Welcome

Message from the President:

Some of you, like me are ready for this long, dreary winter to be over. I have used my snowshoes some but am ready for my tennis racquet and some tulips instead.

What a fantastic conference and meetings we had in Las Vegas! Special thanks to the Council on Education for a great program with really dynamic speakers and topics. We received wonderful feedback from the attendees about this program which was great to hear. We had a great board meeting and a leadership meeting on Sunday with a lot of regional chairs and chapter chairs present. The sharing of information was rich, the sharing of best practices and successes was meaningful and the guest speaker we had talking about motivating a volunteer group was pretty wild. No one could have heard Dr. Gloria Heatherington and not been pretty “wowed” by her. We all agree motivating people to step up to leadership, to get or stay involved in our work is a process that needs constant tender loving care and attention, particularly in these economic times. I appreciate those that made it to Las Vegas for our meeting, our program, and our exhibits and surely hope you had a lot of fun. Also my thanks to the council chairs or designees who presented at the meeting along with Becky Strode, Steve Nibbelink, and John Driscoll who presented a best practice for all of us to learn from. We all agreed nothing replaces having time together as a volunteer group to bond, to share, to strategize and to evolve.

Joe and others are working hard on the new DHS committees we are involved with in protecting our infrastructure. He needs some volunteers for these subcommittee roles so please contact him if you are interested. Barlon Lundgren ran a great meeting in Atlanta I spoke at a week or two ago which targeted many new members. Evelyn attended the San Diego meeting and a new chapter is in the process of being chartered.

Our long term care task force chaired by Patrick Donaldson with Laverne Glover-Collins and Peter Troy playing active roles is really pushing to have some services, products and publications for the long term care market soon. We will start with some changes on our website and really focus on this industry sector as a target market. We know with demographics changing this population need to be served, have a gap with security and will only grow in the foreseeable future. This group is very open and welcoming to new members on this task force. They need some help with a plate full of dynamic initiatives so please contact one of them with your interest.
Our Guidelines Taskforce under the Council on External Affairs continues to flourish with the completion of their 23rd guideline. The board voted to separate out this taskforce so it will become a separate committee in June titled the Committee on Guidelines. This gives it the separation and support it deserves. Congratulations to Russ Colling and his team on tenacious and needed work and we know these guidelines are already helping professionalize and increase visibility for our industry.

We are still working to have a closer alignment with some other organizations that may complement what we do. One of these is the Security Management Services, a division of the National Health Service in the UK and we hope to have their executive director join us for our annual general meeting this June. We must have a strong and continued focus on the “I” in International and we ask your help in going after people in hospitals or similar organizations abroad or simply outside the US. We need help with this but healthcare security is a global function, discipline and need so we have to globalize our work to make this association even richer. I need help with this so please consider this carefully and I would be grateful if you would contact me with your suggestions.

Our councils and commission continue to do hero’s work. They are diligently moving forward with great initiatives, deliverables and projects to make us better suited to be the industry expert, to serve our members and to ensure we have the most relevant body of knowledge we can. I thank all of those working in these groups so very much for their efforts and encourage any of you interested in joining the Council on Education, External Affairs, Member Relations or the Commission on Accreditation to talk to me, the board, and certainly the chairs of these groups soon for planning purposes since membership changes are made this June for all volunteer groups.

Finally we have what is promising to be an amazing Annual General Meeting (AGM) in the beautiful harbor of Baltimore this June. The Baltimore planning group is working very hard with Evelyn, Nancy, the Council on Education and the board to ensure a valuable time, a huge return on your investment and a great time for all. Check out the details or get a brochure from Nancy with all the details of this event if you haven’t seen it. Now, more than ever is a need for us to bring our interests, our intellect, and our ideas together to help move our organizations and our industry forward. Talk to those you do business with and remind them exhibiting at this show will be very important to them as well as to us. Remember to sign up and to attend. You can’t put a price tag on this type of education or networking and many even do this on their own dime which we appreciate.

Hope to see you all and share some Maryland “crab” with you all in June.

With warm regards and wishes for a lovely spring to all,

Bonnie Michelman
Caring Starts at Your Front Door

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Executive Director’s Letter

2009 is already filled with exciting new activities at IAHSS! The Midwinter conference is over and was a great success, planning is in the final stages for the wonderful program planned for the Baltimore AGM, and planning has started for the 2010 Myrtle Beach AGM.

Have you registered for the AGM? Register early and enjoy a $100 savings on the registration fee. During these tougher economic times, consider sharing a hotel room with a co-worker to cut costs. Or car pooling and driving to the AGM instead of flying if you live close and it is doable. Think out of the box and cut costs – you do not want to miss this premier event!

Several new products are on the way! A new Canadian version of the Basic manual, new powerpoint training briefs, and one-day seminars in key locations. More information will be released soon on each!

The Basic Training manual is being revised in 2009. Plan according to complete the certification testing.

Having a tough time making it to a scheduled session to sit for the CHPA certification exam? It will be available online soon!

A membership drive is currently underway and we encourage you to participate. For every new member you bring to IAHSS who becomes members during the months of March and April, your name gets entered into the drawing for a stipend which can be used for IAHSS products including AGM expenses.

Perhaps the most exciting is the new website design. If you have not visited the website please do! It’s easier to navigate and has lots of new features. Please let us know your thoughts on the new site.

How can I help you? Shoot me an email at evelyn@iahss.org and I’ll get back to you quickly.

