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Safety and security policies on psychiatric acute admission wards: results from a London-wide survey

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Abstract

Very little research evidence is available regarding current safety and security procedures on acute psychiatric wards. This includes controversial areas such as the temporary removal of personal property, the searching of patients and visitors, the use of alarms and modern technology, and locking of entrances to regulate those entering and leaving. This is also despite widening dismay over increasing violence within a variety of hospital settings, the comparatively high risk of physical assault faced by mental health professionals and an abundance of literature and training in regards to violence management and prevention. To gain an understanding of current safety and security measures, a London-wide survey of acute admission wards was undertaken revealing a wide variety of measures and policies in operation. Over 100 NHS and private wards were sent questionnaires; there was a response rate of 70%. Results show that a significant proportion of acute admission wards are now locked at all times and a small proportion of units have 24-hour security/reception staff on-site and a low level of modern technology usage such as CCTV and electronic access systems. There is wide variation in items banned, restrictions placed on inpatients, and the searching of patients and visitors. Two independently varying emphases of ward security policies were identifiable, the first aimed at preventing harm to patients using door security, banning of items and restrictions on inpatients. The other is aimed at reducing risks to staff via searching of patients, use of security guards and sophisticated alarm systems. There is some preliminary evidence that these security policies are differentially associated with levels of absconding and violent incidents. Further research to guide practice is urgently required.

Keywords: guards, locked door, restrictions, rules, security, wards

Introduction

Hospital safety and security has become a major issue of concern for staff working in all areas of health care, both in the UK and overseas. Recent literature reflects a worrying trend of increasing violence in hospitals as a whole and an alarming increase in the number of assaults on staff members. There is a great deal to think of when considering safety and security on mental health wards. Systems certainly need to be in place that protect staff from patient assault but arguably other considerations, more specific to psychiatry, are thrown into the equation through the communal nature of such wards. There is a need to protect vulnerable patients from other patients; patients, property and staff from unwanted outsiders; patients from themselves; and, at times, the public from patients. Hospitals typically have a range of different policies and procedures that address these issues.

These policies bring to the surface concerns about the human rights and liberty of psychiatric patients. Examples include the confiscation of property, the locking of ward doors, restrictions on freedom and the use of security guards. For mental health professionals, it can be difficult to balance the safety and security of patients, staff and the public whilst respecting the rights and choices of individuals. This can be a bewildering area for psychiatric nurses, arguably creating a diversity of opinion on levels and types of psychiatric ward safety and security required. As a first step towards providing empirical data on which further discussion can take place, this paper reports a survey of ward safety and security policies.

Literature review

Much of the available literature refers to the need for increased safety and security in general hospitals and the need to protect staff from physical assault. Although a great deal of this is relevant to psychiatric wards, there is little evidence utilizing such wards or units as examples.

Research into the experiences of Norwegian mental health practitioners found that 100% of nurses and 60.9% of other clinicians experienced a violent assault at some point in their career (Wynn & Bratlid 1998), whilst Gould (2000) serves a reminder that nursing is, according to the Health and Safety Executive (HSE), Britain's 'most dangerous job.' McKay (1994) adds that mental health services fall within a greatest risk category along with ambulance and Accident & Emergency services.

In response, the government are committing Trusts to a statistical reduction in assaults on staff (O'Dowd 2001). In addition to a 'zero tolerance' campaign aimed at tougher sentences for offenders and better reporting of violence by staff (Gould 2000), many Trusts are increasing security measures not only for the protection of their workforce but also to protect property and those patients entitled to care within a safe, therapeutic environment. This is a view shared by the Royal College of Psychiatrists (1998) who indicate that a psychiatric unit's ability to be safe whilst feeling safe is fundamental to care. Staff may be more reluctant to take on a 'zero tolerance' stance towards violence deemed a result of acute mental illness and, in reality, those patients detained for treatment under the Mental Health Act cannot justifiably be ejected or discharged if causing a disturbance or damaging property, etc. Concern about violence to staff has led to significant work in the UK on the prevention and management of aggression, most notably the endeavour to agree a national policy on training for physical restraint. This work is building upon: a national survey of practitioners; an analysis of education and training programmes; and an analysis of policies in this specific area (UKCC 2001).

