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Management of Hospital Security in General Hospitals of Southwestern Uganda

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Abstract

The management of security varies in different organizations including hospitals, and security is one of the major support services needed for ensuring a safe environment of care. This study determined the management of security in general hospitals in Southwestern Uganda. A descriptive-cross-sectional study, which employed both quantitative and qualitative methods of data collection and analysis, was carried out. Common security concerns were theft, assaults, workplace violence and elopement with generally low chances of security concerns happening and poor preparedness to handle them in case they occurred. Only two out of six hospitals fairly met the security standards with identified gaps like lack of security guidelines, security plans, security committees, and non-availability of training opportunities for security personnel. Hospital managers and other policy makers involved in the management of hospital security should work together and address the security gaps existing in general hospitals in order to improve on the management of security.

Keywords

Security, Security Managers, General Hospital, District Police Commanders, Security Committee, Security Personnel

1. Introduction

Hospitals are perceived as institutions of tradition that historically resisted becoming victims of insecurity whereby more efforts have been put on offering services based on open and friendly access to the public. This has been practiced for decades implying that hospitals should be open 24 hours a day and seven days a week whereby people of any type walk in and out without being stopped. Such traditional practices have been reversed following continuous criminal threats that have resulted into dropping of the open door policy in hospitals (Aldridge, 2006).

Hospital security departments and staff are usually challenged to offer a safe environment for employees, patients, and visitors. This is attributed to their designated nature of being open and accessible to the public which is likely to favor entry of perpetrators of crimes and other dangers to the hospital if not properly protected (Schneider, 2008).

Traditional security methods including the use of local tools like sticks and bows may not offer standard protection to the health care facilities. Such institutions may experience complex risks like infant abduction, extortion and reputation risks especially when an incident occurs (Matheson, 2010).

Security managers face unique challenges especially those related to hospital security needs affecting patients, employees and other assets which have always served as a hindrance in securing environment of care bearing in mind that no hospital is without a risk (Vellani, 2006). Hospitals are required to meet their security needs through security risk management which is essential for all hospital security managers. Such managers are charged with prioritizing the identified risks, developing an effective hospital security plan and reduce the risk to manageable and acceptable levels (Warner, 2003).

Studies conducted by Erickson and Williams- Evans (2000), reported that 82% of the nurses surveyed in the United States had been assaulted during their careers while 80% of the assaults on registered nurses were not reported. This shows that their growing incidence of security issues including assault yet little about health care security is known to the public and few countries across the globe are committed to offering specific legal deterrents for assaulting

professionals including nurses among others.

Visitors of various categories can also raise security concerns for the hospital. Such concerns are witnessed in the form of visitor- violence against patients which is one of the security concerns that continues to threaten the reputation of many health care institutions across the globe – a factor that has on many occasions challenged hospital managers in terms of high volume of visitors (Murzycki, 2012). Hospitals are integral part of health care systems and their ability to mount an effective response in the face of threats to global health security depends largely on the performance of health system itself. Data from Eastern Mediterranean region reveal that 85% of the population has been directly or indirectly involved in conflict situations (Siddiqi et al, 2008).

In Africa, countries like Sudan, Libya, and Somalia have fallen suit to complex security emergencies that require humanitarian assistance and need to work on disaster risk preparedness. Such complex security incidents have also prevailed in South Africa including rape of a female doctor in one of the hospitals which prompted tightening of security measures in hospitals (Kabane, 2010). Studies conducted by Hove et al (2013) have revealed that rising crime and insecurity in the sub-Saharan region has emerged due to the urban crisis in cities. Crime and violence act as major deterrents to investment, especially in health related organizations.

In Uganda, hospital security emergencies have ranged from simple to complex including the 2010 bomb blasts in Kampala. This created security alertness to most organizations including hospitals where in addition to this cases of stealing babies have been witnessed in some hospitals (URN, 2012).

2. Methodology

The study focused on the management of security in six general hospitals. A census of government hospitals (Kisoro Kambuga Itojo hospitals in Kisoro, Kanungu Ntungamo districts respectively) and three PNFP hospitals (Nyakibale Rugarama and Mutolere hospitals in Rukungiri, Kabale, and Kisoro districts) was considered. Irrespective of whether PNFP or government hospitals, all were referred to as general hospitals although with varying bed capacity contrary to 100 bed capacity of a typical general hospital.