Always,

Evelyn

Welcome New Members
January – February 2009

JASON BARTON
ED BERGER
SHANNON BERKBUEGLER
GARY F. BROWN
JOHN D. BYERS
JERRY CASTORAL
MARCO B. CHOATES
MICHAEL CONWAY
DAVID A. DAGENAIS
JOSEPH A. DeMARCO
DOUGLAS D. DRIVER
PAUL FERRO
CRAIG FOY
KEVIN R. FREDERICK
FRANK R. GAFFNEY
ROBERT P. GIORDANO
IRENA GOLOSOCHKIN
RACHEL H. HAGERTY
JOSH HANNIGAN
THOMAS H. HENNINK
GEORGE HOHENBERGER
SHAWN S. HOSS
RICK D. JONES
SCOTT A. JUPP
LESLEY KEELEY
DARRYL A. LANCASTER
TODD A. LAUSCHER
HEIDI E. LIEAK
ROBERT A. LOSEMAN JR.
ROBERT E. MACKIE
ANDREW T. McQUEEN
JAMES D. MONROE
DAVID L. MUELLER
HOLLY R. MULLER
DENNIS P. O’CONNELL
CATHY PENROD
ROBERT M. PICCIANO III
SHAWN REILLY
SIMON J. RISK
LAURA SANKOWICH
REGINA S. SMITH
STEPHAN M. SMITH
GARY WOODWARD
DAVID L. ZIMPFER

Congratualtions
New CHPA’s

Steven R. Bourg
Traci L. Vandecandelaere
Tom W. Evans
Randy J. Kolentus
Eric J. Swanson
Geoffrey T. Povinelli
Daniel Yaross

CHPA Renewal: If you received your CHPA in 2005 you must recertify in 2008. To obtain an application contact the IAHSS at 888-353-0900.
Recent Shooting and Gun Incidents: New Violence Presents Difficult Challenges For Healthcare Security

SPECIAL REPORT

Nov. 14, 2008 – A technician in a laboratory building of St. John’s Mercy Medical Center, O’Fallon, MO, is taken hostage by her estranged boyfriend who enters the facility with a gun. A SWAT team is called and a standoff ensues until she breaks free and opens a door to allow the SWAT team to enter. As they do, the suspect shoots her several times. She dies at the scene. The assailant is killed by police.

Nov. 26, 2008 – A 48-year-old Imaging Department employee, fired the previous day, walks into Central Peninsula Hospital, Soldotna, AK with a 9 mm pistol and a .223 caliber rifle. He shoots and kills its Imaging Director and critically wounds the Imaging Services Director. After being wounded by police in a shoot-out in the hospital parking lot, he kills himself.

Dec. 14, 2008 – Gaston County (NC) police officer W. E. Howell, working off duty as a security officer for Gaston Memorial Hospital, Gastonia, is informed that someone is in the ER waiting room brandishing a gun. Officer Howell proceeds to the area and approaches the subject. The suspect points his gun at another man. Officer Howell draws his firearm and orders the suspect to lay down his weapon. The suspect does not comply and appears about to fire. Officer Howell shoots the suspect.

Dec. 27, 2008 – At 2:15 PM, a man walks into a medical office building on the campus of St. David’s Medical Center, Austin, TX and shoots a female medical worker in a doctor’s office after a brief argument. The man then goes to a relative’s home and shoots himself.

Jan. 5, 2009 – A female patient is brought into the ED by ambulance. With her in the ambulance is her brother. As she is being triaged, she becomes belligerent, complaining she is not being taken care of quickly enough. A security officer attempts to calm him down. Instead, he becomes more belligerent and pulls a gun. Other officers disarm him.

Feb. 14, 2009 – A 35-year-old former per diem nursing supervisor at Lakeside Memorial Hospital, Brockport, NY, who was fired four days earlier, has been arrested in connection with four shooting deaths which began at 5 a.m. in the parking area of the hospital. Two persons driving by, it is reported, tried to intervene when they see him in a violent argument with a female nursing assistant. He shoots and kills the assistant and one of the others, and critically wounds the third person, it is charged. He then reportedly goes to the home of an LPN with whom he worked previously at a nursing home and shoots and kills her and her husband.

The above incidents, which took place over a three-month period, would be disturbing in “normal” times. But given the additional emotional stress of a recession, we can expect more frequent violence of the kind inherent in actions by fired employees, persons involved in domestic disputes, and disturbed patients and visitors – armed, and filled with incredible anger. In this report we’ll give details of what happened in those incidents and present suggestions for preventing and dealing with such difficult situations.

‘REVENGE’ BY FIRED EMPLOYEES

This scenario, while not uncommon in other industries, has been relatively rare in healthcare until the two incidents described above. In 1998, hospital security professionals were shocked at the news that a colleague, Ken Kuck, a supervising officer and 20-year veteran of the Loma Linda University Medical Center security force, was shot and killed outside his office by an employee, Ariel Ramirez, a parking enforcement officer, who minutes earlier had been fired. Susan Douma, current security director at Loma Linda Medical Center, describes the quandary. “You can’t have everyone who walks in go through metal detectors, and you can’t frisk everyone.” She says it’s a matter of training hospital personnel to “be aware.”

Central Peninsula Hospital: Fired Employee Targets Supervisors

Central Peninsula Hospital, Soldotna, AK, is a 46-bed hospital 75 miles south of Anchorage. According to reports in the Peninsula Clarion and Anchorage Daily News, Joseph Marchetti returned to the hospital the morning after he was fired armed with a 9 mm pistol and a .223 caliber rifle. He sought out his former...
boss, Imaging Director Mike Webb, and shot him in the stomach. He then shot Imaging Services Director, Margaret Stroup. Then he began spraying the building with the rifle, aiming his shots towards the imaging center. After firing some two dozen rounds, he reportedly began making his way towards the exits. Here he encountered Webb again, in a wheelchair; being readied for transport to an Anchorage hospital. He shot him again, killing him.

By this time, Officer Johnny Whitehead of the Soldotna Police had arrived at the hospital. He found Margaret Stroup alive but unresponsive, and provided cover for her until a physician arrived and they moved to a safe location. He then proceeded with Alaska State Trooper Eugene Fowler to the main entrance, as dispatch indicated Marchetti had exited the building. The two lawmen moved to the parking lot where they could see Marchetti. By now other state troopers and police had arrived. Marchetti was pacing up and down nervously, threatening the police. Then he turned and began moving toward a nearby neighborhood and school. Soldotna Police Chief John Lucking is quoted as saying that was a risk he could not take. The police opened fire, wounding Marchetti, who turned a gun on himself.

Afterwards, hospital officials doubled security patrols and began reworking their security measures. One thing they learned was that staff were confused about the codes. When Marchetti entered the facility, a “Code Yellow” was announced, meaning everyone should lock themselves in their rooms. But the smoke and dust from Marchetti’s rifle rampage set off the fire alarms, resulting in a “Code Red.” This requires an evacuation.