In addition to increased numbers of security guards and better use of Closed Circuit Television (CCTV), other more radical ideas are being discussed which, according to writers such as Naish (1997), could be taking us closer to a US style of hospital security. One such progression is the call for an NHS police service, an idea receiving some support

(Munro 2000).

The Standing Nursing and Midwifery Advisory Committee (Department of Health 1999) reported concerns about safety and security procedures on acute psychiatric wards, pointing in particular to deficiencies in: risk assessment by staff; the use of special observation to prevent suicide; and design faults such as improperly glazed windows on upper floors. The theme of environmental dangers was taken up again more recently by the confidential inquiry into homicides and suicides, which highlighted the need for security precautions to protect suicidal patients from themselves (Department of Health 2001) and has led to widespread location and removal of potential ligature points on acute wards nationally in the UK. These reports continue a theme in the psychiatric literature that has existed for some time (Benenson & Resnik 1973).

The available literature on psychiatric ward security tends to favour increased safety measures and a need for well-planned units from the outset. A recent Department of Health (2000) on the safety of high-security hospitals suggested a return to locking patients in their room at night because of large lapses in security and the wide availability of pornography and illicit drugs. Although this is a highly specialized branch of psychiatric nursing, there are some comparisons with local acute admission wards where illicit drug use by inpatients is seen as a major security issue. (Ryrie & McGowan 1998).

Measures implemented by open psychiatric wards in the USA can also be compared to UK high-security hospitals. Qadir (1982) describes the use of airport-style metal detectors and full searches both at the entrance to the hospital, before entering a ward, and for patients returning from leave. He goes on to justify the right to search by arguing that the hospital administration has a responsibility to protect patients, staff and visitors from violent acts. The Royal College of Psychiatrists (1998) offers several points for consideration when deciding on security in UK psychiatric inpatient units, including the need for a receptionist or security

staff on a 24-hour basis, the use of CCTV cameras, being clear about the type of patient that will be treated and clear, practicable admission criteria.

Clearly there currently exists a high degree of concern about the safety and security of psychiatric wards. However, despite the profusion of recommendations in various reports, plus plentiful evidence on the risks posed by psychiatric inpatients both to themselves and others, there is a paucity of evidence about the operational policies of wards in the UK. Given this situation, it was decided to conduct a survey of wards as a first step to pursuing further investigations in this field.

Aim of survey

The aim was to describe current safety and security measures used on acute psychiatric wards in London, and to explore the relationships between them.

Methods and sample

A postal questionnaire was sent out to 122 NHS and 19 private acute admission wards using a database of hospitals and units within the M25 area, compiled by the research team.

The number of valid responses was 87 (17 responses were discarded as not coming from acute admission wards), representing a 70% (87 wards out of a possible 124) response rate. The mean number of beds per ward was 20.6, 84% of wards were mixed gender (10% female only, and 6% male only), and 87% were within the NHS.

Instrument

Previous clinical experience and a trawl of relevant literature were drawn upon to provide the various possible security practices in use. The questionnaire was then formulated using

an iterative process of consultation and change amongst the research team. The questionnaire comprised four main parts:

- A survey of banned items. Sixteen items known to be banned at times from psychiatric wards were listed and respondents asked to identify by tick boxes which items were always, sometimes or never banned. Spaces were provided for respondents to report additional items banned on their wards, and to provide information on the rationale for those bans.
- The searching of patients, visitors and property, with similar fixed choice responses.
- Similar information about practices such as locking of bathroom doors, or the counting of cutlery.
- Items which were either present or absent, e.g. intercom systems, panic alarms, CCTV, etc.

A final question asked the respondent to estimate the frequency with which the ward door was locked, over the previous 6 months, on a seven-point scale ranging from 'never' to 'always'. The questionnaire concluded with 1.5 pages of additional space for respondents to provide additional comments on ward safety and security policies.

