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

Executive Summary

Healthcare systems are responsible for securing their physical environments for the safety of patients, staff, management, visitors, and others. This task is complicated by the diversity and number of individuals interacting with their services, employees, and facilities daily. These touchpoints each represent a potential vulnerability that has a potential to negatively impact the organization, its people, or operations if appropriate security measures are not implemented and maintained. The need to manage these interactions while ensuring the seamless flow of operations requires healthcare institutions to staff their security departments adequately, provide them with sufficient resources and training, and adopt comprehensive physical security strategies.

Methodology

In late 2024, COSECURE Enterprise Risk Solutions conducted a benchmarking study researching healthcare security department staffing levels and composition. The research also sought to identify the different roles within healthcare security departments, department reporting structure, 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 additional research conducted during 2019 and 2023 on the same subject.

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

Participants

Representatives from 53 healthcare systems responded and contributed their data to the survey. Not all of these responses could be used for all aspects of the survey. Some chose only to answer the questions about defensive tools usage and/or training and did not provide demographic data, so they were not included in the staffing benchmarks.

Forty-three respondents were located in the US, and the remaining ten were located worldwide in Canada, Columbia, Egypt, France, Mexico, Nigeria, Singapore, and Spain. The respondents provided data for healthcare systems consisting of between 1 and 61 hospitals, for a total of 498 (with approximately 7% of all US hospitals) contributing data. The organizations contributing data also operate 187 long-term care facilities and 6,694 ambulatory care locations.

The survey also asked about the responding organization's total number of employed staff and licensed inpatient beds. Responses to the question regarding staff varied from 13 to more than 150,000, with a median of 12,000. Responses regarding licensed beds varied between 70 and 7,126 for a total of 77,581 beds across all respondent organizations, making up 8.5% of all licensed hospital beds in the US and a median number of 875 licensed beds.

During our engagement with healthcare clients, we have seen an increasing tendency for previously independent hospitals to become affiliated with university systems in the US. Consequently, we asked several clarifying questions about whether the respondent healthcare organization was affiliated with a university or university system and, if so, what security resources and functions were shared between the healthcare organization and the university. Of the respondents, 44% were not affiliated with a university system, while 56% did share some affiliation. Most of those sharing affiliation (34.6%) reported that while they were part of a university system, their healthcare organization had separate governance from the university.

Of those hospital systems affiliated with a university or university system (23), only two responded that the security department leader for the healthcare organization reported to the university's Police or Public Safety Department. The respondents also indicated negligible levels of resource sharing between the healthcare organization's security and the university police/public safety departments, with 74% reporting no shared resources/functions. Of those that did share functions, the most commonly shared were investigations and dispatch or systems monitoring (26%).

Survey Responses on Staffing Levels in Healthcare Security Departments

	Respondents	Percentage
None of the above	17	73.90%
Investigations	6	26.10%
Security systems design	3	13.00%
Security systems and access card programming	3	13.00%
Dispatch and security systems monitoring	6	26.10%
Training	4	17.40%
Police patrol	1	4.30%

Reporting Structure

Respondents were asked to identify the title of the senior-most security leader in their organization. The most common title for this person was Director (28%), followed by Chief Security Officer (16%), Vice President (12%), Senior Director (8%), Manager (8%), Executive Director (6%), Associate or Assistant Vice President (4%), and Responsible Prevention Security (4%), with other individual organizations reporting titles including Deputy Chief Operations Officer, Senior Vice President, Police Chief, Superintendent of Police, Administrative Director, Security Chief, and Security Engineer.

Because each title had significant outliers, we could not draw an actual correlation between the title of the security function leader and the organization's size. However, we did identify a trend in which larger organizations typically placed their security leader higher in their organizational hierarchy.

- Organizations whose security leader held a Vice President level title (VP, Senior VP, Associate/Assistant VP) averaged twenty hospitals (median 11) and had an average of 39,633 employees employed by their organization.
- Those whose security leader held a Chief Security Officer title averaged ten hospitals (median 7) and had an average of 27,125 employees employed by their organization.
- Those whose security leader held a director-level title (Director, Senior Director, Executive Director, or Administrative Director) averaged seven hospitals (median four) and had an average of 14,702 employees employed by their organization.
- Of those holding a Manager title, only one was responsible for security at more than one hospital. Their organizations had an average of 5,196 employees, with half having less than 1,000 total employees.
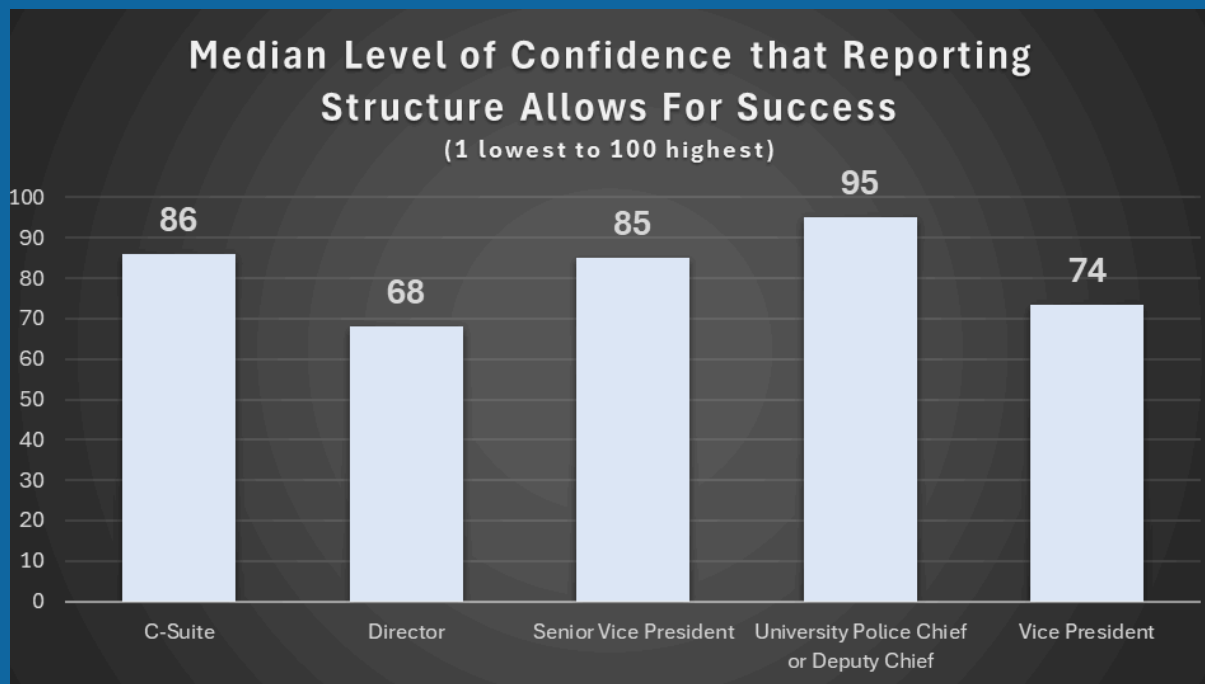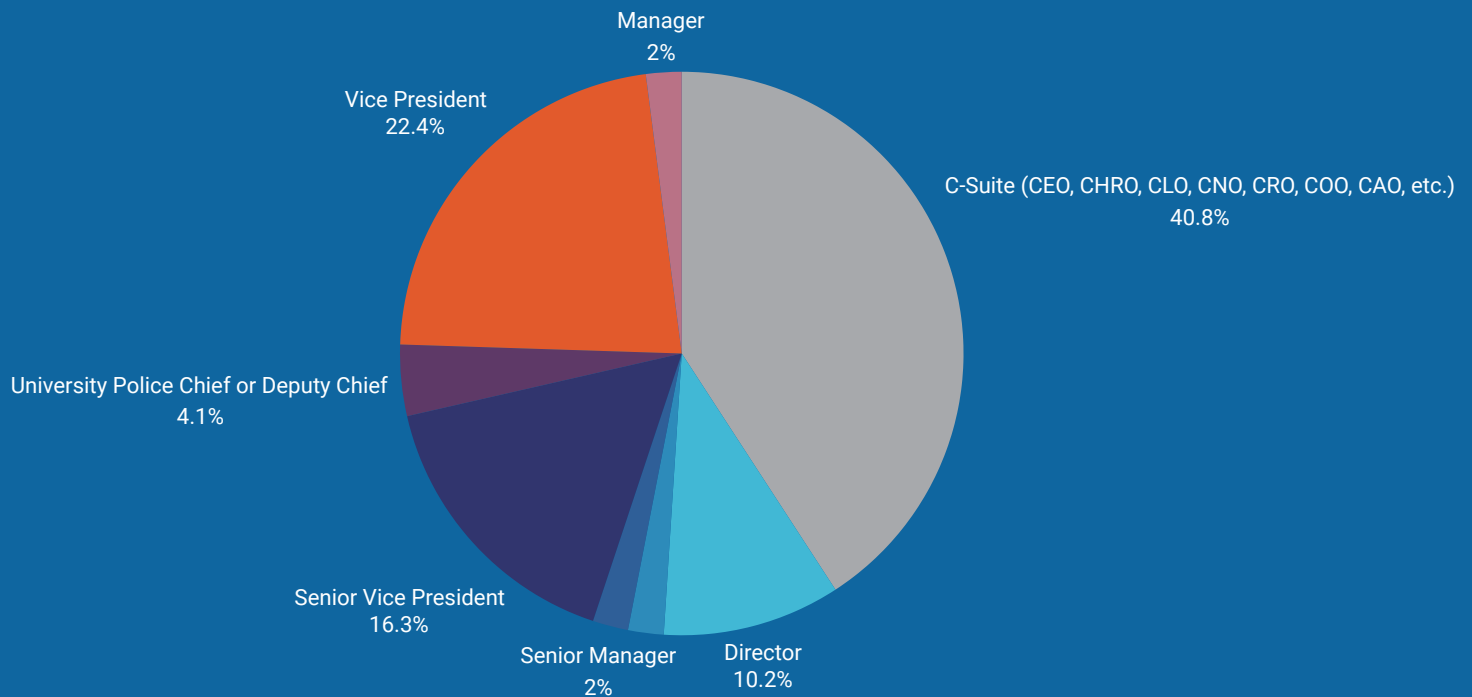
Reporting Structure

