

Benchmarking Healthcare System Security Department Composition, Staffing, Training, and Prevalence of Defensive Tools

Methodology

In late 2019 a healthcare client of Security Advisors Consulting Group (SACG) commissioned SACG to conduct benchmarking study researching healthcare Security Department staffing levels and composition. The research also sought to identify the different roles contained within the Security department, length of training received by Uniformed Security Officers as new hire training, annually recurring training, and types of defensive weapons issued by the organization to its Security Officers. This whitepaper is drawn from that research and from additional research conducted during 2020 on the same subject.

This data was collected via a web-based survey tool which was distributed to health system Security leaders via e-mail and via posting in the discussion forums of both the International Association of Healthcare Security and Safety and ASIS International. Phone interviews were also conducted with select respondents to clarify answers or request elaboration on points made.

Participants

In total representatives from thirty-one healthcare systems responded and contributed their data to the survey. Not all of these responses could be used for all aspects of the survey as some chose to only answer the questions related to defensive tools usage and/or training and did not provide demographic data so were not included in the staffing benchmarks.

The thirty-one respondents were all located in the US and provided data for medium to large healthcare systems consisting of between two and one hundred and sixty-one hospitals, for a total of five

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He has served as the senior most security executive (CSO) for organizations in the healthcare, financial services, education, hospitality sectors, and as a Regional Security Director for Mayo Clinic.

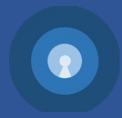
He is a sought-after speaker and prolific author whose contributions have been published in multiple formats.



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hundred and fifty-one hospitals (approximately 16% of all US hospitals that are part of a multi-hospital health system) contributing data.

The survey also asked questions regarding the responding organization’s total number of employed staff and total number of licensed inpatient beds. Responses to the question regarding staff varied from between 2,500 to more than 100,000 with a median of 23,944. While responses regarding licensed beds varied between 250 and 19,000 for a total of 73,465 beds across all respondent organizations, making up 8.1% of all licensed hospital beds in the US, and a median number of licensed beds of 1,331.

STAFFING

Security Department composition

Twenty of the respondent organizations provided demographic data that would allow for staffing benchmarking. Based on their responses, the composition of each Security Department was analyzed for the breakdown between percentage of Uniformed Security Officers, dedicated Dispatchers or Control Center Operators, Investigators, Systems Technicians or Designers, front line Supervisors, Management personnel, or other employees as a percentage of the total Security Department workforce. It should be noted that none of these benchmarks took into consideration the deployment of these staff and Departmental philosophy regarding use of Security Officers for purely patrol and response capabilities versus use staffing fixed posts which may strongly influence department composition as well as other benchmarking measures.