Lakeside Memorial Hospital: Fired Supervisor Targets Co-Workers
Registered nurse Frank Garcia has been arrested for shooting five people in two separate locations on Saturday, February 14, according to local media reports. Four of the victims died. Garcia, 34, was charged with first-degree murder and attempted murder for allegedly shooting three people outside of Lakeside Memorial Hospital, Brockport, NY, a 61-bed facility 20 miles west of Rochester. Police said Garcia was seen arguing violently with Mary Sillman, 23, around 5:15 a.m. When a man, Randal Norman, 41, and a woman, 57, Audra Dillon, stopped to intervene, Garcia allegedly began shooting a handgun. Norman and Sillman were killed; Dillon was able to get in a car and drive to get help. She was taken to Strong Hospital for surgery; where she is listed in critical condition. Garcia turned up hours later in Canandaigua, NY, where Ontario County Sheriff’s Deputies said he went door to door looking for the home of Christopher Glatz, 45, and Kimberly Glatz, 38. Police said Garcia found the home and shot and killed the couple, execution style. He was apprehended later in the parking lot of a restaurant.

Lakeside Hospital officials said Garcia worked there as a per-diem nursing supervisor for three months until he was let go on February 10. Sillman was described as a certified nursing assistant at Lakeside’s Beikirch Care Center. According to press reports, Garcia had previously worked at Wesley Gardens, a nursing home in Rochester, from March 2006 through March 2008 before he was suspended. He was fired in October of 2008. Lakeside hired him the same month. Kimberly Glatz, an LPN, one of the shooting victims, worked at Wesley Gardens from June of 2007 to December 2007.

A hospital official was quoted as reporting that, “we did contact the last previous employer and confirmed his employment dates.” However, the hospital was not informed he had been fired. The official added that following the weekend’s incident, security practices probably will not change. “However, the hospital is looking into improving security, including adding cameras to the parking lot and adding a security officer between the hours of 3 a.m. and 6 a.m.” An officer was said to be on duty between 11 p.m. and 3 a.m.

DOMESTIC VIOLENCE: “I KNOW WHERE YOU WORK”
Violent incidents at work involving employees and boyfriends, husbands, wives, ex-husbands, and even stalkers, have become more frequent because the victims are more accessible there, especially in the open environment that characterizes most hospitals. The two recent incidents cited provide good examples of what can occur. Interestingly, both took place on hospital property (a medical office building and a laboratory) that may not be as well-patrolled as the main hospital area.

Shooting Death In A Doctor’s Office
Police reported the shooting death of a woman at an office building next to St. David’s Medical Center in Central Austin. At 2:15 p.m. on a Friday afternoon, a man walked into an office building next to St. David’s Medical Center; Austin, TX, and shot the woman, who worked for a doctor there, according to police Sgt. Richard Stresing. He said the man then went to a relative’s home in Southeast Austin, shot himself, and died. Stresing said the man and woman knew each other; but Stresing did not know how. “One of the witnesses did say there were words spoken between the two individuals,” Stresing said. “I don’t know if it was an argument ... but he said something and then shot her and walked out.” The three-story Park St. David Professional Building is owned by St. David’s HealthCare, and doctors rent offices in the building. Stresing said. He said the building was shut down after police were called and St. David’s security officials were notified.
Hostage Taking In An Outlying Building
When Jenenne Meadows was taken hostage (and later killed) at a lab on the campus of St. John’s Mercy Medical Center, O’Fallon, MO, in St. Louis County, it was a police matter, not hospital security, according to the hospital’s Director of Public Safety, Rich Bartram. (For details of the incident, see the last issue of DIRECTIONS, Volume 21, Number 4, page 15.) “We don’t provide security for the outlying buildings,” he says. “However, since that incident, we have taken a second look at overall security throughout the entire campus. We are looking at workplace violent response policy. We’re thinking of installing some form of intruder alert system and increased access control.” Access control might consist of card access only so no one could walk in off the street, Bartram adds. At this point, he says is struggling with budget constraints in determining how best to proceed. “In the long run education is the key. That is what limited the tragedy. Everyone in the building did what they had been told to do. They hid.” The perpetrator was an ex-boyfriend of Meadows, Bartram says. It was later learned she had taken him to the doctor the week before.

ER VISITORS UNDER STRESS WAVING GUNS
Two recent incidents illustrate decisions that may have to be made by security personnel, armed or unarmed, when a visitor under stress in an emergency room brandishes a weapon.

Disarming A Gun-Pointing Family Member At Crouse Hospital
Tom Bassett, Director of Security at Crouse Hospital, Syracuse, NY, describes the unusual incident he and his officers had to deal with. An ambulance pulled into the ED ambulance bay with a female patient complaining of chest pains at 3:45 p.m. on January 5. Riding in the ambulance with her was her brother, 58-yr old Tom Lefler. Bassett recalls that the patient was moved into a room within five minutes, but the brother accosted the ED secretary, complaining the staff was not treating her fast enough. The secretary assured him they were doing everything possible for her; but he became more and more belligerent and was creating a scene. The security officer manning the ED approached him to try to calm him down. Lefler was wearing a Corrections Department cap, so the officer at first thought he was a Corrections officer. He attempted to reason with him, but then detected alcohol on his breath. He told Lefler he smelled like he had been drinking. The brother became more belligerent. The officer called for backup.

Two more security officer arrived within two minutes, Bassett says. The three escorted Lefler to a vestibule area, out of sight of other ED patients and relatives. They asked to see his ID. At this point, Lefler pulled a gun, pointed it at the first officer’s head and said, “Here’s your ID.” The other officers immediately jumped him, and knocked the gun out of his hand. One officer kicked the gun out of reach, and another retrieved it. Lefler was subdued. The gun was taken out of the area and the officers started to remove the rounds. It was not loaded. By now the police had been called. The police took him away. Bassett notes the case is still under investigation, but Lefler turns out to have an extensive criminal record, and was on parole when the incident occurred.

Bassett is extremely proud of his officers. “They did everything picture perfect,” he says. “We’re even using the video of the incident as a training video, and the local police department is using it for that purpose as well.” Bassett believes that this incident was unusual in that Lefler came into the ED in the ambulance. “If he had walked in, someone may well have noticed the bulge of the gun. But in this case, the standard precautions were bypassed.” He notes the root cause analysis which followed the incident came up with one conclusion. “Be more alert when a relative or friend arrives in the ambulance with a patient.”

