, 63 F.Supp. 446 D.C. Va.; *Montgomery Ward & Co. v. Freeman*, 199 F.2d 720 C.A. Va	Code of Virginia § 9.1-146
Washington	*Jack v. Rhay,* 366 F.2d 191 9th Cir; *State v. Bonds*, 653 P.2d 1024 Wash. 1982	WA Rev Code § 9A.16.080 WA Rev Code § 4.24.220
West Virginia	*Allen v. Lopinsky*, 94 S.E. 369 W. Va.; *State v. Sutter*, 76 S.E. 811 W. Va	WVC §61-3A-4
Wisconsin	Keenan v. State, 8.Wis. 132	WI Stat § 943.50
Wyoming	WY Stat § 7-8-101	WY Stat § 6-3-405

Some examples of the acceptable use of handcuffs by private security officers in the healthcare setting, using the citizen's arrest guidelines, might include detaining:

- A shoplifter
- Visitors for physically fighting
- A family member for causing a disturbance on the property and refusing to leave
- A person for distributing illegal substances
- A person for making threats with a weapon

If the person who commits a crime is also a patient at the facility, the use of handcuffs becomes much more complicated. Patients will be discussed in detail in the following section.

CMS

Using handcuffs to restrain patients, is far more complex and generally ill advised. The following is an excerpt from the CMS Interpretive Guideline §482.13(e):

"CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term weapon includes, but is not limited to, pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in

order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients."[14]

In short, handcuffs are not permissible for use in any way if the goal of the interaction is to restrain the person for medical treatment. The only time it is allowable to use handcuffs to restrain a patient is if he commits a crime for which law enforcement will be notified with the expectation that the patient will be charged with a crime. For example, if a patient kicks a caregiver during assessment or treatment, he has committed the crime of battery; however, the patient may have a medical condition such as a head injury that makes him unaware of, or unable to control, his actions. A crime has been committed, but without intent, it is unlikely the hospital administration or local law enforcement would view the situation as criminal. The goal is to medically restrain the patient in a way that is safe for staff and the patient so that treatment can continue. In this example, the use of handcuffs is not appropriate under CMS guidelines.

Consider a different example where a patient is being seen in the emergency department for pain and wants to be prescribed a narcotic medication. When not given the narcotic he is seeking, the patient grabs hold of the caregiver and pushes her against a wall screaming that he wants his narcotic. This is a similar situation of assault and battery. However, in this circumstance, the patient is willfully taking criminal action. The use of handcuffs may be appropriate here as staff is no longer attempting to treat the person but rather safely control the person until law enforcement arrives to take custody. Notice the use of the word "may." We will see later that even in situations that appear to meet the criteria for law enforcement level action under the CMS guideline, it is not necessarily interpreted that way by CMS.

With regard to application of restraints, CMS demands patients are managed with the minimum necessary force to control. Even for medical restraint application, CMS has strict guidelines and prefers patients are managed with proactive de-escalation techniques to limit the use of any kind of restraint when at all possible.

[14] Centers for Medicare & Medicaid Services. CMS state operations manual, appendix A. Regulations and interpretive guidelines for hospitals. Section 482.13(e). Retrieved August 2, 2018 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

OSHA

OSHA does not have specific regulations for workplace violence nor do they have a specific stance on the use of handcuffs. They simply expect employers to take the necessary actions to create a safe environment for employees. Under the General Duty Clause Section 5(a)(1) of the Occupational Safety and Health Act of 1970, employers are required to provide a place of employment that is "free from recognized hazards that are causing or are likely to cause death or serious harm."[15] OSHA's purpose is to protect employees in the work place and the agency does not care why a healthcare worker is assaulted. Over the past 10 years as work place violence in healthcare has accelerated beyond that of many other industries, OSHA has taken a harder stance and cited several large healthcare facilities for failure to protect employees from work place violence.