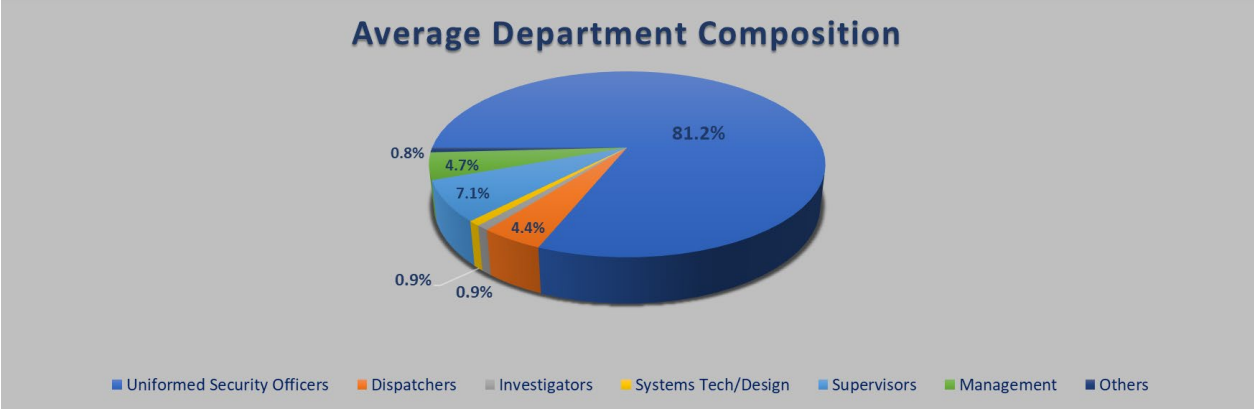
	Uniformed Security Officers	Dispatchers	Investigators	Systems Tech/Design	Supervisors	Management	Others
System 1	82.1%	3.9%	1.4%	1.4%	8.9%	2.1%	0.0%
System 2	88.0%	5.1%	0.4%	0.0%	5.1%	1.5%	0.0%
System 3	75.0%	4.3%	0.5%	1.3%	11.2%	5.0%	2.6%
System 4	89.6%	3.2%	0.6%	1.9%	3.2%	1.3%	2.6%
System 5	78.0%	3.7%	1.2%	1.2%	9.8%	6.1%	0.0%
System 6	77.5%	4.9%	2.0%	1.0%	11.8%	2.9%	0.0%
System 7	73.0%	9.5%	0.0%	1.4%	8.1%	6.8%	0.0%
System 8	69.0%	3.4%	5.4%	0.7%	10.2%	11.2%	1.4%
System 9	85.9%	0.0%	0.0%	1.0%	7.8%	4.4%	0.0%
System 10	80.3%	7.6%	0.8%	1.0%	5.0%	3.6%	1.0%
System 11	83.1%	12.3%	0.0%	0.0%	3.1%	1.5%	1.6%
System 12	92.6%	2.2%	0.4%	0.2%	3.3%	1.3%	0.0%
System 13	83.3%	11.1%	0.0%	0.0%	0.0%	5.6%	0.0%
System 14	75.0%	0.0%	0.0%	0.0%	10.0%	5.0%	0.0%
System 15	74.5%	7.4%	1.5%	2.4%	8.9%	5.3%	10.0%
System 16	76.6%	3.1%	4.7%	1.6%	9.4%	4.7%	0.0%
System 17	86.2%	0.0%	0.0%	3.4%	3.4%	6.9%	0.0%
System 18	85.4%	0.0%	0.0%	0.0%	9.8%	4.9%	0.0%
System 19	82.1%	5.1%	0.0%	1.3%	7.7%	3.8%	0.0%
System 20	71.8%	6.8%	2.4%	1.5%	6.3%	7.8%	3.4%
Average	80.4%	4.7%	1.1%	1.1%	7.1%	4.6%	1.1%



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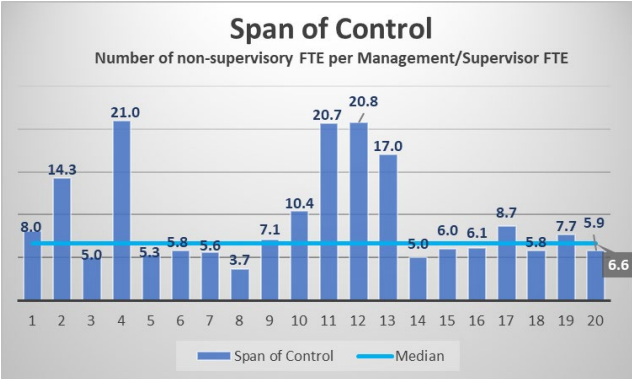
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Span of control

Based on the replies from the twenty respondent organizations that had provided sufficient data to allow for staffing benchmarks to be developed, we undertook to better understand supervisory span of control in healthcare Security Departments.

This was accomplished through analysis of the number of non-supervisory, or individual contributor, FTE reported as *Security Officers, Dispatchers, Investigators, Security Systems Technicians or Designers, and other Security Department employees* divided by the number of supervisory FTE reported as *Supervisors or Management* reported by the respondents.



While this is not a direct correlation to traditional span of control calculations that take into account only a supervisor or manager’s direct report FTE, it does provide us with a rough correlation and is the most accurate approximation that can be obtained based on the data collected. This data showed span of control within the reporting organizations ranging from 3.7 to 20.8 individual contributor FTE per supervisory or management FTE with a median of 6.6 and an average of 9.5.

While this data does range widely based on organizational structure, geographic distribution of the organization, and organizational philosophy; the majority of respondent organizations fall solidly in line with typical recommendations of a span of control of between 5 and 12 direct reports per management employee with 25% falling above this range and only 5% falling under it.