The study explored the management of security in general hospitals in terms of security concerns, security in puts, effectiveness of security processes and security related challenges in order to generate information that would enable hospital managers design better security management strategies.

For security concerns, interview guides and questionnaires were employed to identify relevant features regarding security concerns among key informants and security personnel while a checklist was applied to security personnel in hospitals to assess the likelihood of security concerns happening and the preparedness to handle them in case they occurred. This covered specific security concerns like

assaults, violence and bomb threats among others. The likelihood of a security threat happening in a hospital was assigned scores as high (3), medium (2) and low (1) while the scores for preparedness to handle security threats were good (3), fair (2) and poor(1).

A security concern qualified to be of high likelihood if it was presumed to occur anytime in that hospital and cause a lot of destruction/loss; medium likelihood if it could happen but prevailing circumstances are not supportive and low likelihood if the security threat has never happened and the prevailing conditions are not supportive. On the other hand, to qualify for good preparedness to handle a security concern meant that necessary resources like personnel, equipment, and conducive environment of care were available; fair preparedness meant that some of the resources to use could be available but in scanty and inefficient quantities while poor preparedness meant that there is nothing in place to adequately counteract the security concern in case it occurred.

For determining availability of inputs to manage health care security, a general checklist was used. Such inputs assessed for their availability included security tools, modern security equipment, security infrastructure and security personnel. For effectiveness of health care security processes in general hospitals, a nine security standard observation checklist of New Jersey Hospital Association, (2004) guidelines on emergency preparedness for hospital security was adopted and modified to suit the standards for hospitals in developing countries like Uganda. The nine security aspects were:

1. Addressing security issues concerning patients, visitors, personnel, and property
2. Reporting and investigating all security incidents that involve patients, visitors, personnel, and property.
3. Providing appropriate identification for visitors, patients and staff.
4. Controlling access and egress from sensitive areas.
5. Hospital leadership that has designated a person responsible for monitoring security
6. Emergency security procedures that address security issues
7. Providing vehicular access to urgent care areas
8. Having a security orientation and education program for hospital staff
9. Continuous performance monitoring of actual or potential security risks.

Each security standard was assigned specific criteria to be met with different scores under which full compliance with the criteria was assigned a score of two (2), partial compliance one (1) and none compliance zero (0). The overall rating for the compliance with the criteria to meet the standard was based on the sum of the scores in the nine security standards and were categorized as; 0-2 for not meeting the criteria, 3-5 for fairly meeting the criteria and above 5 for fully meeting the criteria.

Both qualitative and quantitative data were collected during July and August 2013 from 33 security personnel and 18 key informants purposively selected basing on their

knowledge and expertise in hospital security issues. The key informants included Medical Superintendents, Hospital Administrators, District Police Commanders and the Gombolola Internal Security Officers (GISOs) of the area where the hospitals are located while at the hospital level, all security personnel were interviewed.

Data was collected using pre-tested interviewer-administered questionnaire and checklists which were administered to security personnel while interview guides were administered to key informants. The researcher was principally responsible for data collection and analysis.

Quantitative data that generated frequencies for descriptive data was analyzed using SPSS version 16.0 and results presented using tables and text while qualitative data was categorized into themes. Respondents were encouraged not to disclose personal information in the questions as a measure to ensure confidentiality and anonymity throughout while individual consent was verified by each respondent signing on the questionnaires and were reassured that the study was purely academic.

3. Results

All the security personnel interviewed were males with 57.6% of them in the age bracket of 30-39 years.

3.1. Security Concerns

The likelihood of most security concerns happening were generally low despite the fact that most of the respondents' (70%) view regarding the preparedness of general hospitals to handle most of the security concerns was poor as in table 2.

Security concerns including assaults, elopement, workplace violence and fighting were found to occur more often but theft being the most pronounced in general hospitals by both security personnel and key informants as affirmed by statement that: '*Our hospitals are sources of theft. Some time back, some intruders were made to drop a motorcycle they had stolen from the nearby hospita*l' (Area GISO, July 2013).