Shooting A Gun-Pointing Family Member At Gaston Memorial Hospital
A man who was shot and killed by an off-duty police officer at Gaston Memorial Hospital, Gastonia, NC, on December 14, died from a single gunshot wound to the chest, his autopsy report shows. According to the Gastonia Gazette, Keyjuantas Devance Tims, 29, of Gastonia, allegedly pointed his gun at another person in the hospital waiting room around 11 p.m. that night. Gaston County Police Officer W.E. Howell shot Tims after repeatedly warning him to place his hands on a counter, according to a witness account. Howell was performing off-duty security work for the hospital. Tims was treated at Gaston Memorial Hospital and transferred to Carolinas Medical Center in Charlotte, where he was pronounced dead.

Tims mother told WSOC-TV that she had brought him to the hospital because he was acting strangely and had pulled a gun on her. Tims allegedly pointed a gun at his mother’s friend in the emergency room when Howell approached him. The officer had been told that there was a man with a gun inside the hospital. Tims, it was reported, was a convicted felon and not permitted to have a handgun. He was convicted in 2006 of possession of a firearm by a felon, forgery and breaking and entering and had been previously incarcerated twice.

Gaston Memorial Hospital was placed on lockdown after the shooting and doctors and nurses tried to revive Tims. Gaston County Police provide off-duty officers to work private security at the hospital 24 hours a day. Howell has been placed on paid administrative leave, which is customary when police officers are involved in a shooting. The State Bureau of Investigation is probing the incident, also a standard practice.

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WHAT CAN BE DONE TO PREVENT SUCH INCIDENTS?

As difficult as it may be to anticipate that an employee, someone involved with an employee, a patient’s family member, or even someone coming in off the street, will turn violent and employ life-threatening weapons, there are steps that can and should be taken.

**Glasson: Minimize The Potential For Violence**

“You have to balance the need for customer service and relations with security and safety,” says Linda Glasson, Security Manager, Sentara Obici Hospital, Suffolk, VA. “You must assess your vulnerability and develop your procedures based on that assessment, but you don’t want to seem unfriendly to your customers.” Some facilities are fortunate in having low vulnerabilities, she notes, and so can minimize such aspects as access control and surveillance. Those that have high vulnerabilities must intensify all security factors. “You can’t completely prevent such situations,” she says. “You seek to minimize the potential for violence.”

Glasson holds regular staff orientations, emphasizing the importance of reporting any suspicious behavior or incident. She also emphasizes that they call 911 in an emergency and know what questions the 911 operator will ask. “They have just 10 seconds with the 911 operator,” she points out. “It can be critical that they be able to specify their location and the details of the situation.”

She also holds what she terms a “mystery badge” exercise each year. In this, an individual is given a dummy badge – it may be one with a photo that is not of the person, or a badge that is not of the correct type. The purpose is to see how long it takes someone to notice the badge is not proper. The staff member who does receives a meal voucher or other award.

With her security staff, she works with the local police doing table top drills and briefings.

**Sarratt: Encapsulate Units Where Violence Is Most Likely To Occur**

Walter Sarratt, Director of Security and Safety at Hillcrest Baptist Medical Center, Waco, TX, has done a statistical analysis of hospital areas in which violence is most likely to occur. It comes as no surprise that the ED is number one. But following close behind are the Rehab unit and the Neonatal unit. “In all three you have a lot of family situations, or broken family situations, or boy friend/girl friend situations – all of which can become volatile,” he observes.

His approach has been to ‘encapsulate’ these units – that is, effectively seal them off from the rest of the facility. He does this by having double doors on the entrance to the units. The security officer sits in the vestibule between the double doors, and so observes everyone who enters.

Sarratt says such measures are well worth it because “trouble_follows people in from the street.”

Sarratt also offers unique educational opportunities for his staff. “We’re only 12 miles from former President Bush’s Crawford ranch, so we get regular training briefings from the Secret Service,” he says. He also has a barter deal with the Waco Police Department. They use a vacant building on the hospital campus for training, and in turn train five of his security staff at a time on a regular basis in dealing with an active shooter.

**Colling: Recognizing Precursors, Reporting Threats: Keys To Preventing Violence**

“In health care, you divide violence into two broad categories,” says Russ Colling, CHPA, CPP, Colling & Kramer Consultants, Salida, CO, author of the text, Hospital Security. “In the first category, there are precursors and warning signals, accounting, for 90 to 95 percent of all incidents. The other category consists of ‘spontaneous’ events. Even there, if you look back, you can say, ‘oh, two months ago he wrote this strong letter... You have to train supervisors to be more astute in looking for these precursors. It’s just like gauging the escalation of potential patient violence.”

The foundation for preventing violence in healthcare, Colling stresses, is that the hospital needs a policy that all staff are to report any threats or suspected threats of violence. That policy must be is strong and enforced, he adds. “Generally there is a threat assessment team. It can be only a few people – human resources, security, and maybe nursing. The team looks at the threat, assesses how serious it is, establishes levels of seriousness and steps that have to be taken for each one of that threat levels.” This isn’t a 9 to 4 threat assessment team, he emphasizes. Emergencies take place 24 hours a day, seven days a week. “You have to have someone with the authority at 2:30 in the morning, whether it’s the head nurse if you don’t have a security department, or the security supervisor, to act independently in taking preventive steps, even if it means bringing in a security officer that’s off duty to stand in front of a room.”

Colling feels strongly that threats in an employee’s private life also must be reported. “There’s more family stuff than the other. Once you assess the threat level, then you match that with a preventive action. If it is extreme, you take such steps as reassigning a nurse to another unit, or to a different shift. If it’s an office clerk who works in a front office, you reassign him to work in the back of the building.”

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Most confrontations take place in the parking lot or garage, Colling adds. “A common thing we do is to arrange for an employee to park in a safer place, maybe in the doctor’s parking area. We find that in a lot of instances, they wait for them at their car. In some cases, we have even picked up the employee at work and brought them home.” Colling also advises encouraging a threatened employee to report to the police and get a restraining order. “It may not be worth the paper it’s written on, but not to encourage them to get one could be considered a dereliction of duty.”

In connection with concern about violence by a fired employee, Colling cautions that such actions do not always take place immediately. “In many instances,” he reports, “the fired person may come back a year or two or three later. It isn’t as instant as one would expect.”

The hospital has received “overwhelming” positive approval from families, Sawyer reports. “The families are happy we screen everyone.” This cooperation, he adds, has made the program a definite safety improvement. He emphasizes that “we want to authenticate why people are here, not just registered sex offenders. We don’t want anyone in the hospital who has no legitimate business here. In two instances, Sawyer says, “we had individuals walk up to us and say ‘I saw the news story on TV and I want you to know I’m registered as a sexual offender.’ We show total respect and we move on from there.”