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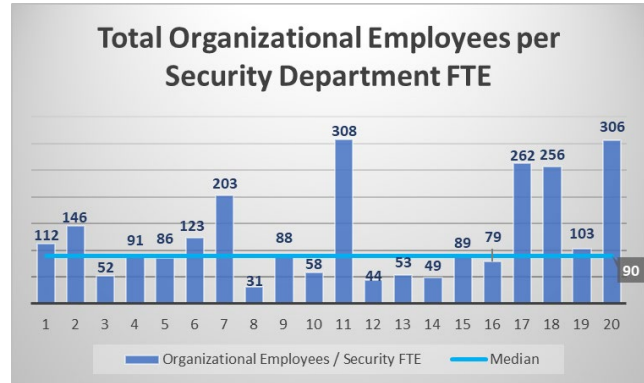
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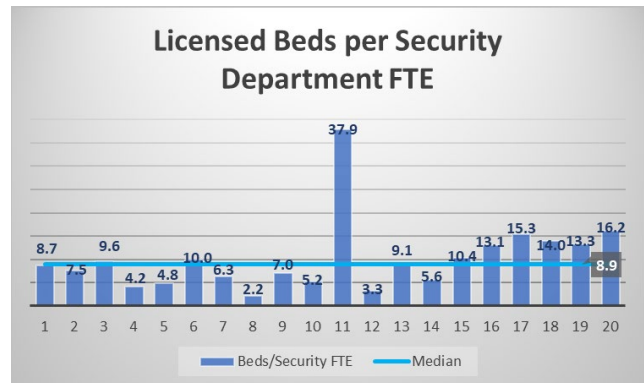
Security Department total FTE staffing benchmarks

The respondents' answers indicating total Security Department FTE ranged from 29 to 2,040 with a median of 206.

To establish benchmarks that could be applied uniformly across all healthcare systems surveyed, SACG determined that we would benchmark staffing levels against total number of staff employed by the healthcare system and against the total number of licensed inpatient beds in the system's hospitals.



Responses detailing the total number of organization employee FTE per FTE assigned to the Security Department ranged from 31 to 308 with a median of 90 and an average of 127. While total licensed inpatient beds per Security FTE ranged from 2.2 to 37.9 with a median of 8.9 and an average of 10.2.



In the respondent organizations the total licensed inpatient beds per Security Department FTE ranged from 2.2 to 37.9 with a median of 8.9 and an average of 10.2.

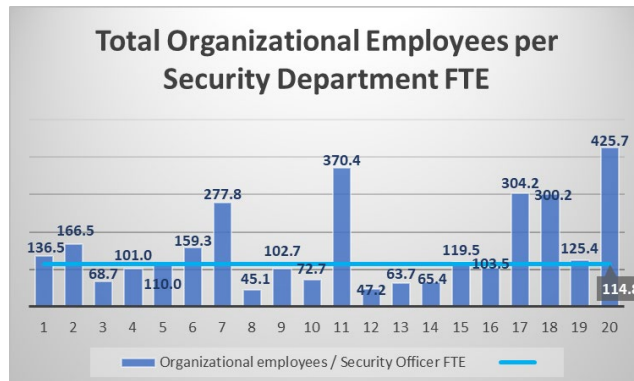




Uniformed Security Officer staffing benchmarks

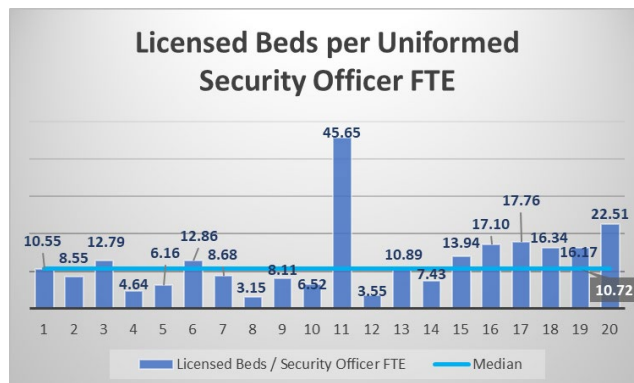
The respondents' answers to the question "How many FTE does your department have dedicated to uniformed Security Officer staffing" ranged from 25 to 1,530 with a median of 162.

Responses detailing the total number of organizational employee FTE per FTE of uniformed Security Officer staffing ranged from 31 to 308 with a median of 90 and an average of 127.



In the respondent organizations the total licensed inpatient beds per uniformed Security Officer FTE ranged from 3.15 to 346.65 with a median of 10.72 and an average of 12.67.