Data analysis

Survey results were entered into statistical data analysis computer software and cross-checked. Exploratory data analysis revealed no self-contradictory responses, therefore no returns were excluded. Analyses were conducted using descriptive statistics and Pearson correlation tests. Additional comments provided on the survey form were subjected to

simple content analysis, with frequency of theme occurrence being used as an index of importance and relevance. These details were used to add depth to the understanding of the quantitative data.

Findings

The main findings of the survey are summarized in Table 1. Most notable was the degree of variation between different wards, with little overall agreement about what are appropriate safety and security policies. Items that were always banned in one place were only sometimes or never banned in others. A wide range of additional items that were either sometimes or always banned were identified by respondents, including: glass bottle, lighter fuel, mobile phones, tools (e.g. chisels), knitting needles, kettles, laser pointers, etc. Several respondents (16%) mentioned dressing gown cords, ties, belts or shoelaces as being sometimes removed from patients, with none reporting a blanket ban of these items. Similar disagreement was seen in most aspects of the survey. One in four acute admission wards in London were permanently locked, and a further 45% were locked some of the time.

There was considerable concern around the use of legal and illegal drugs on wards and the disturbed and violent behaviour that this led to. Some wards had associated the ordering of illegal drugs with the possession of a mobile phone, and therefore banned the latter item. Others had banned the use of Khat, a currently legal stimulant drug used mainly by Somali immigrants.

Summed scores were produced for each dimension of the survey (i.e. 'banned items', 'door security', etc.), and these subscores were themselves summed to provide an index of the degree of security in operation on a ward. Examination of the correlation matrix of the subscores demonstrated that they fell into two independently varying clusters (see Fig. 1), which we have termed 'Type A' and 'Type B' security. That is, wards appeared to

independently vary on these two dimensions, with there being no association between the two. For example, an individual ward might have a high level of Type A security and a low level of Type B, or vice versa, or low levels of both, etc.

Both forms of safety/security were found to vary inversely with distance from central London. The closer the ward was to the centre of London (Charing Cross), the higher the degree of security was likely to be (Type A, $r = -0.23$, $P = 0.03$; Type B, $r = -0.19$, $P = 0.08$; Total security index, $r = -0.28$, $P = 0.01$).

No relationship was found in this study between any aspect of security and whether the ward was situated in the psychiatric unit of a general hospital or in a specialist psychiatric hospital. In addition, no relationship was found between the use of CCTV on wards or units and any other aspect of security. There were no significant differences between private and NHS facilities, or by gender of occupants. Size of ward (bed numbers) was inversely correlated with Type B security ($r = -0.23$, $P = 0.05$) and no other variable.

Nine of the wards responding to this survey had taken part in a previous study of inpatient wards (the methods and findings of which are fully reported in Bowers *et al.* 2000) during which Ward Atmosphere Scale (WAS; Moos 1974) data were also collected. For these nine wards, Type A security was associated positively with absconding rates ($r = 0.66$, $P = 0.05$), and Type B security was strongly inversely correlated with the anger and aggression subscale (defined as the extent to which patients argue with other patients and staff, become openly angry and display other aggressive behaviour) of the WAS ($r = -0.82$, $P = 0.01$).

Discussion

Security measures tend to arouse strong feelings among nurses, who may in many ways be ambivalent about placing restrictions of any kind upon those for whom they are caring. They

are trained to consider the ethical implications of their actions (Armstrong *et al.* 2000) and security measures may challenge client's autonomy and dignity, rights they are taught to respect from the outset of nurse training. The sympathy nurses feel for stigmatized mentally ill patients, plus the desire to enhance patients levels of control over their own lives, seem at times to contradict the requirements of maintaining patients' safety. Thus there has been a long debate amongst nurses on ways to resolve the apparent conflict between the caring and controlling aspect of the role (Burrow 1991). Overlaid upon this is the inheritance of a history of psychiatry that makes 'non-restraint', 'open doors', and 'least restrictive alternatives' the symbols of modern ethical practice and the symbolic antonyms of previous inhumane and barbaric treatments of the mentally ill (e.g. chaining patients to walls, keeping them on straw, beating them like recalcitrant beasts, etc.). Hence, security issues are always emotive issues for psychiatric nurses.