Other security concerns pronounced by key informants included night intruders with intention to steal hospital property and the risk of being near the border with countries where most security concerns have prevailed which was supported by the statement that:

Our hospitals have always become victims of theft and we have lost a lot of items including generators, spare parts for a vehicle, bed sheets and phones from patients. This always puts us on task to frequently appear in courts of law to give statements regarding property loss and the culprits (A hospital administrator, July 2013).

3.2. Security Inputs in Hospitals

Generally results indicated non-availability of modern security equipment including management aspect of security inputs as security work plan and guidelines among others. None of the general hospitals had a security committee and there was no evidence of security meetings taking place as illustrated by one of the hospital managers who said that; '*We have not always encouraged meetings in our hospitals because even if you call for it there is no facilitation and staff will not respond*' (A medical superintendent, July 2013).

Hospital managers (medical superintendents and hospital administrators) and security personnel agreed to the fact that security personnel use local tools such as sticks, spears, pangas and torches to execute their duties as asserted that: '*We used to have armed security guards, but we were stopped due to shortage of funds to sustain their allowances*' (A hospital administrator, 02 July 2013).

Table 1. *Security concerns in the general hospitals studied.*

Security threat	Likelihood of the security threat happening in the hospital						Preparedness of handling the threat					
	High		Medium		Low		Poor		Fair		Good	
	F	%	F	%	F	%	F	%	F	%	F	%
Bomb threats (n=33)	12	36.4	9	27.3	12	36.4	29	87.9	2	6.1	2	6.1
Civil disturbances (n=33)	1	3	6	18.2	26	78.8	32	97	1	3	-	-
Hazard exposures (n=33)	2	6.1	-	-	31	93.9	30	90.3	3	9.1	-	-
Hostage situations (n=33)	2	6.1	3	9.1	28	84.8	32	97	1	3	-	-
Mass causality (medical) (n=33)	2	6.1	2	6.1	29	87.9	31	93.9	2	6.1	-	-
Mass casualty (trauma)(n=33)	2	6.1	6	18.2	25	75.8	32	97	1	3	-	-
Workplace violence (n=33)	4	12.1	16	48.5	13	39.4	17	51.7	14	42.4	2	6.1
Infant abduction (n=33)	1	3	9	27.3	23	69.7	26	78.8	4	12.1	3	9.1
Terrorism (n=33)	10	30.3	10	30.3	13	39.4	29	87.9	4	12.1	-	-
VIP visits(n=33)	4	12.1	8	24.2	21	63.6	26	78.8	7	21.2	-	-
Theft (n=33)	11	33.3	17	51.5	5	15.2	13	39.4	16	48.5	4	12.1
Robbery (n=33)	1	3	6	18.2	26	78.8	30	90.9	3	9.1	-	-
Drug loss (n=33)	3	9.1	9	27.3	21	63.6	28	84.8	1	3	4	12.1
Fire explosions (n=33)	3	9.1	16	48.5	14	42.4	26	78.8	7	21.2	-	-
Assaults (n=33)	2	6.1	15	45.5	16	48.5	26	78.8	7	21.2	-	-
Burglary (n=33)	1	3	7	21.2	25	75.8	31	93.9	2	6.1	-	-
Elopement (n=33)	9	27.3	15	45.5	9	27.3	19	57.6	12	36.4	2	6.2
Loss of Information (n=33)	1	3	8	24.2	24	72.7	27	81.8	6	18.2	-	-
Fighting (n=33)	1	3	16	48.5	16	48.5	19	57.6	12	36.4	2	6.1

While District Police Commanders (DPCs) and Gombolola Internal Security Officers (GISOs) indicated that guns were the most common security equipment hospitals should possess in addition to detectors, scanners for checking people as they enter, enough security lights, batons and walk talkies.