The survey asked additional questions related to the individual and functional area to which the senior security leader for the organization reports. The respondents indicated that it was most common (41%) for the security leader to report to someone within the organization's C-Suite (i.e., CEO, CAO, COO, etc.). The second most common (22%) reported to a Vice President.

The survey also asked respondents for their perception of how well their organization's reporting structure for security "allows your security department to influence change within your organization successfully?" Respondents were asked to rate this question on a sliding scale of 1 to 100, with one being "not at all" and 100 indicating the highest level of influence.

The survey question results indicated the healthcare security leaders who reported to an affiliated University's Chief of Police had the highest level of confidence that this structure allowed them to be successful. However, the small sample size (two) may have influenced this result. For those who reported to a leader within the healthcare organization, the responses indicated elevated levels of confidence in the security leader's ability to influence change the higher the reporting structure of the organization their direct supervisor was. Those reporting to the C-Suite reported a median confidence level of 86, while those reporting to a Director had a median confidence level of 68.

Function	Respondents	Percentage
C-Suite (CEO, CHRO, CLO, CNO, CRO, COO, CAO, etc.)	20	40.80%
Director	5	10.20%
Executive Vice President	1	2.00%
Senior Manager	1	2.00%
Senior Vice President	8	16.30%
University Police Chief or Deputy Chief	2	4.10%
Vice President	11	22.40%
Manager	1	2.00%

Pie chart: Security Department reporting structure

- Manager — 2%
- Vice President — 22.4%
- University Police Chief or Deputy Chief — 4.1%
- Senior Vice President — 16.3%
- Senior Manager — 2%
- Director — 10.2%
- C-Suite (CEO, CHRO, CLO, CNO, CRO, COO, CAO, etc.) — 40.8%

Median Level of Confidence that Reporting Structure Allows For Success
(1 lowest to 100 highest)

Category	Value
C-Suite	86
Director	68
Senior Vice President	85
University Police Chief or Deputy Chief	95
Vice President	74

STAFFING

Security Department Composition

Forty-two respondent organizations provided demographic data that would allow staffing benchmarking. Based on their responses, the composition of each Security Department was analyzed for the breakdown between the percentage of

Uniformed Security Officers, Uniformed Police Officers, dedicated Dispatchers, Investigators, Trainers, Workplace Violence Management, Security Systems Support, Line Level Supervisors, and Management as a percentage of the total Security Department workforce.

Security Department Composition

Based on these findings, 43% of the departments responding use some combination of Security Officers and either contracted or employed Police Officers. The remaining 57% percent utilize only non-sworn Security Officers. Dedicated Investigators, Trainers, Workplace Violence Program Managers, and Security Systems Analysts/Technicians were less common, each making up less than 2% of their departments' total staffing on average. Fifty-seven percent (Workplace Violence Program Managers) and 28% (Trainers) of departments indicated they did not have staff filling those roles.

Departments reported that, on average, slightly under 11% of their staff are in supervisory or management positions overseeing others within the department. This percentage ranged from a high of nearly 43% to a low of one organization that reported having no management or supervisory staff.

It should be noted that although there was no actual correlation between the percentage

of staff in supervisory or management roles and the size of the department, all of those departments that reported 20% or more of their staff filling supervisory/management roles were small departments with less than 30 total employees.