Nevertheless, increasing levels of violence (Noble & Rodger 1989) and repeated public inquiries following psychiatric disasters (Sheppard 1996) have led to an growing emphasis on the security aspects of patient care. This survey reveals that the degree of security operated by nurses on acute wards is greater than ever. Despite strong opposition to locking of doors among some groups of nurses (Clark *et al.* 1999), 25% of London's acute wards are now kept permanently locked. It may be argued by some that this constitutes an illegal detention of voluntary patients. The Mental Health Act Code of Practice (Department of Health and the Welsh Office 1999) authorizes the locking of acute wards on a temporary basis, insofar as the ward door is opened on request for voluntary patients to leave and certain other conditions are met. Permanent locking of the ward door is clearly an issue that requires further consideration when the Code of Practice is next revised. The locking of acute wards also raises questions about the role of psychiatric intensive care units (PICUs), which have previously been used, in part, to secure patients with a propensity to abscond (Dix 1995, Bowers

et al. 2002). Locking of acute wards may enable PICUs to take up the more therapeutic role to which they have always aspired (Crowhurst & Bowers 2002), as potential absconders may then be retained on acute wards, leaving PICUs with more resources to concentrate on therapeutic input rather than containment.

Searching of patients, on admission or return from leave, is another hugely contentious and emotive issue amongst nurses, moreover one that is inextricably entwined with the issue of patient rights and with the law. Previously, searching of patients has been carried out under the banner of ‘checking property’, or ‘cleaning the lockers’, enabling a non-aversive rationale to be given to patients. However, some nurses appear to be under the impression that their rights to search patients are strictly limited, a position encouraged by a previous edition of the Mental Health Act Code of Practice (Department of Health and the Welsh Office 1993). Lack of clarity on this issue was one large contributor to the events which were the subject of the Fallon Inquiry (Fallon *et al.* 1999), and large variations in practice still exist, even between hospitals situated only a few miles from each other, or even within the same NHS Trust as documented by this survey.

The sheer variety of policies on banned items underlines the lack of evidence for efficacy in this field. It would appear that these rules accumulate, perhaps based on past events. For example, if one patient uses a nail file to cut themselves, then nail files become banned for everyone thereafter. The rule itself may then go on to highlight how nail files can be used in this way and contribute to a local tradition in self-harm methods. There is evidence that restricting access to the means of suicide is an effective policy at the national level (Department of Health 2001); however, it is not clear if and how these policies function on acute psychiatric wards.

Results from the survey demonstrate a wide use of discretion in enforcing security policies.

Apart from the obvious dangers of items such as weapons, which are nearly always banned,

many items are allowed or restricted according to knowledge of the patient and their history. Similarly, the decision to search is frequently based on attempts to isolate clients or visitors considered a risk in some way, be that violence to others, self-harm, illegal drug use, etc. Although this use of risk assessment prevents unnecessary restrictions on 'low-risk' clients, it is in no way infallible in ensuring wider safety and security. Allen (1997) for example, warns that the prediction of risk is an inexact science incapable of covering all potential risk areas found in acute settings.

The association of high levels of security with inner-city psychiatric units is of interest. This may be because such wards are near to sources of danger (e.g. availability of illicit drugs, alcohol, peers who are bad influences, railway lines, canals, tall buildings, etc.). It may be the case that rural and semiurban hospitals can allow patients more freedom without compromising more safety. It is not imagined that psychiatry in central London will ever return to the use of institutions in the countryside to avoid these problems; however, it is clear that security is of more concern to professionals working in inner-city units because of these invariable external pressures. Alternative interpretations of the data are that inner-city hospitals may be at the forefront of good security practice, or have such unstable staffing complements that they need to rely more on security rules than on developing good relationships between nurses and patients.

Before carrying out the survey, it was expected that wards would vary on a single dimension in the levels of security they operated, with conservative high safety emphasis at one end and liberal ethos at the other. The discovery of two independently varying types of security policies was completely unexpected. Quite what these two types of security represent, in terms of organizational functioning, is not wholly clear. Perhaps Type A security represents the security emphasis of a ward where the protection of patients from themselves is a primary concern (i.e. suicide and self-harm), hence the banning of items and restrictions

on patients. Type B security seems likely to be high on wards where the primary concern is the protection of staff and patients from other patients (i.e. patient violence), hence searching policies for potential weapons and guards/ alarms for dealing with violent incidents.