The significant differences seen in these benchmarks indicate that there is a relatively low correlation between either total number of organizational employees or and organization's number of licensed beds to either the total number of Security FTE or the number of uniformed Security Officer FTE.



DEFENSIVE TOOLS AND WEAPONS

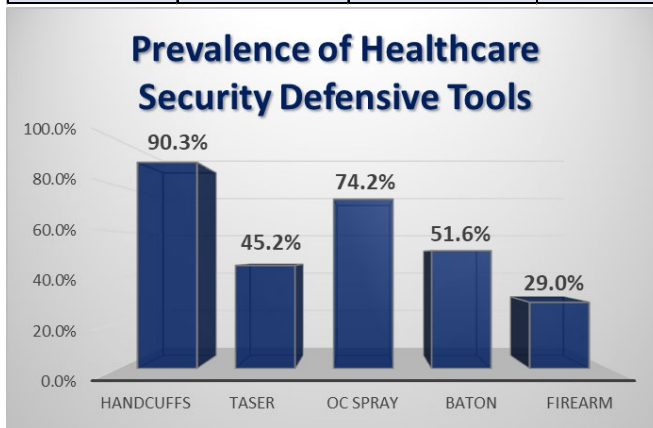
All thirty-one of the respondent organizations provided information on whether members of their Security Department were equipped with any defensive tools or weapons. This analysis was based purely on whether the specific defensive tool or weapon was issued to an of the employees in their organization's Security Department and did not investigate differences in equipment issued to different categories of Security employees, although our follow-up interviews with select respondents did reveal in at least two cases that the health system did have both unarmed Security Officers who were equipped only with less lethal weapons and Security or Hospital Police Officers who were equipped with both less than lethal weapons and with firearms, and one system where only Supervisory personnel were equipped with firearms.





By far the most prevalent type of defensive tool issued to healthcare Security Officers at the respondent organizations was handcuffs, with 90% of organizations indicating that at least some of their Security employees are equipped with handcuffs. All organizations that provided their staff with other defensive tools also provided handcuffs, although several did provide handcuffs without any additional defensive tools.

Type	Total response	Number issuing	% Issuing
Handcuffs	31	28	90.3%
Taser	31	14	45.2%
OC Spray	31	23	74.2%
Baton	31	16	51.6%
Firearm	31	9	29.0%



Firearms were the least prevalent tool included in our dataset, with only 29% of the organizations surveyed issuing firearms to all or some of their Security staff. None of the organizations that issued firearms did so without providing staff with handcuffs and at least one alternative less lethal defensive tool option.

TRAINING PROGRAMS

Security Officer new hire training

Twenty-nine of the respondent organizations, representing four hundred and thirty-four hospitals' Security programs, provided information regarding their training programs for newly hired Security Officers. The remaining respondent organizations did not have a consistent new hire training program across all hospitals in their system with variable

training lengths dependent on location or did not have a defined length for their training program so their data was excluded from the dataset.

Of the twenty-nine training programs six percent of the reporting hospitals provided their newly hired Security Officers only one week of formal training after hire and before being assigned to work independently, while four percent provided seven or more weeks of training with the maximum training program length being more than ten weeks. The remainder of the hospitals' training programs fell somewhere in between these two extremes with an average and median of four weeks.





Eighty-four percent of the respondents reported that the training for newly hired Security Officers consists of a formal Field Training Officer program where designated training Officers are responsible for providing the training. Of these programs, eighty-six percent report that their Field Training program includes formalized task analysis in which the Field Training Officer must observe and formally sign-off that the trainee is able to adequately perform each task that will be required of them once they begin to work independently.



In 24% of these organizations only Supervisors serve as Training Officer, 21% have a separate job description and pay grade for Training Officers, 37% do not have a separate job description but Security Officers assigned as a Training Officer receive a higher rate of pay while engaged in training a new hire, and 14% consider assignment as a Training Officer as a developmental role and do not provide any additional compensation. Sixty-five percent of the organizations that report having a formal Field Training Officer program report that their Training Officers receive formal training on adult learning and the training process before being assigned as a Training Officer.

Of the programs reporting training length, 42.4% reported that they have a process in place to extend the training period if deemed necessary for an individual Security Officer and that they do make use of that process on a regular basis. An additional 45.5% reported that while they do have a process for extending training if necessary, they rarely or never utilize that process and nearly all Officers are cleared to work independently after the standard training period. The remaining 12.1% reported that they do not have a process through which training could be extended and if a newly hired Security Officer had not demonstrated that they were proficient enough to perform the job independently by the end of the standard training program they would be either terminated or reassigned.