Sawyer says that the system — the hospital uses Legend EasyLobby® — prints a badge in less than a minute. “We staff every entrance. We greet you and ask why you are here, scan your license, take a photo, print an ID badge, and you are on your way. The badge will link you to a patient or a particular seminar or event. Anyone over 12 wear must wear a badge. Some people take it off, put it in their back pocket or in their pocketbook. Employees will remind them politely that everyone in the hospital must wear their badge.” Actually, Sawyer finds, families are more prone to wear their badges than employees.

FOR FURTHER INFORMATION, CONTACT:
James R. Sawyer, CHPA, CPP, Children’s Hospital and Regional Medical Center, 4800 Sand Point Way, N.E. Seattle, WA 98105. Ph: 206-987-6213. Fax: 206-987-5172. E-mail: jim.sawyer@seattlechildrens.org
Go to http://www.LegendID.com/ for information on its badging systems
2009 Board of Directors Election

The election results are in! We finished with 320 out of 1708 eligible members voting for a participation rate of 18.74%. By comparison, 226 voters participated in 2008 for a rate of 13.81%.

Web voting satisfaction ratings:
Very satisfied = 79.3%
Satisfied = 18.7%
Neutral = 2%

Election results:
President Elect – Jim Stankevich
VP Treasurer – Lisa Pryse
Member at Large – Jeff Young

Thank you to all candidates for their willingness to serve IAHSS!

Website Changes

Have you visited the website recently? It has received a dramatic facelift! The drop downs buttons are located across the top of the page for easier use. Items have been listed in a manner which is user friendly. The search engine is more powerful than ever! Take a moment and see everything that is available to you as a member on the website.

2009 AGM Baltimore

Have you registered yet? Enjoy a discount price of $695 if you register prior to May 1st.
IAHSS and the Maryland Chapter will host the 41st Annual General Membership Meeting and Seminar Program June 21 – June 24, 2009 at the Renaissance Harborplace Hotel. An outstanding educational program has been planned to help you maintain competency in your profession as healthcare security and safety professional. Exhibitors will display the latest in technology and services. This is an Annual General Meeting you won’t want to miss!

After participating in this event, you will walk away with new information and skills in the following areas:
• Strategies for dealing with surges from a shooting in the community
• Effective handling of forensic patients
• Understanding the basics of ballistics as it relates to the human body
• Strategy for dealing with the everyday threat of violence in the Emergency Department
• An inside look at drug diversion in nursing
• Principles of the public health model and their approach to reducing the burden of violence
• What you have to gain by joining InfraGard
• Survey results from violence survey by ENA
• And much more!

Visit the website for complete information. We know the economic times are tough but it is more important than ever to stay abreast of changes in our profession. Be creative – shave expenses. Share a hotel room, carpool to the event, register early! We hope to see you in Baltimore!
The security team at Dixie Regional Medical Center (DRMC), St. George, Utah, in large part has credited their facility’s safety to the help of two additional, but unusual, staff members: security dogs. In 2004 the DRMC Security division, led by Marty Mangum, brought on “Boomer,” and “Nitro,” two American Kennel Club-registered German shepherds trained in obedience, handler protection and explosive ordinance detection.

The dogs have several uses beyond the obvious, and they are treated as second officers by their handlers, not mere mascots. Dogs and handlers patrol the interior of the hospital, looking for intruders or unsafe situations. But not to ignore other areas, the teams patrol the exterior of the buildings as well as facilities that are closed during the day. The canines have a unique ability to detect people hiding or sleeping outside the building and have, on several occasions, spotted homeless people who were directed to shelters, says Kevin Greenhalgh, DRMC’s Safety and Security Director. Out in the parking lots, the dogs and handlers patrol to deter thefts and vandalism.

Many patients respond to the dogs positively, Greenhalgh says. Sometimes they are used as therapy dogs with patients and family in the hospital. Boomer, Mangum’s dog, is very good with special needs children, as he lives at home with Mangum’s special needs daughter.

Weeks before the dogs were brought on to work full-day shifts alongside their handlers, patrolling the 245 – bed hospital, they were put through rigorous training. Two masters trained Boomer and Nitro at the Zauberberg K9 Academy in McNeal, AZ. From there, Mangum and another trainer, Jason Oliekan, traveled to Arizona where they lived for four weeks training with the dogs daily. The two men learned how to continue training their canine co-workers once they returned home to work in Utah.

The program requires that all dogs be trained on a continuous basis in order to be recertified every year. The animals enjoy this part of their job, Mangum says. “Both dogs are very happy, especially when they train. They consider this time as ‘play time’ and respond very well to these daily activities.” The cost of the dogs is $12,000 apiece. That covers the complete initial training, room and board for the dog and handler during initial training, and the mandatory annual recertification, he reports.

The results from bringing Boomer and Nitro to the force have been positive, Mangum says. The staff enjoys interacting with them; patients who miss their own pets benefit from their presence; and visitors and employees always appreciate an escort out to a dark parking lot at night. “One of the things that is very hard to quantify is that because of the K9 patrols, how many negative incidents have been stopped, moved to another area or simply didn’t happen due to the visible patrol done by these officers?” During the four years the K9 program has been in effect, the dogs have been able to keep the peace without a single injury, he adds.

Mangum and Oliekan point out other hospitals considering a K9 patrol addition to their shifts, should know that the dogs aren’t put away at the end of their shifts. “Prospective handlers know that a K9 program is very rewarding, but also a great deal of work,” Mangum said. “(The dog) is part of the handler’s family 24 hours a day, seven days a week. But in my opinion, it is worth every minute.”

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Planning, Conducting, and Evaluating Disaster Drills on Two Coasts

What is involved in conducting hostage taker and active shooter drills and what lessons can be learned from them? Those questions were clearly answered in a series of coordinated exercises involving healthcare and law enforcement personnel in California and Pennsylvania.

In San Joaquin County, California, located east of San Francisco in the state’s Central Valley, Phillip Cook, Disaster Medical Health Specialist for the County’s EMS Agency, conducted six planned hostage scenario drills between October and December of last year at all but one of the area’s hospital facilities.