In July of 2013, OSHA cited Armstrong Center for Medicine and Health in Kittanning, Pennsylvania with two violations following a complaint alleging that workers were being assaulted by patients in the hospital's behavioral health unit. The serious citations were for hazards associated with the employer's failure to implement programs and procedures to protect workers from injuries resulting from assaults by patients with proposed penalties of $8,000.[16]

In July of 2015, Brookdale University Hospital and Medical Center in Brooklyn, New York reached a settlement with OSHA stemming from a 2014 visit after a nurse was assaulted. OSHA found approximately 40 incidents of workplace violence reported over a three month period including head, eye, face and groin injuries, intimidation and threats during routine interactions with patients and visitors.[17] The most serious incident was the assault of a nurse, who sustained brain injuries when she was attacked while working. Proposed fines of $78,000 were reduced to $15,000 in the final settlement when the medical center agreed to implement and maintain a comprehensive program to safeguard its employees better against assaults and other on-the-job violence. The agreement includes specific engineering and administrative controls such as improved employee training and communication, engagement of outside consultants and more holistic violence prevention efforts.[18]

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[15] Occupational Safety and Health Administration. "Preventing Workplace Violence in Healthcare." Retrieved September 9, 2018 from https://www.osha.gov/dsg/hospitals/workplace_violence.html

[16] Occupational Safety and Health Administration. "Kittanning, Pa., hospital fined by the US Labor Department's OSHA for failing to protect workers from patient assaults." *OSHA News Release – Region 3*, July 15, 2013. Retrieved September 21, 2018 from https://www.osha.gov/news/newsreleases/region3/07152013

[17] Occupational Safety and Health Administration. "Brooklyn medical facility cited by US Department of Labor's OSHA for inadequate workplace violence safeguards Brookdale University Hospital and Medical Center inspected after worker complaints." *OSHA News Release – Region 2*, August 11, 2014. Retrieved September 21, 2018 from https://www.osha.gov/news/newsreleases/region2/08112014

[18] Occupational Safety and Health Administration. "More employee protections against workplace violence, thanks to changes at Brookdale University Hospital and Medical Center." *OSHA News Release – Region 2*, July 6, 2015. Retrieved September 21, 2018 from https://www.osha.gov/news/newsreleases/region2/07062015

In May of 2018, OSHA cited Premier Behavioral Health Solutions of Florida and UHS of Delaware, for failing to protect employees from violence in the workplace. OSHA was responding to a complaint that employees were not adequately protected from violent mental health patients. OSHA cited the two organizations who jointly operate the Suncoast Behavioral Health Center for failing to institute controls to prevent verbal and physical assaults by patients and from using objects as weapons. Proposed penalties total $71,137.[19]

These are only examples of the many citations that OSHA has issued over the past several years making clear their position that creating an environment for healthcare employees that is safe from patient violence is paramount and steep fines will be imposed against organizations who do not.

Dueling Mandates

From the regulatory overview, the following is clear:

- Private security officers working in the healthcare setting are legally permitted to use handcuffs as a means of detaining people in a variety of situations
- CMS strongly oppose the use of handcuffs in any situation where a patient is involved
- OSHA wants healthcare employees to be protected from workplace violence, including violent patients, and will fine facilities for failing to protect them

Herein lies the problem. These two federal agencies are in direct conflict with who is the primary person to protect…is it patients or staff? Adequately protecting both, while following the guidelines, is challenging.