This reporting allowed us to assess the span of control or the ratio of individual contributor FTE to each supervisory/management FTE. While the span of control varied widely from 3:1 to 60:1, most organizations fell between 10:1 and 20:1, with an average of 18:1 and a median of 15:1.
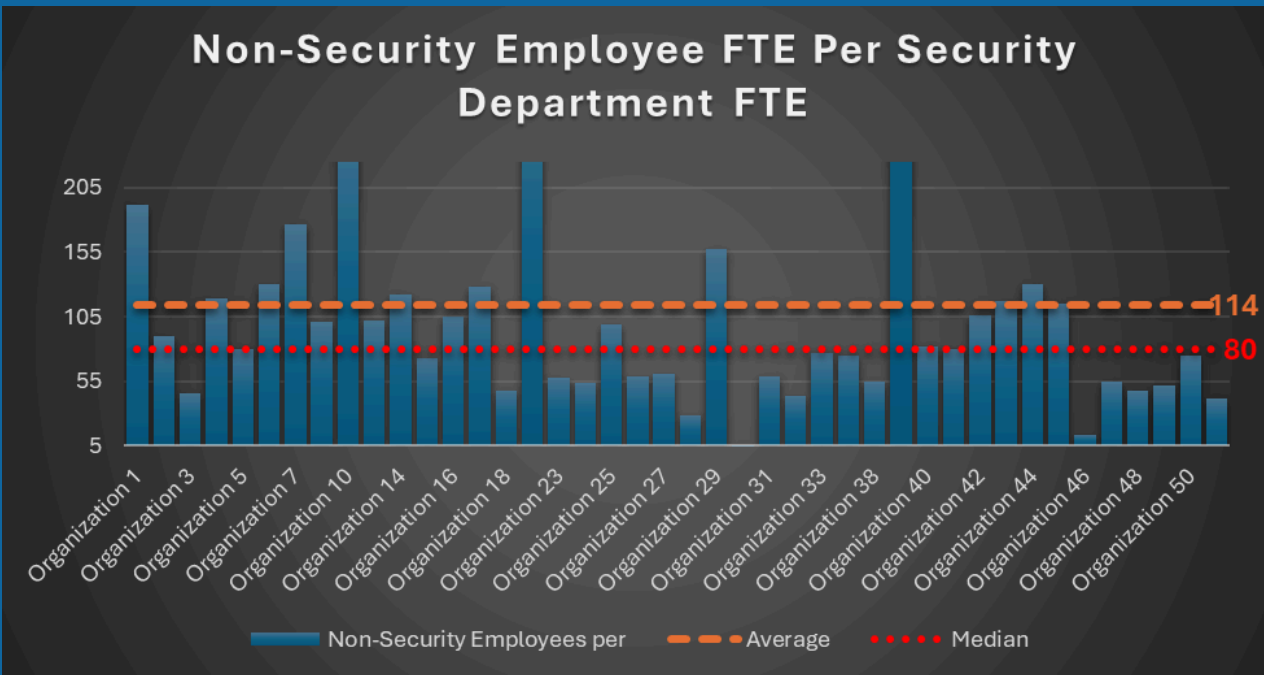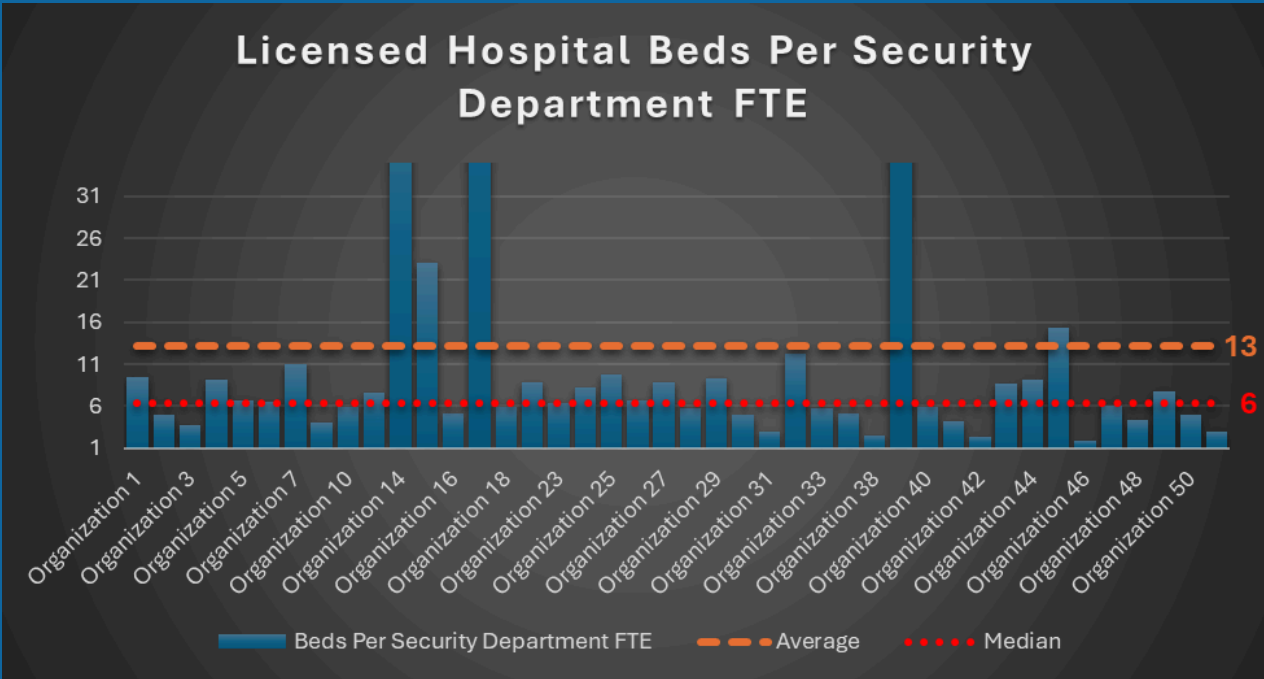
While these average and median spans of control are not out of line with what we often see in the healthcare security environment, it should be noted that they are significantly higher than recommended or commonly seen in many other settings. Law enforcement and business organizations cite typical spans of control of 4:1 to 15:1 and averages of 7:1 to 10:1 to allow for effective oversight and management.

Healthcare Security Department Management Span of Control
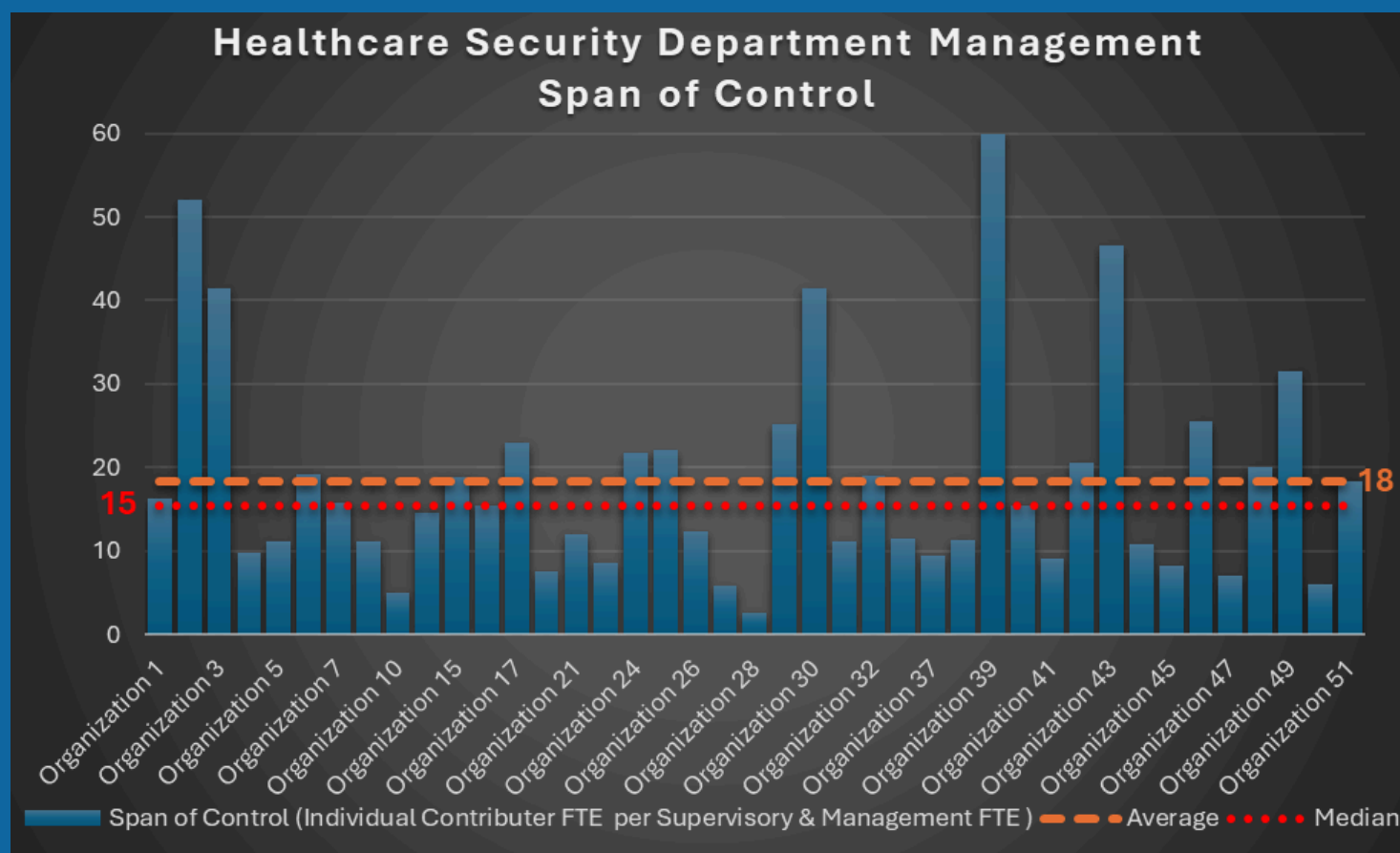
Security Department Total FTE Staffing Benchmarks

The respondents' answers indicating total Security Department FTE ranged from 12 to 1,238, indicating a wide disparity in security department size based on several factors. To establish benchmarks that could be applied uniformly across all healthcare systems surveyed, COSECURE determined that we would benchmark staffing levels against the 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 0.8 to 972.2, with a median of 79.8 and an average of 114.3. The total licensed inpatient beds per Security FTE ranged from 2.9 to 160.0, with a median of 6.4 and an average of 13.2.