In the Allentown-Bethlehem-Easton area of Pennsylvania, Gerald Kresge, Director of Security for the Lehigh Valley Health Network, conducted active shooter as well as hostage drills at the network’s Cedar Crest Hospital campus in Allentown, and Muhlenberg Hospital campus in Bethlehem.

Cook: Expect Approval Delays
Cook, the lead planner for the San Joaquin County exercises, coordinated the Homeland Security program for the county’s public agencies for three years and formulated and presented the concept for the drills to area acute care facilities during a monthly emergency preparedness meeting attended by area hospital emergency preparedness coordinators. “When I approached the hospitals, they were very excited about the idea,” he reports. Despite this initial enthusiasm, Cook says, a year elapsed between the presentation of his proposal and the actual drill exercises. “It’s kind of a delicate situation; people coming in with machine guns.”

Setting Drill Objectives And Scenarios
A coordination team, consisting of area Emergency Preparedness Coordinators and law enforcement agencies and officials created a list of objectives for the emergency drill. The objectives ranged from evaluating the responsiveness of hospital staff to a security threat to evaluating the effectiveness of communications between the Hospital Command Center (HCC) and the San Joaquin Operational Area Disaster Control Facility (DCF), as well as other area emergency response facilities, including the Medical Health Operational Area Coordinator (MHOAC) and the Law Enforcement Incident Command Post (ICP). Also of great importance, Cook says, was determining the ability of an acute care facility to maintain high standards of patient care during an emergency. After the drill coordination team cemented the objectives for the drills, they spent four months logistically preparing for the exercises and creating scenarios for each of the six drills, according to Cook.

Law enforcement members of the coordination team ultimately drove the process of creating authentic situations for the drills, Cook says. Each drill was scripted as far as who would be shot, or taken as a hostage, as well as assigned a primary and an alternate location within each acute care facility to ensure that the drill would still be held if the option of the first location fell through at the last minute.

The Scenario Unfolds
The drill participants consisted primarily of law enforcement volunteers, according to Cook. Hospital employees were warned ahead of time about the drills, but not informed of the details in order to promote more realistic emergency exercises, Cook reports. Each drill began with a ‘bad guy’ entering an acute care facility and, for example, the perpetrator might have been a disgruntled former employee who began the confrontation with verbal hostility and then escalated his or her behavior to physical hostility toward a person or persons, Cook says. Following the taking of a hostage, or hostages, a ‘911’ call was made, followed by the arrival of a local SWAT team. The six drills averaged four to six hours in duration and took place between eight and five, during the work day, Cook reports.

What Went Wrong And What Went Right
Following the drills, Cook and the emergency exercise coordination team discussed what went right and wrong during the drills.

- A primary challenge SWAT team officers experienced during the drills was maintaining effective radio communications as they moved through hospital facilities, according to Cook. The hospitals contained a substantial amount of shielding that blocked radio communications in some areas within the facilities, he says.

- The coordination team and drill participants also raised concerns about the potential for longer hostage standoffs where medications and medical supplies might run low and need to be replenished. Cook says this concern inspired a suggestion for a hospital liaison who would communicate such needs to area law enforcement agencies during real emergencies.

- Prior to the drills, Cook says the area acute care facilities were not accustomed to working with law enforcement. “This really strengthened their [hospitals] relationships with their local law enforcement agencies,” Cook said.

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**Kresge: Makeup Of A Coordination Team**

In Pennsylvania, Kresge says he communicated the need for emergency drills to local law enforcement agencies and officials, who according to Kresge, were very willing to participate in the exercises. Like Cook, Kresge put together a coordination team several months before the actual drills to begin logistical planning and drill scenario and scripting creation. This team consisted of multiple area police departments, the Northeast Counterterrorism Task Force at Bethlehem, the Salisbury Township Emergency Response agency, the City of Allentown’s SWAT Team Director, and the Emergency Preparedness units from each hospital campus, according to Kresge. For their objectives, team members focused on the evaluation of response times for ‘911’ operators and law enforcement officials, as well as the effectiveness of communications between law enforcement officers within hospital facility buildings during emergencies, and the efficiency of law enforcement navigation through hospital buildings while in pursuit of criminal targets.

**An Active Shooter, Hostages, And Bombs**

According to Kresge, the first drill scenario addressed an active shooter situation, while the second drill varied this scenario with the addition of hostages.

To begin the drills, blanks were shot to get the attention of hospital staff, Kresge says. The first drill scenario involved a disgruntled ex-employee blowing up the hospital’s communication system by camouflaging a bomb in a lunch box abandoned near a lost and found receptacle at the front desk of an open, common area within an acute care facility.

During the second disaster drill, a group of people protested a lack of medical coverage in an Active Cancer Center and the protest escalated to physical violence. Kresge reports that during this exercise multiple bombs were planted and multiple hostages were taken as a variation on the active shooter exercise in the first drill.

“We wanted two different scenarios,” Kresge says. The first drill lasted 3.5 hours and the second lasted nine hours because of the multiple hostages taken, Kresge says.

**Unforeseen Issues That Arose During The Drills**

Following the two drills, which were intentionally spaced four months apart, the coordination team reviewed the exercises and addressed several issues that arose during the drills. Kresge reports that the team discussed the disorientation SWAT officers experienced because of the sheer size of the hospital buildings they were required to navigate. During one drill, a rusted exterior door leading from a hospital blood bank could not be opened because it had rusted, Kresge says. Additionally, during the second drill, the natural lead deposits present near the underground radiation areas of the Cancer center caused the police radios to stop working effectively. Kresge reported, “It ate the police radios.”

A future drill at a third area acute care facility is already being planned, Kresge reports.

FOR FURTHER INFORMATION, CONTACT:

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In Brief - U.S.

Hospital Security Officers Rescue Nun From Burning Convent
PORT JEFFERSON, NY.
Two St. Charles Hospital security officers risked their lives January 11th to rescue a nun from a fire at the Daughters of Wisdom convent on the grounds of the hospital. According to press accounts, the officers, Thomas Connors and Eric Surbito, arrived at the scene before town firefighters to find one of the sisters in front of the convent, which was partially engulfed in flames. Told that another sister was trapped in her room on the second floor, they knocked down the front door, which was locked from the inside, and were “hit by heavy smoke,” according to Surbito, who is also a New York City firefighter. Surbito and Connors, a retired police officer and volunteer firefighter, made their way upstairs and, with the assistance of two Port Jefferson assistant fire chiefs, who had arrived on the scene, were able to deliver the second sister safely from the burning building. John Geary, Director of Security at St. Charles Hospital, said his officers went “above and beyond” what is expected of any individual. He said there are at least two dozen fire drills per year to prepare hospital employees for emergency situations. The fire had been caused when a lighted candle accidentally ignited a Christmas decoration at the convent, according to a Suffolk County police press release.