Consider Lehigh Valley Hospital in Pennsylvania, which was cited by CMS in 2010 for using CEWs in situations involving patients.[20] These weapons are specifically mentioned in the same CMS guideline that addresses handcuffs and can be used as part of a law enforcement level action only. The four situations in which stun guns were used at Lehigh were as follows:

- An agitated patient in the Emergency Department received multiple doses of psychiatric medication during a two hour period and was still agitated. Security staff was called and the patient "came at" security, at which point a CEW was used.
- A patient became agitated and began yelling at staff. The patient was using an intravenous pole as a weapon and barricaded himself in the restroom. Security

[19] Occupational Safety and Health Administration. "U.S. Department of Labor Cites Florida Health Facility for Exposing Employees to Workplace Violence." *OSHA News Release – Region 4*, May 2, 2018. Retrieved September 21, 2018 from https://www.osha.gov/news/newsreleases/region4/05022018

[20] Darragh, Tim. "Lehigh Valley Hospital stunned patients." *The Morning Call*, December 10, 2010, http://www.mcall.com/news/local/investigations/mc-hospital-taser-patient-lehigh-valley-20111217-story.html

talked to the patient, but he continued to escalate and ultimately a CEW was used. Police were called and took a report.

- An ED patient ran out of an examination room, slamming the door, hitting the wall and yelling. Medical staff tried to calm the person and eventually involved security. The patient attempted to punch a security officer who then took the patient to the ground. The patient continued to fight with two officers and one used a CEW to subdue him.
- An upset patient left the ED. Security staff called police and pursued the person for fear he would harm himself or others. The patient pushed a security officer, striking the officer with his fist and grabbing for the officer's belt containing pepper spray and a CEW. Another officer warned the patient three times and then discharged a CEW.

Lehigh Valley officials argued that each of these situations constituted law enforcement level action because the patients' actions had risen to the criminal level and the actions taken were not part of the normal course of patient care. The citations stood, however, which jeopardized Lehigh's Medicare and Medicaid status.[21] Lehigh elected to take CEWs away from security officers which raised the question again of employee safety. Consider each of the aforementioned extreme situations had the security officers not had access to devices to help control the individuals who were acting out. Would they have been able to prevent injury to staff?

PATIENT MANAGEMENT

Prisoner Patients

Prisoner patients, patients who are in the custody of law enforcement while needing medical treatment, are the easiest situations for which to discuss the use of handcuffs because they are the most straightforward. The custodial officer who is with the patient is responsible for the use of handcuffs while treatment occurs. That does not, however, absolve the medical care facility of a responsibility to protect the patient while treatment is being rendered. For example, if handcuffs are too tight or are impeding medical treatment, the healthcare worker must assess the safety of continued use of restraint. Security officers should work hand in hand with custodial officers to ensure the process of treating a prisoner patient, while maintaining a safe environment, goes smoothly.

Some best practices related to the management of prisoner patients – particularly those who will be remaining in handcuffs throughout their treatment – include:

- Conduct a meeting between local law enforcement, corrections officers, hospital security and medical care staff prior to the prisoner patient coming to the facility to

[21] Greene, Jan. "Patient Safety Versus Workplace Safety: Stun gun debate illustrates dueling federal mandates." *Annals of Emergency Medicine*, vol. 57, no. 4, 2011, pp. 20A–23A. DOI: https://doi.org/10.1016/j.annemergmed.2011.02.009

review roles and responsibilities of each person in effecting safe care for the prisoner patient and maintaining safety of the environment

- When law enforcement arrives on site with a prisoner patient, a hospital security officer should meet and escort them to the designated area of treatment and review with them the meanings of codes and discuss the actions the law enforcement officer will take in each situation.

- Security officers should maintain close contact with the custodial officer but should not at any time take responsibility for the patient. Hospital security officers are responsible for the general safety and security of the hospital, staff, visitors and patients, but prisoners are the responsibility of the custodial officer.