Licensed Hospital Beds Per Security Department FTE

Legend: Beds Per Security Department FTE — Average — Median

Non-Security Employee FTE Per Security Department FTE

Legend: Non-Security Employees per — Average — Median

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 1 to 950 with a median of 475.5.
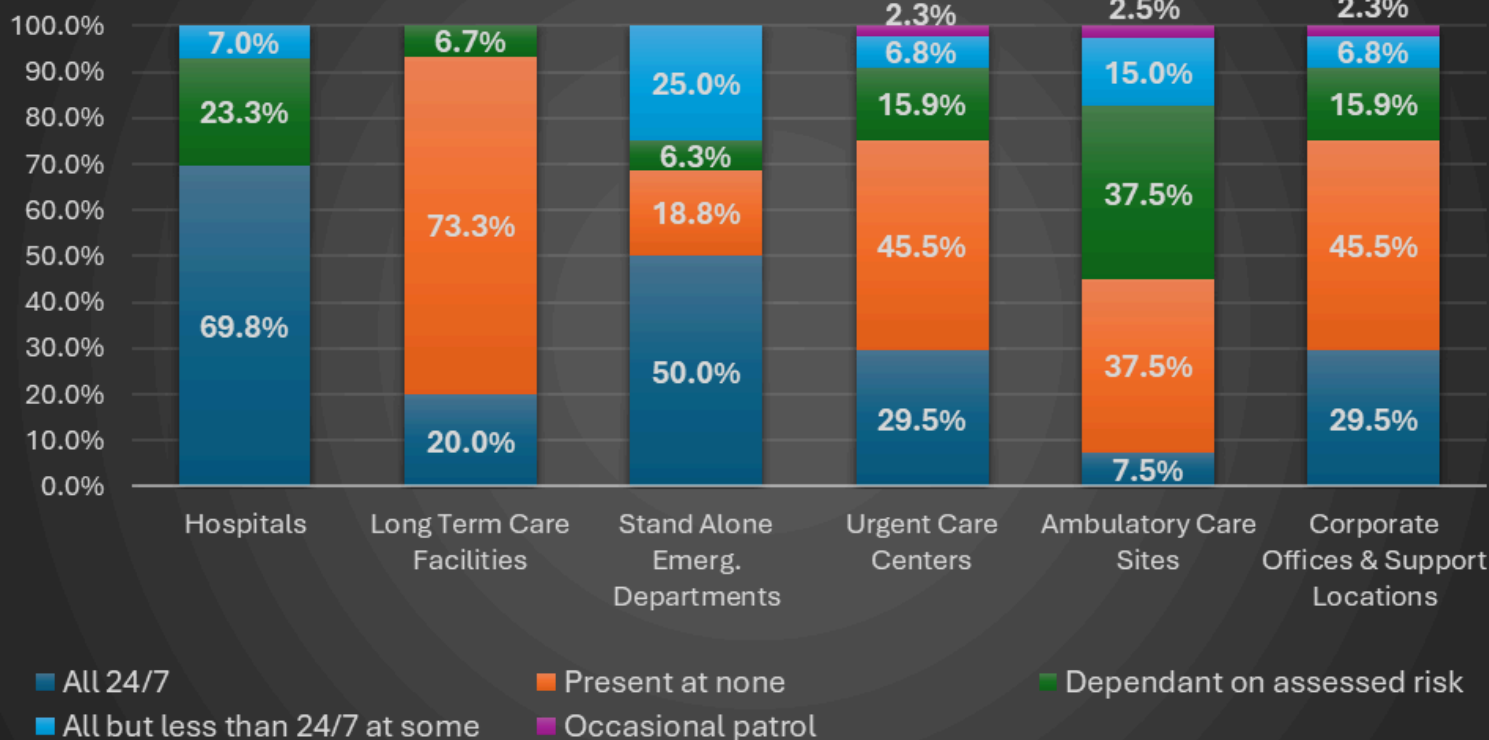
Responses detailing the total number of organizational employee FTE per FTE of uniformed Security Officer staffing ranged from 1 to 1,400 with a median of 113.2 and an average of 167.7.

In the respondent organizations, the total licensed inpatient beds per uniformed Security Officer FTE ranged from 3.0 to 230.4, with a median of 10.7 and an average of 19.1.

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

Hospitals had the highest rate of 24/7 uniformed security staffing with 69.8%, while ambulatory care sites had the lowest with 7.5%. Seventy-three percent of long term care facilities had no security presence, while 20% reported 24/8 security staffing. Nearly half of the responding organizations reported no security or police presence at corporate offices and support locations, while 30% had 24/7 security staffing at those offices and locations."

Uniformed Security Staffing

	Hospitals	Long Term Care Facilities	Stand Alone Emerg. Departments	Urgent Care Centers	Ambulatory Care Sites	Corporate Offices & Support Locations
All 24/7	69.8%	20.0%	50.0%	29.5%	7.5%	29.5%
Present at none		73.3%	18.8%	45.5%	37.5%	45.5%
Dependant on assessed risk	23.3%	6.7%	6.3%	15.9%	37.5%	15.9%
All but less than 24/7 at some	7.0%		25.0%	6.8%	15.0%	6.8%
Occasional patrol				2.3%	2.5%	2.3%

Legend:
- All 24/7
- Present at none
- Dependant on assessed risk
- All but less than 24/7 at some
- Occasional patrol

Healthcare Security Department Duties

The data demonstrated that healthcare security department personnel are responsible for numerous ancillary duties that may or may not be directly linked to ensuring the security of the organization, its patients, employees, and visitors. According to the respondents, 83% of their security departments are responsible for issuing and printing access cards, 65% handle parking management, 64% have responsibility for visitor management, and 50% are involved in emergency management. Just under 39% are engaged in providing security for their organizations' executives or protecting campus VIPs. Only 13.5% are responsible for ensuring the safety and security of their employees while traveling on organizational business.

The data indicates that many healthcare security departments dedicate substantial resources to tasks that may not directly contribute to their mission of providing a secure environment and protecting against violence in the workplace. Nearly 60% of respondents reported that their Security staff are responsible for managing the transport and release of bodies from the organizations' morgue, 40% are responsible for monthly fire extinguisher inspections, 25% are responsible for parking and valet management, and nearly 7% take on facilities responsibilities such as boiler inspections.