To hospital managers, failure to have any modern security equipment in general hospitals was attributed to the fact that there are no trained security personnel to use them; modern security equipment is too expensive for the hospital and no need for guns in the hospital because they can scare patients. This was revealed by one of them who said that:

We have not experienced any big security problems in our hospitals before and we have not thought of investing in modern security equipment which is even expensive to be met by our hospitals budget *(*A hospital administrator, July 2013).

In some hospital managers employed the strategy of checking people on entry and exit to hospitals in order to streamline security procedures. However, this was not supported by their counterparts in other hospitals as revealed by one of them that*; 'our security personnel are not always encouraged to check everybody who enters the hospital because we fear embarrassing the VIPs by screening and checking them at the hospital gate'* (A hospital administrator,

July 2013).

3.3. Staffing of Security Personnel in General Hospitals and Their Associated Work Systems

Although most of the hospitals had security personnel at the time of this study (table 2, they were insufficient. However, there was no standard to compare with. The security staffing capacity in general hospitals ranged from 4 to 6 staff and majority (97%) of them highlighted hospital administrators as their immediate supervisor. However, (87.9%) of security personnel revealed using personal mobile phones as common means of communicating security issues to their supervisors. Some security personnel in general hospitals (18.2%) reported being insecure at their environment of work which they attributed to lack of security equipment like guns which they would use to defend themselves in case of an enemy. This tallied with the fact that 60.6% of them had no specific security training while 90.1% had undergone cadre course called "*Chakamchaka*" (a non informal training for security vigilance and awareness) to prepare them for their current jobs.

Table 2. Assessment of availability of security inputs in the hospital.

Security input	Hospital					
	Itojo	Kambuga	Nyakibale	Kisoro	Mutolere	Rugarama
Security gadgets						
Guns	NO	NO	NO	NO	NO	NO
Batons	NO	NO	NO	NO	NO	NO
Bows	NO	NO	NO	NO	NO	NO
Arrows	NO	NO	NO	NO	NO	NO
Modern security equipment						
CCTV	NO	NO	NO	NO	NO	NO
Intrusion alarms	NO	NO	NO	NO	NO	NO
Electronic metal detectors	NO	NO	NO	NO	NO	NO
Metal detector (handle controlled)	NO	NO	NO	NO	NO	NO
Dog	NO	NO	NO	NO	NO	NO
Private internal security	NO	NO	NO	NO	NO	NO
Security personnel	YES	YES	YES	YES	YES	YES
Security Infrastructure						
Gate	YES∞	YES∞	YES∞	YES∞	YES∞	YES∞
Fence	YES	YES	YES	YES	YES	YES
Outdoor lighting	YES	YES	YES	YES	YES	YES
Exit emergency doors	YES	YES	YES	YES	YES	YES
Burglar proof in stores	YES	YES	YES	YES	YES	YES
Management aspects						
Security budget	YES*	YES*	YES*	YES*	YES*	YES*
Security inventory	NO	NO	NO	NO	NO	NO
Minutes of security meetings	NO	NO	YES	NO	NO	YES
Security management plan	NO	NO	NO	NO	NO	NO
Guidelines on security	NO	NO	NO	NO	NO	NO
Register for security incidents	NO	NO	NO	NO	NO	NO
Reports on routine checks/supervision for security	NO*	NO*	NO*	NO*	NO*	NO*

YES: Hospital gates are available but inappropriate
YES*: Security budget is incorporated in the general budget of the hospital.
NO*: Supervision for security is not specific but part of the general hospital supervision.

3.4. The Effectiveness of Security Processes in General Hospitals

Results from the overall scores in the nine security standards indicated that Rugarama hospital had better compliance with security standards than the rest and was followed by Nyakibale hospital. Only two hospitals fairly met the criteria and nearly all the hospitals (five out of six) were none compliant with the standard that required an orientation and education of hospital employees on security issues.

3.5. Challenges Faced in the Management of Security, Their Effects on Security Management and Mitigation Measures

Lack of security equipment like guns, understaffing and inadequate training are key challenges faced by security personnel while hospital managers cited underfunding, theft and some hospitals being located near the border with insecure countries. The DPCs and GISOs revealed that failure of hospital managers to report security concerns in time, difficult to identify illegal foreigners (intruders) who commit crimes in hospitals, and failure of the witnesses to easily give statements as the common challenges affecting their performance. Such challenges have adverse effects to hospitals in terms of added costs, risk due to untrained and not well equipped security personnel which all deter their efforts to institute better security measures in hospitals.