- If removal of handcuffs is needed to effect treatment, it should be handled by the custodial officer. If the custodial officer is working alone, it may be helpful for a security officer to assist in monitoring the prisoner patient while he is not handcuffed as this presents the highest risk to the facility.[22]

A sample policy regarding prisoner patients from Aurora Health is available online.[23]

Medical Patients

There are many medical conditions that can cause aggressive behavior. Recognizing these signs early allows for more proactive management of the patient and a decreased likelihood of a violent incident occurring during which the patient or others may be hurt.[24] Security officers are part of the care team and, as they are often on standby with patients in the emergency department while their potential for violence is assessed, they can play a key role in recognizing opportunities for intervention. Medical causes of aggression include head injury, mental illness, low blood sugar, swelling in the brain from infection, the post ictal state that follows a seizure and a stroke or brain bleed, among others. Dementia, schizophrenia, anxiety, acute stress and suicidal ideation have also been found to be predictors of violence against healthcare workers.[25]

[22] Gorman, Erin. "Lessons Learned & Best Practices for Managing Forensic Patients in Healthcare Facilities." *IAHSS Foundation Evidence Based Research Series.* April 20, 2016. IAHSS-F RS-16-02

[23] Aurora Health. "Prisoner Patients (Care of Patients under Legal or Correction Restrictions." *Policy No – Clin 484*, June 2015. Retrieved June 22, 2018 from https://medicalprofessionals.aurorahealthcare.org/students/rehab/art/prisoner-patient.pdf

[24] Guthrie, Kane. "Behavioural Emergencies." *Life in the Fast Lane*. October 9, 2017. https://lifeinthefastlane.com/behavioural-emergencies/

[25] d'Ettorre, Gabriele et. al. "Preventing and managing workplace violence against healthcare workers in Emergency Departments." *Acta Biomed for Health Professions*, vol. 89, s. 4, 2018, pp. 28-36. DOI: 10.23750/abm.v89i4-S.7113

Substance Abuse or Intoxicated Patients

In the context of the present opioid epidemic, drug users often seek treatment in an emergency department. As most drugs are used and abused illegally, this again blurs the line between criminal behavior and treatment of patients. In most cases, patients who present to the ER who are intoxicated or under the influence of illegal substances are seeking medical treatment and should therefore receive all protections that being a patient provides. That being said, alcohol and substance abusers do present an increased risk for violence against staff.[23] Though nearly any addictive drug can cause bizarre behavior, some drugs are especially prone to causing violence and aggression. Patients who are under the influence of the drugs listed below should be handled with extreme caution:

- Bath Salts is a term used to describe a number of substances that are made synthetically and produce effects similar to illegal drugs. Bath Salts are illegal in 41 states but can be sold and purchased legally in others. They can cause panic attacks, paranoia, hallucinations, violence and suicidal behavior.
- Cocaine is an illegal, addictive drug that has stimulant properties. Cocaine affects the nervous system and can make users feel euphoric. It can also cause paranoia, anxiety, tremors and convulsions. Large amounts or frequent use of cocaine can cause hallucinations, paranoid delusions, psychosis and depression.
- Anabolic steroids can cause psychiatric effects, especially aggression. These drugs can also cause mania, psychosis, mood swings, suicidal thoughts and violent behavior
- LSD use is characterized by hallucinations and the inability to think clearly. While users can have positive reactions to LSD, negative reactions can include paranoia, delusions, anxiety and psychosis[26]

Risk Factors

There are general risk factors to consider as well as impending signs of possible violent behavior to be aware of when determining how to best manage a patient. General risk factors include younger age, male gender, history of violence, use of weapons, threats to harm, substance abuse and a history of physical abuse. Younger age and male gender are fairly easy to identify by security staff. However, there may not be easy access to patient history information. It is critical that all healthcare team members, including security officers, share whatever information about the patient's current condition is available and that they can recognize the signs of impending violence. These signs include flushing of skin, dilated pupils, shallow rapid respirations, excessive perspiration, restlessness and pacing, impulsivity and intimidating physical behavior such as clenching fists and are signs that an act of violence is imminent.[24, 27] Immediate steps must be

[26] https://drugabuse.com/what-drugs-cause-the-most-insane-behavior/

[27] Crisis Prevention Institute https://www.crisisprevention.com

taken to ensure the safety of the patient and the staff to avoid escalation to a level requiring the use of handcuffs.