Surprisingly, organizations with longer standard training program lengths were more likely to regularly extend the length of their program in individual cases, with 75% of the programs reporting that they did regularly extend their training having standard training

lengths greater than the four-week median. While all of the programs reporting that they did not have a process for extending training fell below the median and had training programs of either one or two weeks, and of the organizations which reported that while they do have a process for extending the training period but rarely make use of it only 21% had standard training programs that were longer than the four-week median.



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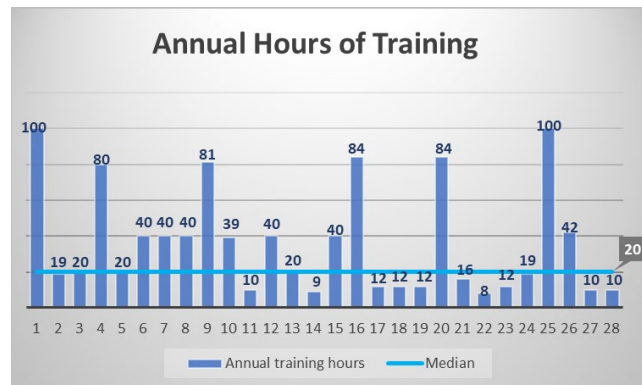


A number of the respondents utilize certifications by on outside organization to demonstrate the trainee’s competency in one or more aspects of their training program. The most utilized third-party certification programs were the Security Officer Certifications offered by the International Association of Healthcare Security and Safety, utilized by 59% of the programs, and Hospital Incident Command System certifications offered by FEMA, utilized by 45% of the programs.

Annual training requirements

Of the thirty organizations responding to a question asking whether they budget and plan for ongoing training for their Security Officers outside of their regularly scheduled shifts, twenty-eight of the respondents reported that they did budget for annual refresher or recertification training.

Of the respondent organizations that responded affirmatively, the maximum budgeted training time per Security Officer was 100 hours, while the minimum (excluding the two which did not budget hours for training) was 9 hours. The average training time budgeted was 36.4 hours while the median budgeted time was 20 hours.

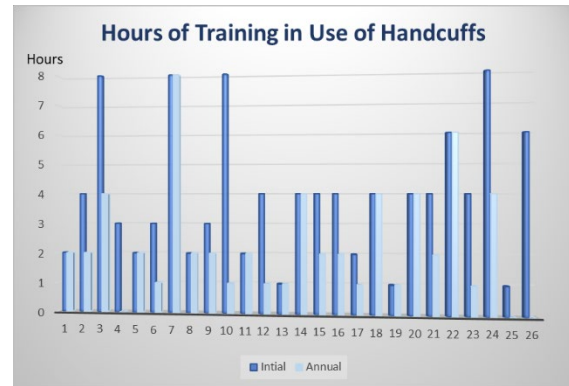


In this data there was somewhat of a correlation between what defensive tools and weapons were issued to Security Officers and the number of hours of annual training that was budgeted. None of the organizations that issued firearms to their Security Officers reported an annual training budget of less than forty hours per Security Officer. A similar correlation was expected but was not seen in organizations issuing their Security Officers defensive tools other than firearms with approximately similar numbers falling above and below the median.



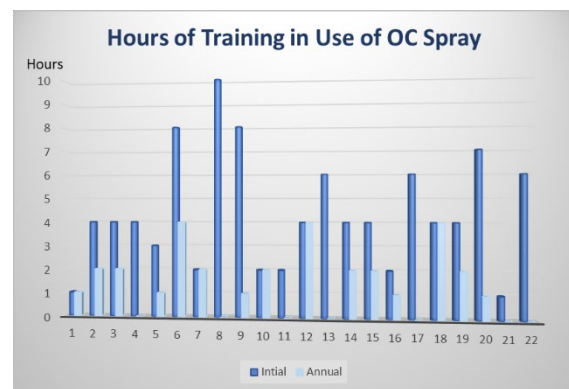
Training for proficiency with defensive tools and weapons

Of the twenty-six respondent organizations that reported issuing handcuffs to some or all of their Security personnel and supplied data related to length of training, initial training in the use of those handcuffs varied between one and eight hours, with an average of 3.9 hours and a median of 4 hours spent on initial training for use of handcuffs.