Hospital’s Security System Thwarts Infant Kidnapping Attempt
NASHVILLE, TN.
A 24-year-old woman has been arrested after posing as a nurse and attempting to walk away with a newborn baby at Metro General Hospital. According to published reports, the woman entered the hospital wearing scrubs, proceeded to the mother’s fourth-floor room, and told the mother she had to take the newborn to have its temperature taken. When the woman tried to leave the maternity floor, an automatic electronic security system was triggered and the floor was locked down. According to the hospital’s spokeswoman, when the system is triggered, the elevators are shut down and the staff goes to alert stations. Within minutes, the suspect handed the newborn over to a doctor and she was detained until police arrived. The security system has reportedly been in place for four years and no other kidnapping attempts have been made.

Infant Kidnapper Sentenced To Five Years
SUDBURY, ONTARIO, CANADA.
A 29-year-old woman, who pleaded guilty to the November 2007 to kidnapping of a newborn from Sudbury Regional Hospital, has been sentenced to five years in prison. According to press reports, the incident was captured on the hospital’s security video. The newborn girl was found safe, eight hours later, more than 100 miles away from the hospital. Since the kidnapping, the hospital has reportedly improved security in the labor, delivery, recovery, and postpartum units. Hugs Infant Protection bracelets, magnetic door locks, and an enhanced surveillance camera system have all been employed and, according to the hospital’s CEO, if hospital staff are not wearing their photo ID’s they are sent home. Parents are also given handouts with tips on keeping their newborn safe.

Woman Posing As Hospital Employee Attempts To Abduct Two Newborns
CHRISTCHURCH, NEW ZEALAND.
A 20-year-old woman has been charged with kidnapping after attempting to abduct two babies from St. George’s Hospital. According to media reports, the woman, posing as a hospital employee, entered a room in the maternity ward and asked the father to take the baby for blood tests. The father replied that the tests had already been done and later reported the incident to his wife and to hospital staff. The woman, again posing as a hospital employee, allegedly then entered a second room in the hospital, which was occupied by a woman she knew distantly. The hospital’s CEO would reportedly not confirm whether the suspect had taken the baby from the room, but police were called by staff who found the woman by the mother’s room door. She reportedly has been charged with taking a two-day-old boy with intent to deprive his mother of possession of the child.

Dementia Patient Found Dead On Hospital Roof
PITTSBURGH, PA.
An 89-year-old woman, suffering from dementia, was found dead on the roof of Montefiore Hospital at the University of Pittsburgh Medical Center. The woman had been reported missing the day before and police are unsure as to how she got to the roof or how she died. According to published reports, when the woman went missing all hospital personnel, as well as hospital security and city, university and other nearby police departments were notified and a search of the entire complex continued throughout the night. In response to the patient’s death, UPMC executives have enacted a new system called “Condition L,” which they believe will improve hospital searches, the way “Amber Alerts” search for missing children. It would summon every available employee, including those in security, nursing, maintenance and housekeeping, to assist in a coordinated search of the hospital complex. Other means of preventing patients from wandering off reportedly being considered by the hospital include fitting dementia patients with electronic monitoring devices and using trained search dogs.

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Belligerent Patient Drives Truck Into Emergency Room
LUKFIN, TX.
A 30-year-old patient, who reportedly had been belligerent while seeking treatment at Memorial Health System of East Texas, drove his car through a plate glass window next to the emergency room. According to media reports, the man had been escorted out by security personnel after he became agitated with doctors. He then drove his pickup into an office at the Temple Imaging Center at the hospital. The office was under construction at the time of the accident and the two workers who were inside when the crash occurred were not injured.

Machete-Wielding Man Taken Into Custody
LAKELAND, FL.
A 46-year-old man was taken into custody after he waved a machete over his head and threatened to kill himself and others outside the emergency room of the Lakeland Regional Medical Center. A 22-year-old sheriff’s deputy, who was off-duty but in her marked sheriff’s car, pointed her weapon at the man and made him drop his machete after she got patients and staff away from him. The suspect was handcuffed and taken into custody by a police officer who arrived on the scene.

Parking Lot Break-Ins Prompt Safety Concerns
ALBUQUERQUE, NM.
Employees at Lovelace Women’s Hospital reportedly have asked for more security officers following a streak of parking lot burglaries. One employee stated in published reports that her car had been burglarized twice over the last couple of months. In a statement released by the hospital it was noted that vehicle break-ins do occasionally occur and that anyone parking at the facility should remove any valuable items from their vehicle to discourage this type of behavior. A hospital public relations manager reportedly did not know if there were any plans to add security cameras.

Threatening Video E-Mail Heightens Security At Hospital
WINNIPEG, CANADA.
A 41-year-old former employee at Grace General Hospital has been charged with uttering threats to cause death or bodily harm and two counts of careless use of a firearm, weapon, or ammunition after sending a threatening e-mail video to co-workers at the hospital. According to a police spokesperson, although the threat was non-specific, it was serious enough that everyone on the e-mail list had legitimate concerns. Security at the hospital and health offices has reportedly been heightened as a result of the court’s decision to release the suspect on bail. A spokeswoman for the Winnipeg Regional Health Authority would not disclose what types of additional security measures are in place.

Leading Colombian Drug Lord Killed In Hospital Bed
MADRID, SPAIN.
A 59-year-old man, who was reportedly linked to two of Colombia’s most powerful drug cartels, was fatally shot while he slept in his room at Doce de Octubre Hospital. The victim was admitted to the hospital with heart and lung problems and shared a private room with one other patient who was unharmed after the shooting. According to published reports, a hit man entered the fifth-floor room where the victim was sleeping, took out a silencer pistol, and shot him four times, killing him instantly. The attack prompted panic over the alleged negligence of hospital staff and the lack of control over visitors wandering around the hospital. Madrid’s health authorities reportedly denied further security measures were necessary and said “such changes would limit people’s freedom, and imply a loss of humanity and accessibility for visitors.”