Response

While none of these medical issues or violence risk factors guarantee an individual will be violent toward staff, security officers should be much more alert to the increased potential for violence or aggression. There is always a cause for aggression, usually a combination of intrinsic and extrinsic factors. A good starting point is to assume that any aggression indicates a patient's distress, or an attempt to communicate an unmet need by someone whose coping abilities are failing. The person wants something, wants to do something or is afraid of something.[28] Care givers and security officers should be proactive in managing these patients while trying to identify and meet these needs. Proactive management techniques could include extra comfort items such as food, drink and blankets if appropriate, dimming the lights and decreasing stimuli from the environment, providing earlier opportunities for calming medication or earlier consideration for use of physical or chemical therapeutic restraints if less aggressive techniques are failing. As was mentioned earlier, handcuffs should be used on patients in only the direst circumstances when lives have been placed at risk. It is rare that a situation, if managed proactively early on, should escalate to the point of imminent danger where the use of handcuffs may be necessary.

BEST PRACTICES

Prevention

The most critical component of a management strategy for the use of handcuffs in the healthcare environment is the strategy to prevent their use in the first place. The first tool is de-escalation training for staff. There are many programs available such as the Crisis Prevention Institute (CPI),[27] Verbal Judo,[29] Non-Abusive Psychological and Physical Intervention (NAPPI)[30], Management of Aggressive Behavior (MOAB),[31] and the Ten Domains of De-escalation.[32] These programs teach staff to recognize and respond to violence cues to help patients regain control. They also teach staff how not to inadvertently escalate situations as well as give staff increased confidence in dealing with agitated people. For this reason, training should not be limited to security or behavioral health staff, but instead offered to all staff members who might encounter an upset person or family member.[27]

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[28] Harwood, RH. "How to deal with violent and aggressive patients in acute medical settings." *Journal of the Royal College of Physicians of Edinburgh*, vol. 47, iss. 2, June 2017. doi: 10.4997/JrCPe.2017.218

[29] Verbal Judo http://verbaljudo.com/

[30] Non-Abusive Psychological and Physical Intervention https://nappi-training.com/

[31] Management of Aggressive Behavior (MOAB) https://www.moabtraining.com/

[32] Richmond, Janet et. al. "Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup." *Western Journal of Emergency Medicine*, vol. 13, iss. 1, pp. 17-25, February 2012. doi: 10.5811/westjem.2011.9.6864

It is also critical to foster a team environment between nursing, security and administration. Recognizing, preventing and responding to violence is the responsibility of everyone involved with the care of a patient. Security teams should understand the medical protocols and medical teams should understand the security protocols.[33] Care givers and security staff must work together and be supported by hospital administration that patients will not be permitted to be abusive toward staff.[34]

Hospitals should have mechanisms in place to alert staff if a patient has previously been violent in the facility. This flag can be part of the medical record, registration process or security system as long as it quickly informs staff that the patient has demonstrated a violent tendency in a previous encounter.[35] If a patient is pre-identified as having acted out, actions can be taken proactively such as involving security early or clearing the patient's room of anything that could be used as a weapon.

The last key component to prevention is a strong workplace violence program. OSHA requires it and facilities will have more success mitigating violence if employees feel supported and safe. The program should encourage reporting incidents including verbal abuse and near misses. It must also provide appropriate follow-up support to victims and others affected by workplace violence. Incidents of violence must be reviewed to determine contributing factors and opportunities for intervention and improvement. There are many resources available to assist in developing healthcare workplace violence prevention programs, the most comprehensive being OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.[2]

Strong Response to Criminal and Abusive Behavior

It is also important for healthcare organizations to have strong policies and practices against criminal and abusive behavior. Simply being a patient or under the influence of drugs or alcohol does not excuse abusive behavior. When behavior is criminal and conducted with mal-intent, patients should be charged and prosecuted.[36] Additionally, when crimes are committed on property, especially those that involve threats or violence, it is important for employees to see security officers using the tools available to them such as handcuffs to detain criminals and have them removed. Staff must feel that their safety is important to administration and that abusive or criminal behavioral will not be tolerated.