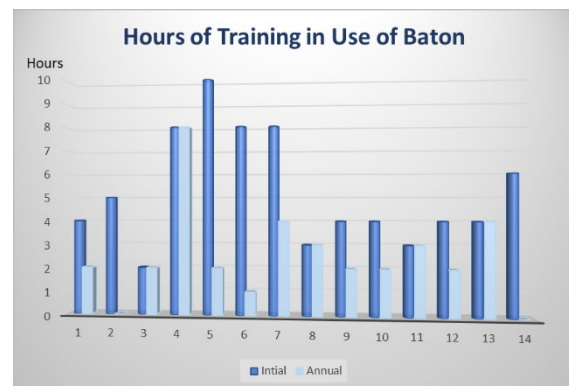
Three of the respondent organizations reported that their Security personnel did not receive any annual refresher or recertification training on the use of handcuffs, while the remaining twenty-three reported annual refresher training budgets of between one and eight hours with an average of 2.3 hours and a median of 2 hours.

Of the twenty-two respondent organizations that reported issuing oleoresin capsicum (OC or “pepper”) spray or foam to some or all of their Security personnel and supplied data related to length of training, initial training in the use of that OC spray varied between one and ten hours, with an average of 4.4 hours and a median of 4 hours spent on initial training for use of OC spray.



Seven of the respondent organizations reported that their Security personnel did not receive any annual refresher or recertification training on the use of OC spray, while the remaining fifteen reported annual refresher training budgets of between one and eight hours with an average of 1.4 hours and a median of 1 hour.

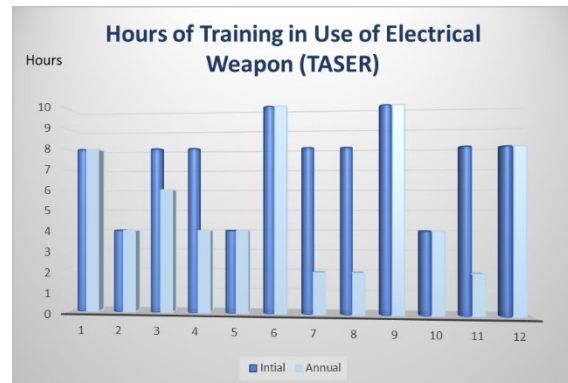
Of the fourteen respondent organizations that issue impact weapons or batons to some or all of their Security personnel and supplied data related to length of training, initial training in the use of that baton varied between two and ten hours, with an average of 5.2 hours and a median of 4 hours spent on initial training for use of baton.





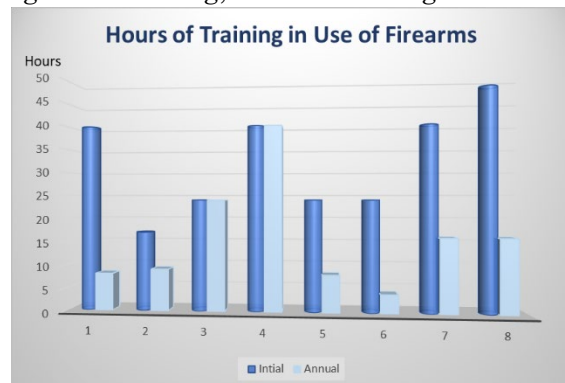
Two of the respondent organizations reported that their Security personnel did not receive any annual refresher or recertification training on the use of batons, while the remaining twelve reported annual refresher training budgets of between one and eight hours with an average of 2.5 hours and a median of 2 hours.

Of the twelve respondent organizations that reported issuing TASERs or other electrical weapons to some or all of their Security personnel and supplied data related to length of training, initial training in the use of that TASER varied between four and ten hours, with an average of 7.3 hours and a median of 8 hours spent on initial training for use of the TASER.



All of the respondent organizations issuing TASERs reported conducting annual refresher training with that training ranging between two and ten hours with an average of 5.3 hours and a median of 4 hours.

Of the eight respondent organizations that reported issuing firearms to some or all of their Security personnel and supplied data related to length of training, initial training in the use of that firearm varied between seventeen and forty-eight hours, with an average of 32.1 hours and a median of 32 hours spent on initial training for use of firearms.



All of the respondent organizations issuing firearms reported conducting annual refresher training on firearm use, with that training ranging from between four and forty hours with an average of 15.6 hours and a median of 12.5 hours.