However, security personnel suggested regular internal security meetings, recruiting of more trained security personnel, joint patrols between hospital security personnel and police as mitigation measures in addition to effective use of available resources, and promoting the policy of every visitor to be a security guard of each other which were earmarked by both hospital managers and DPCs.

4. Discussion

The preparedness of general hospitals to handle security concerns in hospitals was generally poor. This is an indication that general hospitals are prone to even more adverse security concerns given such fertile conditions for them.

Most general hospitals had inadequate way of handling security due to use of local security tools, inappropriately trained security personnel, understaffing and lack of modern security equipment that would be used by the few who have the skills. Such inadequacies in security affect hospitals and mainly expose them to security vulnerabilities and concerns (Vellani, 2006).

The tools commonly used were sticks. These would not be used to counteract any invasion involving modern security equipment like guns which are always used by most perpetrators of security events in many organizations including hospitals. Therefore, a situation where appropriate security tools are lacking, coupled with inappropriately trained security personnel and understaffing that grossly affect most hospitals still creates many security loopholes.

None of the hospitals had security guidelines, security management plans, security inventory and no evidence of any security meetings. Developing effective security management plans and ensuring security meetings take place are some of the core functions of hospital managers (Warner, 2003). A situation where such tools were absent indicates a high deficiency in prioritizing hospital security management.

The DPCS and GISOs highlighted guns to be major items required for hospital security and most hospital managers reacted contrary with the view that guns can scare patients and any other visitors who come to the hospital. This also relates to the fact that all the hospitals lacked policies and guidelines regarding security management. The availability of such policies would support the use of security equipment like guns that would be used in addressing security concerns that warrant their use.

The security budget in all the hospitals was not specified but incorporated into the general budget of the hospital. Bearing in mind the constricted budget often allocated to general hospitals where more efforts are directed to curative services (MOH-Annual health sector performance report, 2012), security management will continue limping to unacceptable levels unless the system is redirected to specify the budget for security in general hospitals.

None of the hospitals had a hospital security committee that would be responsible for overseeing the security of the hospital. Such committee would also be charged with developing a security plan (Rogers, 2010). A situation where such inputs are lacking limits the capacity of hospital managers to emphasize hospital security management issues at The results show that all the security personnel in general hospitals were males. This means that in case a security concern involving a female happens in a hospital where checking of the culprit is required, there would be no compatible security personnel to do the needful thus posing high chances of retarding security processes including investigations and giving of statements in the courts of law since no male is allowed to check a female and no female is allowed to check a male. This has policy implications in the sense that some cases regarding hospital security issues will keep pending in the courts of law due to delayed investigations.

The common security concerns in hospitals included theft, assaults and work place violence. However, their likelihood of happening in hospitals was reported to be minimal. This does not rule out the fact that security concerns can occur at any time although most hospital managers argued that they have not experienced any big security problem before. The openness nature of our general hospitals which is likely to contribute to a significant number of security concerns including work place violence and damage of property (Matheson, 2010).

Some general hospitals are located nearer to unstable

country borders like Democratic Republic of Congo where insecurity has prevailed for a long time. This exposure to insecurity sometimes results into various problems to hospitals including physical and psychological injuries to patients, the families of the victims and to some extent the hospital incurring financial costs (Schweizer, 2013). This means that the management of security should not be viewed at hospital level only but as an international issue that requires joint action. Such security issues in hospitals have always deterred the services of hospital managers and security personnel especially in identifying the intruders (foreigners) or giving statements in courts of law to enable investigations and action. This has security management implications to hospital managers and so may require inter-sectoral collaboration between Ministry of Health and Ministry of Internal Affairs to handle hospital security issues.

The supervision accorded to security in hospitals was not adequate yet security personnel like any other workers need to be supervised and guided on how to appropriately secure the environment of care in a hospital setting which calls for joint supervision by hospital managers, DPCs and GISOs in order to revitalize security functions in general hospitals.