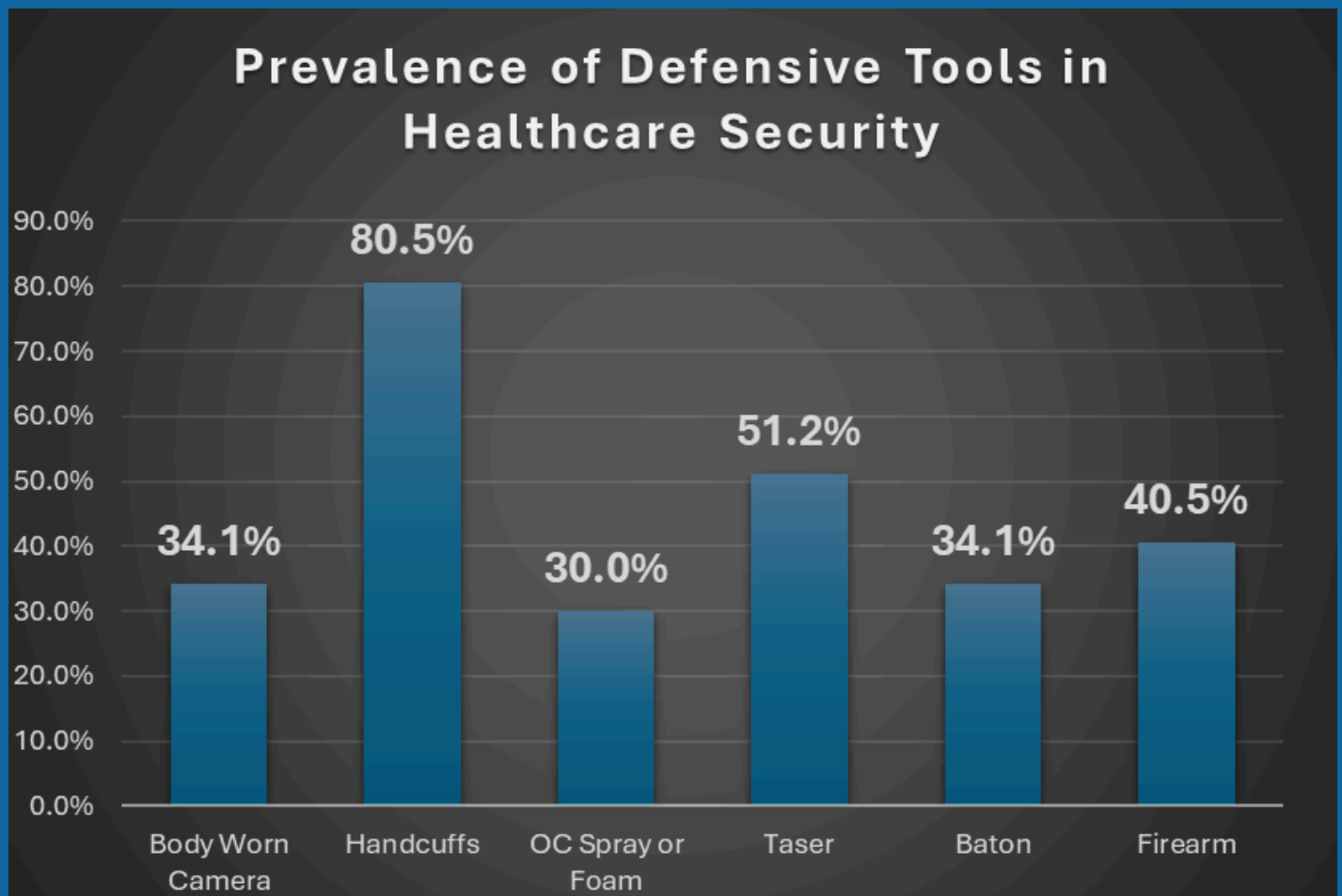| Respondents' Security Department is Responsible For:	
Parking management	65.4%
Valet operations	25.0%
Employee/patient shuttle operations	25.0%
Emergency management	50.0%
Executive/VIP protection	38.5%
Travel security management	13.5%
Visitor management	63.5%
Morgue transport/ body releases	59.6%
Project management for Security system installations	80.8%
Physical installation and repair of security systems	53.8%
Physical installation and repair of door hardware	26.9%
Management of physical keys	42.3%
Issuing and printing access cards	63.5%
Programming access cards.	82.7%
Safety program management	42.3%
Facilities duties	7.7%
Life safety devices inspections	40.4%

Defensive Tools and Weapons

All 53 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 any of the employees in their organization's Security Department and did not investigate differences in equipment issued to different categories of Security employees or differences in equipment issuance to Security employees at different types of facilities.
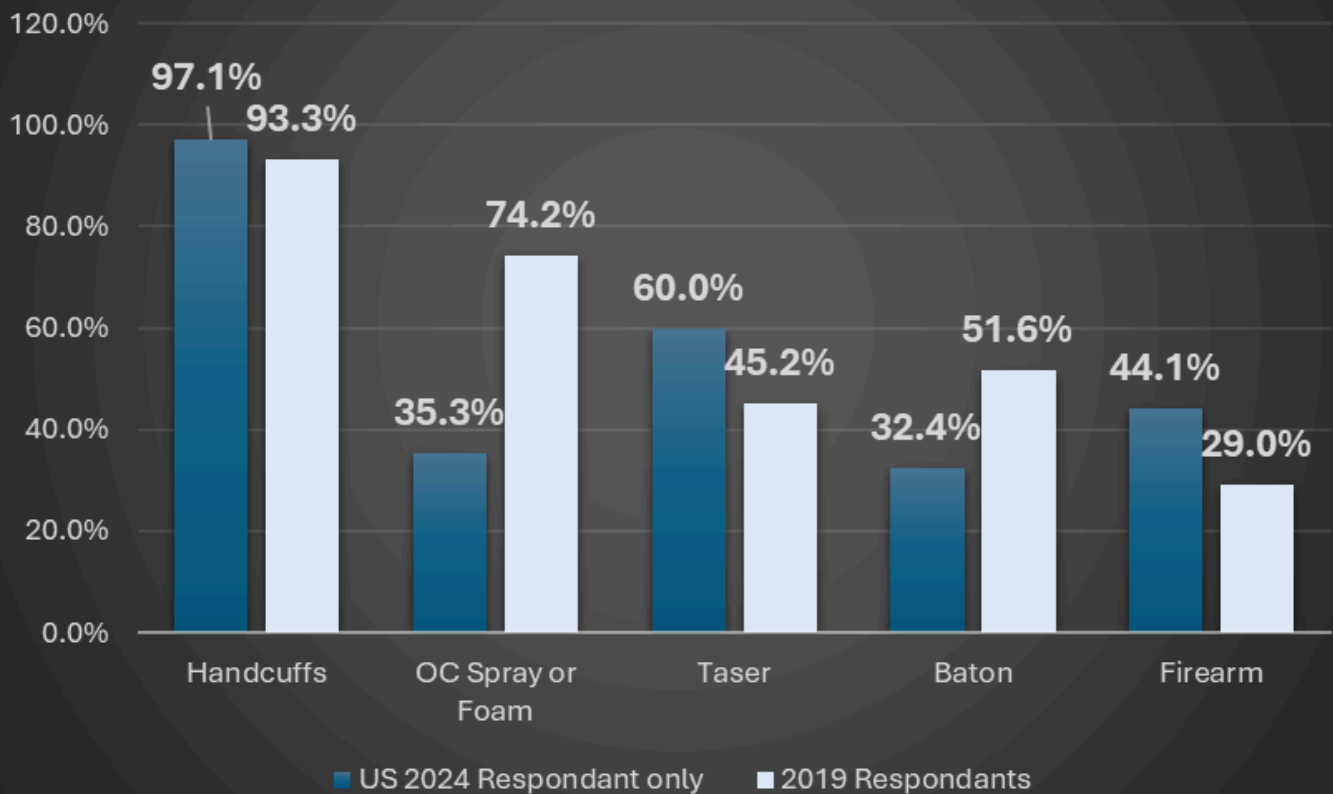
By far, the most prevalent type of defensive tool issued by the respondent organizations to healthcare Security Officers was handcuffs, with 80.5% of organizations indicating that at least some of their Security employees are equipped with handcuffs.

It should be noted that this, as well as all other defensive tool issuance, varies dramatically by the country where the facility is located, with several respondents from France stating that it would be illegal for healthcare security staff to carry handcuffs in their country. All organizations that provided their staff with other defensive tools also provided handcuffs.

Oleoresin capsicum (OC or "pepper") spray or foam was the least prevalent tool in our dataset. Only 30% of the organizations surveyed issued pepper spray or foam to all or some of their Security staff. This was a significant shift from the 2019 survey when 74.2% of the respondents said they provided pepper spray or foam to their security staff.