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[33] Cloney, Lee. "Responding to Violence in Healthcare." *Security Management*. June 26, 2017. https://sm.asisonline.org/Pages/Responding-to-Violence-in-Healthcare.aspx

[34] The Joint Commission. "Preventing violence in the health care setting." *Sentinel Event Alert*, iss. 45, June 3, 2010. Retrieved September 9, 2018 from https://www.jointcommission.org/assets/1/18/sea_45.pdf

[35] Vogel, Lauren. "Abusive patients: Is it time for accountability?" *Canadian Medical Association Journal*, vol. 188, iss. 11, pp. E241–E242, August 9, 2016. doi: 10.1503/cmaj.109-5266

[36] Weber, Ryan. "Patients are people first." *Security Management*, February 2018. Retrieved September 1, 2018 from https://sm.asisonline.org/Pages/Patients-Are-People-First.aspx

Use of Force Policy, Training and Proper Technique

Although physical intervention is considered to be the method of last resort, sometimes hospital employees are left with no alternative but to use this approach when someone becomes a danger to themselves or others. It is imperative that healthcare organizations have evidence based, well developed Use of Force policies governing how and when security officers should use force. This policy should be developed by a multi-disciplinary team in order to consider use of force from all relevant angles to create the most comprehensive plan.

Specifically regarding handcuffing, the Use of Force policy should include when the use of handcuffs is permitted and when it is not, how to minimize risks associated with the use of handcuffs, and the training required. The policy should state that handcuffs should only be used by competent staff members who are trained in their use, who receive continuing education and who are well-versed in any applicable regulations, laws and policies pertaining to their use.

Awareness of restraint-related positional asphyxia and how to avoid positioning that could restrict breathing is of critical importance in use of force policy and training as this can cause death. Positional asphyxia is death as a result of body position that interferes with one's ability to breathe.[37] Especially dangerous is the facedown floor position most commonly used during handcuffing. Security officers must be careful not to use their own bodies in a way that restricts someone's ability to breathe, such as sitting or lying across a person's back or stomach. When a person is lying face down, even pressure to the arms and legs can interfere with a person's ability to move his or her chest or abdomen in order to breathe effectively. Officers must be trained to watch for signs of distress from the individual being handcuffed and to move them to a side, seated or standing position as soon as it is safe to do so.[36, 38] Factors that can increase the risk of positional asphyxia or other significant medical issues during the handcuffing process include obesity, extreme physical exertion prior to or during a restraint, heart disease, breathing problems and use of alcohol or drugs.[37] These risk factors should be incorporated into policies and training.

While the application of handcuffs seems fairly straightforward to those in the law enforcement and security profession, the risks are real and reviewing those risks in detail must be part of any training program. Consider the recent use of handcuffs at a South Dakota facility. On July 14, 2018, a 35-year-old man who was acting out died of an apparent heart attack in the emergency room at Rosebud Indian Health Service hospital. He was involved in an altercation during which security officers pepper-sprayed him and restrained him, at one point handcuffing him faced down on the floor. Inspection records

[37] US Department of Justice. "Positional Asphyxia – Sudden Death." *National Law Enforcement Technology Center Bulletin.* June 1995. Retrieved September 1, 2018 from https://www.ncjrs.gov/pdffiles/posasph.pdf

[38] Schubert, Judith. "Responding to Abusive Patient Behavior." *Crisis Prevention Institute*. Retrieved September 23, 2018 from https://www.crisisprevention.com/Blog/June-2011/Responding-to-Abusive-Patient-Behavior-Part-2

show the man had been using methamphetamine and was hallucinating. When physicians couldn't get him to take medicine to calm down, they called on a security officer to restrain him. He was placed on the floor, where a security officer handcuffed him while other hospital employees helped hold him down. They pepper-sprayed the man when he continued to resist restraints on the floor. Following the incident, physicians noted an irregular heartbeat. They moved him to the bed and began life-saving efforts to no avail. The specific cause of the man's death has not been released. Rosebud was cited by CMS and placed in Immediate Jeopardy Status.[39]