The associations of Type A security with high absconding, and Type B security with low aggression, are intriguing and suggest that these levels of security practices have a very real impact upon patient behaviour, and possibly a real difference in efficacy. The statistical relationships found were strong for such a small sample, indicating that they may be very important and are worthy of further exploration.

Conclusions

The scale of variation in practice is outstanding. Where there is a lack of knowledge about what is an appropriate or efficacious level of security, policies seem to be determined by local tradition and history of patient behaviour. Further research is thus urgently required to address the question of efficacy. This perhaps applies particularly to the practice of locking doors, where there is currently little evidence to guide practice. Without this further evidence on all the variations in policy and procedure described here, no firm recommendations can be given to practitioners.

The discovery of two different types of security gives a different shape to that future research, indicating that it is not the efficacy of individual rules that needs to be evaluated, but rather the efficacy of the overall shape of security policy in terms of the levels of Types A and B. Many other interesting questions are raised about the potential relationship of the different types of security and, for example, management styles, use of special observation, etc. The authors are currently seeking funds to further extend and explore the results of this survey in this way.

Lastly, given the contentious nature of security policies in psychiatric nursing practice, it

is hoped that this paper will stimulate open debate and sharing of views around what is appropriate, efficacious, ethical and legal in the practice of acute care.

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Table 1
Summary data from the survey

	Always/yes		Sometimes		Never/no	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Banned items						
Weapons	86	89	10	10	1	1
Illegal drugs	85	88	0	0	2	2.1
Alcoholic drinks	83	86	2	2.1	1	1
Penknives	78	80	8	8.2	1	1
Meds/tablets	70	72	9	9.3	5	5.2
Solvents	60	62	23	24	3	3.1
Razor blades	43	44	34	35	10	10
Scissors	36	37	43	44	8	8.2
Flexes/cables	17	18	51	53	18	19
Disposable razors	16	16	50	52	21	22
Nail files	8	8	52	54	25	26
Plastic bags	4	4	36	37	47	48
Lighters/matches	2	2	56	58	26	27
Pencils/pens	1	1	25	26	60	62
Perfume/after-shave	1	1	24	25	62	64
Batteries	0	0	17	18	69	71
Restrictions						
Locked cleaning cupboard	80	82	5	5.2	2	2.1
Plastic tumblers	26	27	45	46	16	16
No boiling water	17	18	26	27	43	44
Bathrooms locked	13	13	39	40	35	36
Plugs removed	9	9	24	25	53	55
Plastic crockery	9	9	40	41	37	38
Taps removed	8	8	18	19	60	62
Plastic cutlery	6	6	44	45	37	38
Cutlery counted	1	1	15	15	71	73
Door security						
Intercom at unit entrance	35	36	–	–	52	54
Intercom at ward entrance	31	32	–	–	56	58
Locked	24	25	44	45	16	16
Swipe card at ward entrance	16	16	–	–	71	73
Key pad at ward entrance	14	14	–	–	73	75
Swipe card at unit entrance	13	13	–	–	74	76
Key pad at unit entrance	8	8	–	–	79	81
Alarms						
Panic alarm sounds ¹	54	56	17	18	13	13
Personal panic alarms	43	44	–	–	44	45
Emergency telephone ext.	41	42	–	–	46	47
Panic alarms in rooms ²	35	36	31	32	19	20
Panic alarms in office only	3	3	–	–	84	87
Guards						
Access to security guards	30	31	–	–	57	59
Security desk at unit entrance	18	19	–	–	69	71
Searches						
Bag search	38	39	48	49	0	0
Pockets search	24	25	59	61	4	4.1
Bed space search	12	12	70	72	5	5.2
Return from leave search	9	9	68	70	10	10
Rub-down (e.g. airport)	3	3	26	27	57	59
Strip search	1	1	7	7.2	78	80
Visitors searched	0	0	28	29	57	59