Prevalence of Defensive Tools in Healthcare Security

Tool	Percentage
Body Worn Camera	34.1%
Handcuffs	80.5%
OC Spray or Foam	30.0%
Taser	51.2%
Baton	34.1%
Firearm	40.5%

Shifts in Prevalence of Defensive Tools in US Healthcare Security

Tool	US 2024 Respondant only	2019 Respondants
Handcuffs	97.1%	93.3%
OC Spray or Foam	35.3%	74.2%
Taser	60.0%	45.2%
Baton	32.4%	51.6%
Firearm	44.1%	29.0%

In our 2019 benchmarking, 29% of respondents issued firearms to their Security employees; in 2024, the number of US organizations providing their security staff with firearms increased to 44.1%. Issuance of tasers or other electronic control devices also increased from the 2019 polling, with 60% of the polled organizations indicating that they issue these devices, in contrast to 45% who responded affirmatively in 2019. In 2024, 34.1% of the respondents equipped their uniformed officers with body-worn cameras. We believe this to be a significant increase from 2019, although this data was not collected as part of the 2019 survey.
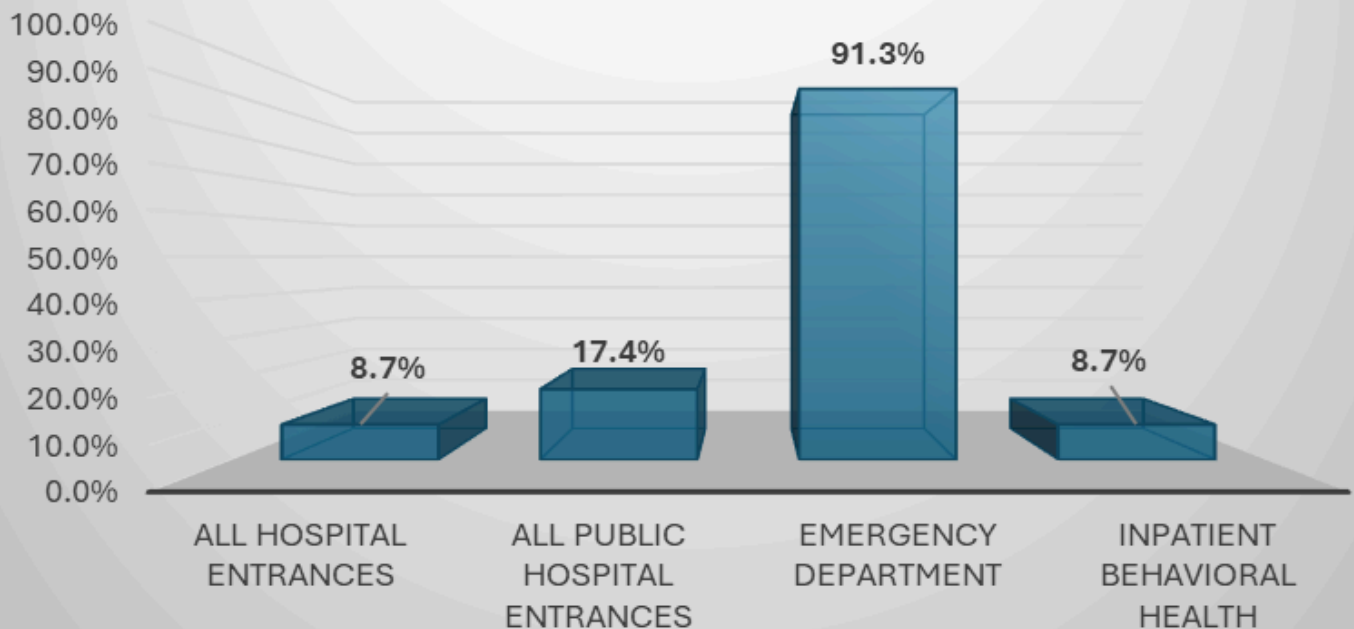
Weapons Detection

Nearly 64% of the respondent organizations stated that they deploy weapons detection technology at their US-based facilities. Ninety-one percent of those organizations deploy weapons detection in their emergency department, 17.4% at all public hospital entrances, and 8.7% at all hospital entrances and inpatient behavioral health facilities.

Of the organizations that utilize weapons detection at entry points, 65.2% reported the use of hand-held traditional metal detectors, 65.2% employ advanced walk-

through weapons detection (EVOLV, Athena, Metrasens, CEIA, SafePointe, etc.), 52.2% used walk-through conventional metal detectors, 13% used pass through X-Ray screening for packages, and 8.7% utilized canines (K-9) trained for scent-based weapons detection. None of the organizations used video analytics to detect brandished weapons or sound analytics to detect gunfire.

Areas Where Deployed
(Facilities currently utilizing weapons detection)

Area	Percentage
ALL HOSPITAL ENTRANCES	8.7%
ALL PUBLIC HOSPITAL ENTRANCES	17.4%
EMERGENCY DEPARTMENT	91.3%
INPATIENT BEHAVIORAL HEALTH	8.7%

Of the organizations that utilize weapons detection at entry points, 65.2% reported the use of hand-held traditional metal detectors, 65.2% employ advanced walk-through weapons detection (EVOLV, Athena, Metrasens, CEIA, SafePointe, etc.), 52.2% used walk-through conventional metal detectors, 13% used pass through X-Ray screening for packages, and 8.7% utilized canines (K-9) trained for scent-based weapons detection. None of the organizations used video analytics to detect brandished weapons or sound analytics to detect gunfire.

Type(s) of Weapons Detection
(Facilities currently deploying weapons detection technology)

- ■ Walk-through traditional metal detectors
- ■ Hand-held traditional metal detectors
- ■ Pass through X-Ray screening for packages/belongings
- ■ Advanced/enhanced walk-through weapons detection (i.e. EVOLV, Athena, Metrasens, CEIA, SafePointe, etc.)
- ■ Canine (K-9) trained for scent based weapons detection
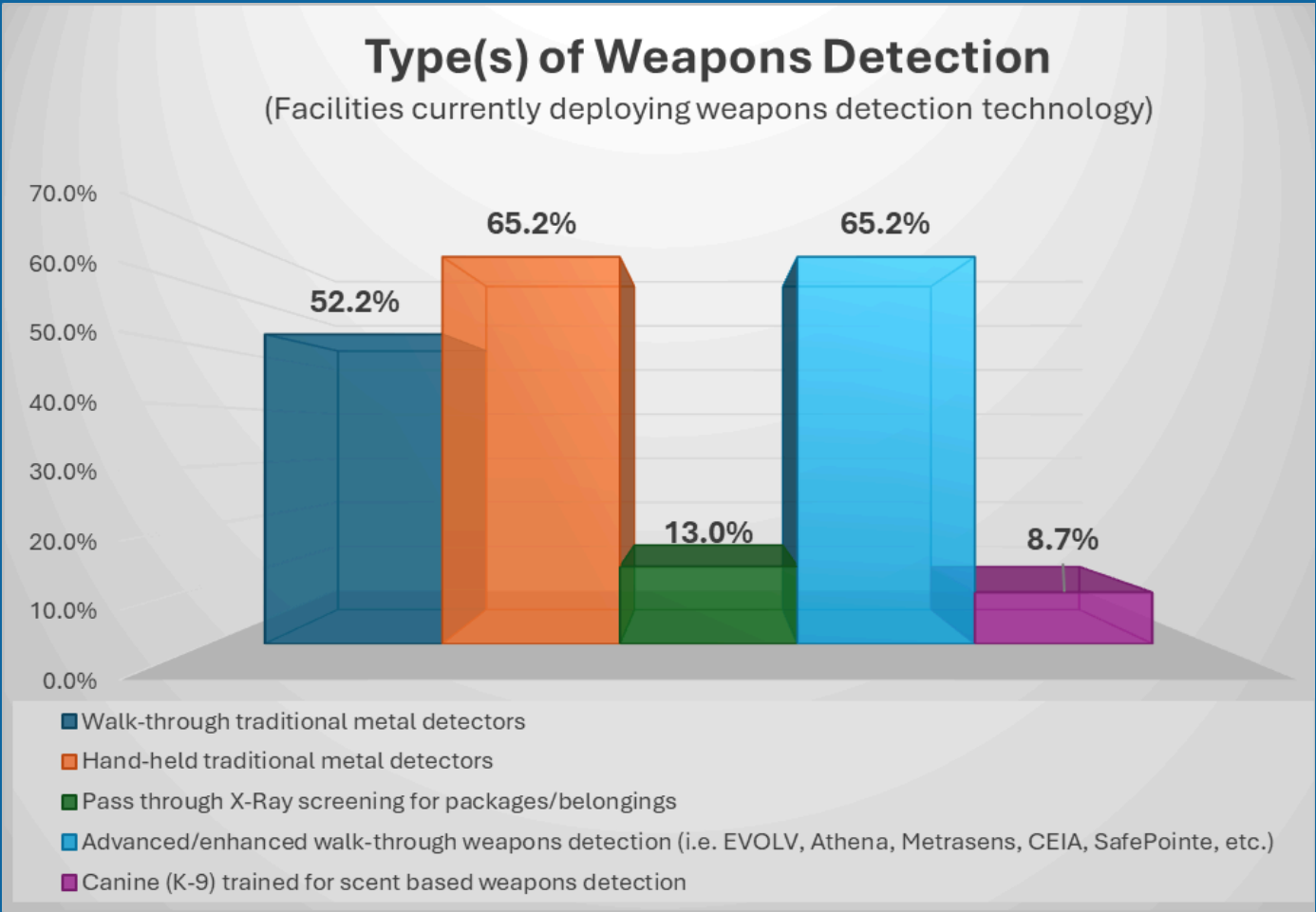
Training Programs