Relationship with Local Law Enforcement

The final key to successful management of handcuff use in the healthcare security arena is to have a strong relationship with local law enforcement. When a person is placed in handcuffs by security staff, the expectation is that the person will be removed from the property by local law enforcement and charged with a crime. If law enforcement officers choose to take a different action or not press charges, it opens the hospital up to significant liability in detaining the person. It also decreases the morale of security staff when they see their efforts to maintain campus safety are not taken seriously or handled in the way they expected.

Law enforcement in the jurisdiction where the healthcare facility resides should meet regularly with hospital administrators and/or security team members to discuss roles and responsibilities, expectations and policies to clearly define the incidents when security officers may use handcuffs. The recent unlawful arrest of an on duty nurse in Utah[40] shows that poor relationships with law enforcement can have significant consequences for both employees and healthcare facilities. Multiple organizations including the International Association of Health Care Security and Safety,[41] the Greater New York Hospital Association[42] and the Minnesota Hospital Association[43] have come out with specific recommendations for integration and collaboration between hospital staff and law

[39] Ferguson, Dana. "Federal report reveals patient died needlessly in South Dakota IHS hospital." *Sioux Falls Argus Leader*, August 17, 2018. https://www.argusleader.com/story/news/politics/2018/08/17/indian-health-service-federal-report-details-deadly-deficiencies/1018539002/

[40] Kelly, Matt. "The Many Compliance Lessons From Utah Arrest." *Radical Compliance*, September 4, 2017. Retrieved September 21, 2018 at http://www.radicalcompliance.com/2017/09/04/compliance-training-lessons-utah/

[41] Kehoe, Bob. "Spelling Out Collaboration with Law Enforcement. New guideline sets points of communication." *Hospitals and Health Networks*, October 19, 2017. https://www.hhnmag.com/articles/8661-spelling-out-collaboration-with-law-enforcement

[42] "Hospital Coordination with Local Law Enforcement. Hospital Guidance Document." *Greater New York Hospital Association.* Not dated. Retrieved September 21, 2018 at https://www.gnyha.org/wp-content/uploads/2017/08/NYPD_Coordination_FINAL_6Dec2016.pdf

[43] "Healthcare and Law Enforcement Collaboration Road Map." Minnesota Hospital Association. 2017. Retrieved September 21, 2018 at https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Health_Care_and_Law_Enforcement_Collaboration_Road_Map.pdf

enforcement. If policies and procedures are discussed and agreed upon ahead of time, a smooth transition to law enforcement will occur.

There is one additional item worth noting regarding the interaction between healthcare organizations and law enforcement, specifically with regards to the use of handcuffs. CMS requires healthcare staff, including security officers, to advocate for a patient during an incident in which law enforcement is used. The same CMS Interpretive guideline quoted earlier goes on to say: "The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner)."[14] While it appears this is referring to prisoner patients, it is possible a hospital could be cited by CMS for law enforcement officer actions against any patient of the facility if it is deemed the hospital staff did not advocate and allow for the safe provision of care for the patient during a law enforcement intervention.

CONCLUSION

The use of handcuffs in the healthcare setting is a complicated issue. The federal regulations related to patient protection and worker protection are in direct conflict, putting security officers in the middle with the expectation that they will somehow navigate the inconsistencies to protect both. Though perhaps counter-intuitive, the most successful and purposeful use of handcuffs in the healthcare setting is to prevent their use in the first place, especially with regards to patients. This can be best accomplished through workplace violence programs and de-escalation training. In the circumstances in which they are needed, strong polices, a healthcare team environment, training and a collaborative relationship with local law enforcement are the keys to success.

Author

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