Security infrastructure plays a key role in better security management systems. At the same time poorly designed hospital facility systems and faults related to health care infrastructure can result into multiple security events that underpin security in most hospitals (Turner, 1988; Ulrich et al, 2004; BSIA, 2009; Sullivan et al, 2011). However, it is unfortunate to note that the original form in which hospitals in Uganda were constructed did not consider security aspects as part of hospital infrastructure. Nevertheless updating of hospital fences, repairing of gates including limiting the number of outlets (small gates) and streamlining lighting system can be of better advantage to the hospitals.

Results revealed that most hospital managers reacted contrary to the strategy of checking people at the gate as they enter and exit the hospital in fear of embarrass some of the Very Important Persons (VIPs) who visit the hospital. This indicates that people continue to enter and leave the way they want which is dangerous to hospital managers and security personnel especially in exacerbating loss of hospital property. Therefore hospital managers in collaboration with their security personnel should design and stick to security regulations that ultimately save hospitals from such encounters.

All security personnel in general hospitals use personal mobile phones to communicate security concerns to hospital managers yet not facilitated especially in terms of airtime. This would render some security concerns to go unreported, therefore imperative for integrating communication and medical technology into the general hospital budget as a measure to improve safety and security of the hospital (Rogers, 2010).

All the hospitals studied were non-compliant with the criteria to meet the established security standards. For effective security management, general hospitals should be able to perform better in security parameters such as monitoring and patrolling designated areas, identification for visitors, patients and staff, and access control to sensitive areas among others. This would require adhering to the criteria necessary for meeting the desirable security standards. Therefore, a situation where most of the general hospitals were none compliant in meeting the standards indicates that security management in our hospitals is still at stake.

Furthermore, the functionality of these security processes would serve as a concrete foundation for hospital managers and security personnel to better identify security concerns in hospitals and be able to design appropriate security management interventions in hospitals.

Inadequate funding was a major challenge affecting most general hospitals indicating that provision of necessities such as security equipment, salaries, and uniform for patients and security personnel among others in addition to security activities including maintenance of security equipment, training of security personnel and procurement of equipment will always be at stake. Researchers like Meyer (2011) emphasize that training of security personnel is vital. Therefore, none availability of training opportunities for security personnel coupled with inadequate funding in general hospitals continue to threaten the performance of hospital managers unless the budget allocation is revised by parties concerned. .

Results showed that offering adequate and safe environment of care to general hospitals proved a challenging venture to hospital managers and security personnel yet a safe environment of care in health care institutions is a requirement for hospital security management (Vellani, 2006). This relates to the policy of every visitor to be a security guard of each other thus demanding for quality supervision of security programs in hospitals and be able to harmonize the safety of patients, employees and visitors in a hospital setting.

5. Conclusions

General hospitals in south western Uganda lack the capacity to manage health care security especially in terms of security infrastructure, security personnel and security equipment. Much as there was evidence of security threats occurring in these general hospitals the preparedness to handle them was poor. The compliance for meeting established security standards was below threshold designated for fully meeting the standards. Their inadequacies originated from poor staffing, lack of required security equipment, poor financing and poorly designed security infrastructure. The aspects of security management in terms of having security committees, guidelines, security plan and training opportunities for security personnel were lacking in most general hospitals. The fact that some general hospitals are located near the borders with insecure countries was identified as a major security challenge. The policy of every visitor to the hospital being a security guard to each other was earmarked among mitigation measures for security concerns in general hospitals.

Recommendations

Hospital Managers need to consider availability of training opportunities for security personnel, avail job descriptions, establish hospital security committees and improve on funding in addition to provision of appropriate security equipment.

GISOs, DPCs and Police in general need to emphasize security support supervision, strengthen joint handling of culprits of security issues with hospital managers, encourage joint patrols in and around the hospitals and promote the culture of regular security meetings.

The Uganda Ministry of health should avail national security policy/guidelines, establish a standard tool kit for security equipment in general hospitals, increase funding and encourage multi-sectoral approaches especially bringing the Internal Affairs ministry on board so that security issues in hospitals can be handled holistically.

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