Security Officer New Hire Training

Forty-five respondent organizations provided information regarding their training programs for newly hired Security Officers. Of these 45 training programs, 10 reporting organizations provided their newly hired Security Officers one week or less of formal training after hire and before being assigned to work independently. Fifteen provided four or more weeks of training, with the maximum training program length being 13 weeks. The remainder of the hospitals' training programs fell somewhere between these two extremes, with an average of nearly four weeks and a median of approximately two-and-a-half weeks.

The respondent organizations used multiple modalities to train their newly hired security officers. Seventy-eight percent of the respondents reported that the training for newly hired Security Officers consists of a formal in-person classroom program.

Eighty-nine percent provided on-the-job training to their Security Officers, 67% offered web-based interactive training, and 53% delivered their training via self-directed reading.

Some respondents utilized certifications from outside organizations 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, used by 56% of the programs, and county or state-specific security licensing utilized by 33%. Thirty-six percent of the respondents include First Aid/CPR certification as part of their training.

New Hire Training (hours)

Length of Security New Hire Training (hours) ••••• Median

Annual Training Requirements

Thirty-nine of the 45 organizations offering initial training programs for Security Officers reported providing annual refresher training. The length of the refresher training programs varied from one hour to 87 hours per year. The yearly average training time budgeted was 19 hours, while the median budgeted time was 16 hours. The remaining six organizations provide no annual training for Security Officers.

Annual Refresher Training (hours)
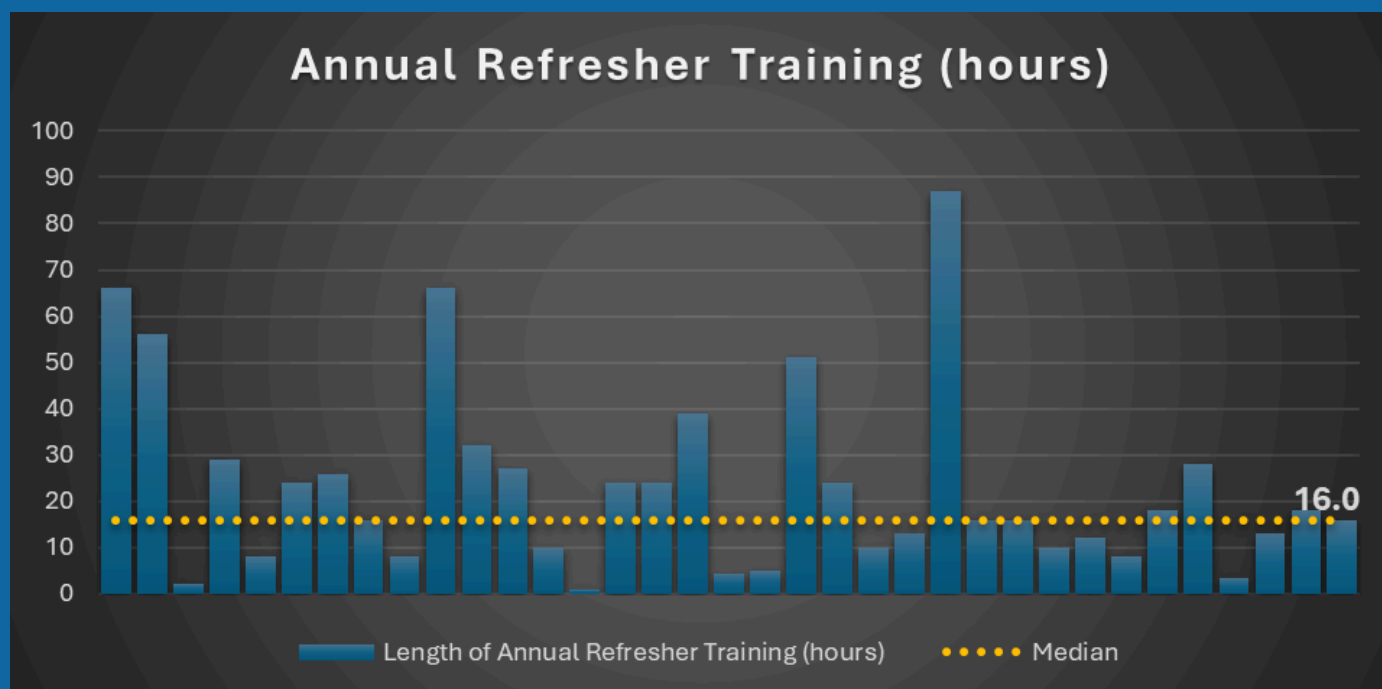
Training for Proficiency with Defensive Tools and Weapons

Of the 15 respondent organizations that reported issuing handcuffs to some or all of their Security personnel and supplied data related to the length of training, initial training in the use of those handcuffs varied between one and 24 hours, an average of five hours and a median of four hours spent on initial training for the use of handcuffs.

Four 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 11 reported annual refresher training budgets of between one and 24 hours, with an average of three hours and a median of two hours.

Of the 12 respondent organizations that reported issuing 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 two and eight hours, with an average of five hours and a median of four hours spent on initial training for use of OC spray.

Three 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 nine reported annual refresher training budgets of between one and four hours, with an average of two hours and a median of one hour.

Of the 14 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 widely between one and 40 hours, with an average of 11 hours and a median of eight hours spent on initial training for use of a baton.

Annual firearms training for Security Officers varied significantly among the reporting organizations. Two respondents reported providing just two hours per year of refresher training, while one organization provided 40 hours of annual firearms training. The organizations averaged 12 hours of annual firearms training, with a median of eight training hours each year.

Firearms Training (hours)

Legend: Intial Firearms Training, Annual Firearms Training
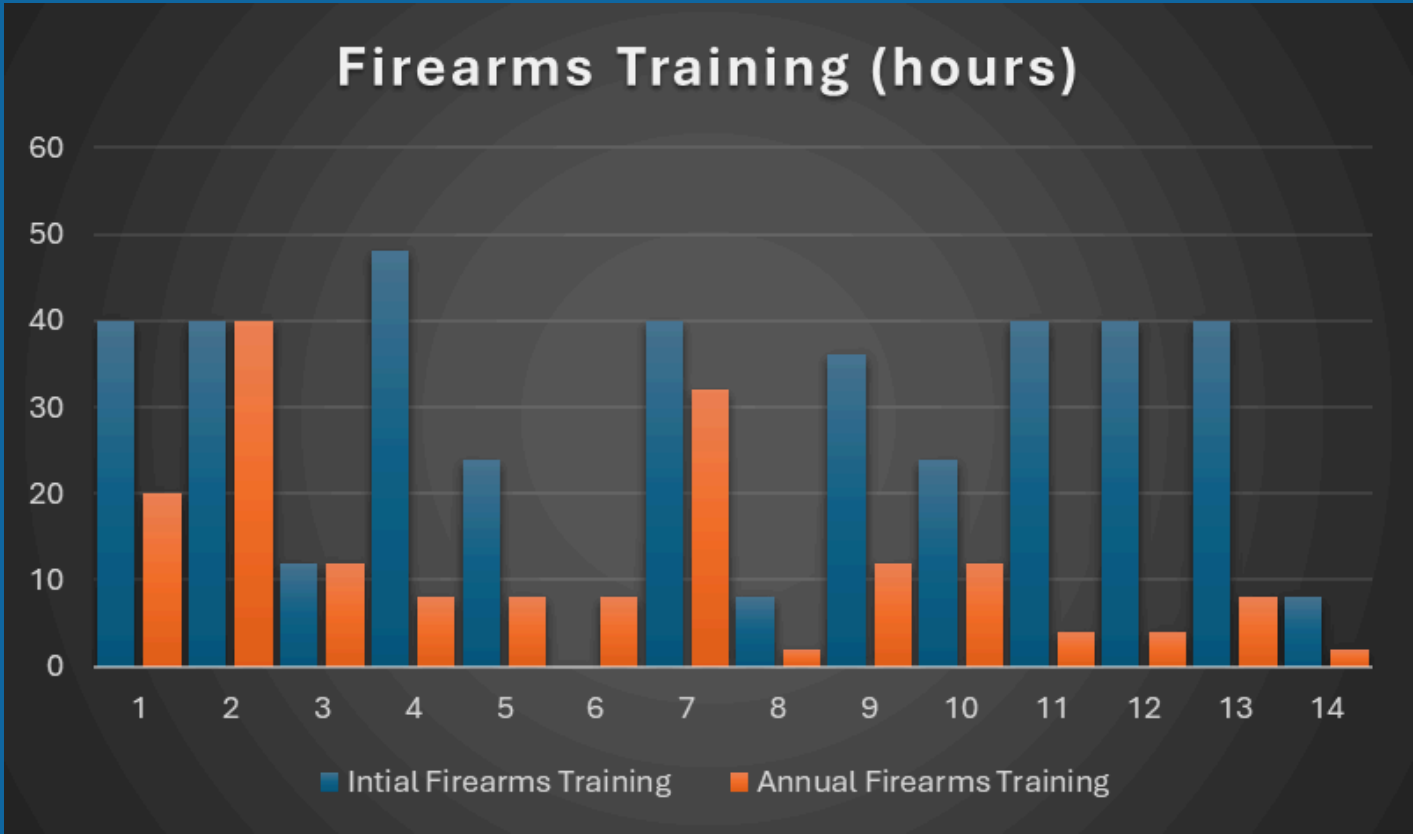
Final Thoughts

The newest iteration of our benchmarking study revealed some interesting trends that reflect the changing environment and nature of healthcare security programs. We continue to see increased emphasis on violence prevention, professionalization of the security function for healthcare organizations, and organizational changes to security programs that better reflect the needs of their organizations. These changes are driven by changing risk profiles and organizational realignments arising from shifting budgetary concerns and mergers and acquisitions in the healthcare industry. Our key takeaways from this study include data points in the program leadership, department staffing, equipment, and training.

Security Program Leadership

The developing strategic nature of security management for healthcare systems was reflected in the fact that of the respondent organizations, nearly half of their security program leaders report directly to a member of the organization's C-Suite or senior leadership team, with the majority reporting at the C-Suite or Vice President level (82%). While we had not gathered this information in previous benchmarking surveys, anecdotal evidence suggests that the trend is for healthcare security leaders to report to those higher in their organization structure and have more significant exposure to senior leaders than they have historically had.

Interestingly, the healthcare security leaders who expressed the highest level of confidence that their reporting structure set their organization up for success were those who operated in an academic medical center setting and reported directly to the University's Chief of Police rather than hospital leadership. Not surprisingly, they were followed closely by those who reported directly to their organization's senior leadership team members. This is contrasted by security program leaders who report to someone of Director level or lower, with those leaders reporting average and median confidence levels of 66 and 69 on a scale of one to 100, versus average and median confidence levels of 89 and 80 for those reporting at the Police Chief or C-Suite level, and those reporting at a Vice President level (VP, EVP, SVP) falling between those two extremes.
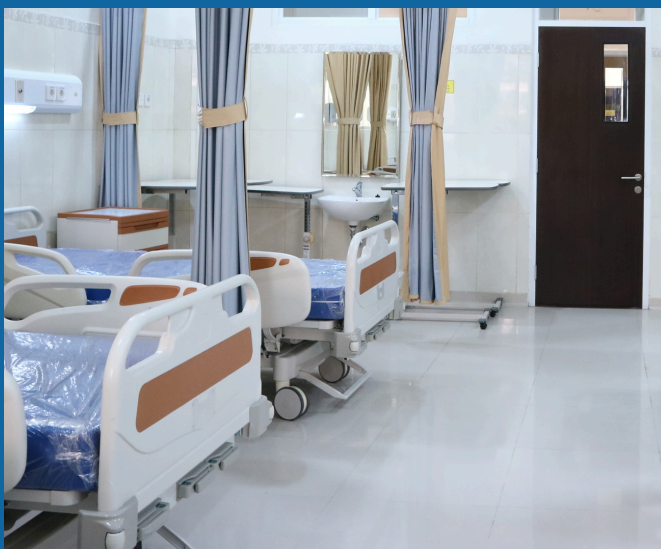
Department Staffing

We benchmarked the number of uniformed security or police staff for the organization against the number of non-security employees and against the number of licensed inpatient beds, and these benchmarks remained surprisingly consistent. The median total number of non-security employees to uniformed security FTE decreased slightly from 114.8 to 113.2 (1.4%), while the median number of licensed hospital beds per uniformed security FTE remained the same at 10.7.

We see the potential impact of budgetary pressures on healthcare security staffing in the ratio of supervisory and management employees within the departments, affecting the span of control for those supervisory employees.

Our 2019 benchmarking indicated a median ratio of supervisory and management FTE to non-supervisory FTE of 1:6.6 and an average of 1:9.5. In 2024, this jumped to a median of 1:15 and an average of 1:18, well outside the average spans of control of 1:7 to 1:10 that allow for effective oversight and management which are typically cited by law enforcement and business organizations.

Equipment

Shifts in the use of defensive tools by healthcare security departments in the US have occurred in the last five years. While handcuffs remain widely issued to healthcare security and police officers, increasing in prevalence from 93% to 97%, the deployment of Oleoresin Capsicum (OC) spray or foam and impact weapons such as batons have decreased significantly. Fewer than half of the health systems surveyed issued these tools—35% and 32%, respectively, down from 74% and 52%. While not as drastic, we did see increases in the number of departments issuing tasers and firearms to their staff (60% and 44%, respectively), with the prevalence of each to 15%.

We also continue to see increased deployment of weapons detection technology across hospitals in the US, with 64% of respondent organizations reporting its use. This is up from 47% at the time of our last benchmarking two years ago. We attribute this to changes in the actual and perceived risk environment, coupled with technological advances, that can ease the burden of managing a weapons detection screening point by reducing the need for secondary screening and increasing throughput. However, none of the systems had deployed video or sound-based analytics-based weapons detection technology.

Analysis

There are significant differences both in guiding philosophy and levels of risk which create foundational differences in the security programs of healthcare organizations across different countries. This leads to challenges in benchmarking these security programs across borders, and the relatively small sampling of non-US based respondents makes drawing too many inferences on the current state of healthcare security outside of the US challenging based on the data received.

Healthcare organizations located in the US appear to be adapting their security programs to better align with their organizational structures and enhancing their abilities to detect and respond to potentially deadly threats through investments in weapons detection technology, arming their Security staff with firearms and Tasers, and positioning their Security leaders into the ranks of executive leadership.

This is contrasted by the apparent decreased emphasis on training and supervision of the Security staff who are responsible for protecting the organization, its patients, employees, and visitors on a daily basis. As healthcare organizations continue to develop and refine their security strategies they should remain cognizant of ensuring the competency of their Security staff to manage all types of situations that they may face based on the organization's risk profile.

A final area to note is that with the increasing prevalence of University based healthcare systems and academic medical centers in the US market, there may be unrealized efficiencies that these healthcare organizations can achieve through closer alignment and resource sharing with the Public Safety or Police Departments or their affiliated universities.

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