Former Hospital Official Charged With Antiques Theft
BEVERLY, MA.
The former associate vice president of support services at Beverly Hospital has been arrested and charged with stealing antiques owned by the medical center during a renovation project. According to published reports, after realizing the items were missing, the hospital formed an investigative team. The hospital’s plant operations manager and another hospital manager apparently saw some of the stolen items in an online photo of the suspect’s home which was up for sale. A police officer, who had been to the suspect’s home in the past for an unrelated matter, also remembered some of the missing items when the hospital approached authorities about the thefts. Police reportedly seized three paintings, a grandfather clock, several wooden room dividers, and assorted furniture from the suspect’s home.

Unattended Purse Stolen From Employee Area Of Hospital
NACOGDOCHES, TX.
A purse was reportedly stolen after being left unattended in the employee area of Nacogdoches Memorial Hospital. According to published reports, hospital security viewed the video tapes and saw another hospital employee, who was later fired, take the purse. It was later found abandoned with $70 missing.
Expanding Coverage of Security & Safety Week To the Hospital and Local Communities

When Brad Timmons took over as director of campus security and safety at Medical Center Hospital, Odessa, TX, in January, the first thing he wanted to do was make sure his people received the recognition they deserved as part of the overall healthcare community. His 15 Security offices, along with some 30 officers from the local police department, are in charge of safety at the four-square-block regional medical center that treats more than 100,000 patients annually. So when Timmons put out the word across campus that October 12-18 was to be Healthcare Security & Safety Week, he made sure to emphasize that what was being celebrated were his staff’s contributions as “Partners in Quality Healthcare.”

Nurses, physicians, doctors and administrators are all commonly recognized as key players in the hospital, but “security guys always just kind of get pushed aside,” when it comes to recognition, Timmons says. “They need to be recognized as part of the whole health-care team, be seen as a part of the whole health-care community.”

And the recognition did not only come in the form of the pizza parties, baseball caps and cafeteria meal tickets given to his staff. Notices also went out to every hospital employee letting them know about security week and letting them know that their health-care security and safety professionals work around the clock to ensure that the employees and patients remain safe. The celebration included no special safety drills — “we do that year-round, anyway” — but was meant “purely for appreciation.”

Timmons also obtained full cooperation of the hospital’s marketing and public relations department which issued a press release that attracted coverage from two local TV stations. The release included the “20 Quality Contributions to Quality Healthcare” provided by security and safety officers via the IAHSS website.

FOR FURTHER INFORMATION, CONTACT:
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The “20 Quiet Contributions...” can be accessed on the member’s log-in page on the IAHSS website. Click on the Reference Materials link.


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Stolen Wallets Finance Thief’s Shopping Spree
DALTON, GA.
An unidentified man reportedly stole wallets from two employees’ purses in the Ob-Gyn ward at Hamilton Medical Center and then used the stolen credit cards at stores in Dalton, Fort Oglethorpe, Calhoun, and Cartersville. A security camera also captured the thief at a CVS store in Calhoun. Dalton Police are asking anyone with information on this crime or the man’s identity to contact them.

Woman Steals Patient’s Purse; Takes Cross-State Cab Ride
NAPLES, FL.
A woman who allegedly stole the purse of an elderly patient who was sleeping at Naples Community Hospital, is accused of taking a cross-state cab ride using the victim’s money. According to published reports, by the time the victim woke up and discovered her purse was stolen, the suspect was long gone. She reportedly used a stolen credit card to pay her cab fare to the east coast and other charges totaling almost $1,500. A detective from the Naples Police Department was quoted as saying that he believed the suspect did not act alone. A statement released by the hospital claims there are policies in place to help safeguard patient’s valuables and that patients’ safety and security are of the highest importance. An investigation is ongoing.

Suspected Rapist Flees Hospital
OROVILLE, CA.
A 52-year-old man, who is awaiting trial in a rape case, reportedly escaped from Oroville Hospital where he was admitted for medical reasons. According to published reports, the man was being guarded by a private security company when he slipped out of his restraints and fled from the hospital’s main entrance around 3:30 a.m. The man had been arrested on suspicion of rape and failure to register as a sex offender. He was recaptured 12 days later.

Convicted Rapist Hired At Public Hospitals
LOS ANGELES, CA.
Top health officials are reportedly trying to explain how an ex-cop convicted of rape was hired twice to work in public hospitals. The 48-year-old man was fired last year after it was reported that he was among many employees with criminal records working at the former Martin Luther King Jr.-Harbor Multi-Service Ambulatory Care Center. He was then re-hired through a staffing company that assigned him to the Edward R. Roybal Comprehensive Health Center. The county’s chief executive and the interim health services director allegedly place the blame on the man’s re-hiring on a supervisor at Roybal who failed to do a “Live Scan” background check for convictions in accordance with county policies. According to published reports, the county’s chief executive has been asked to establish protocol for staffing agencies to use when doing background checks on workers at county agencies. The Office of Public Safety is also being called on to tighten security at public health facilities including requiring all personnel to wear ID badges.
An Interview With:

Dr. Robin McFee on Terrorism/WMD Preparedness

Robin McFee, D.O., is a physician and medical toxicologist with expertise in terrorism and weapons of mass destruction (WMD) preparedness. A consultant to government, health, law enforcement and first responder agencies across the country and internationally, Dr. McFee is a member of the Global Terrorism, Political Instability and Crime Council of the American Society of Industrial Security (ASIS). With clinical expertise in poisons and many WMD agents, she has authored numerous articles on terrorism, health care and preparedness, and has co-authored two books: Toxicico-Terrorism and The Handbook of Nuclear, Chemical and Biological Agents. Dr. McFee serves on a variety of national WMD-related advisory boards and is a toxicologist/research consultant for the Long Island (NY) Regional Poison Control Center.

Q. In the recent Mumbai attack in India, gunmen attacked a hospital, and people were shot indiscriminately. Could a similar incident happen here?

A. Absolutely, it’s possible. Mumbai gives us an important learning experience. It’s a vivid illustration that hospitals may be the last line of defense in a terrorist attack. But not every hospital is prepared. We seem to have this pervasive concept that we’re protected by two oceans, and it can’t happen here. And the farther away we get from 9-11, the less real it feels. We’ve got preparedness amnesia. In addition, we have increasing demands on our time and a variety of pressures – and now, by the way, we have to worry about terrorist attacks.

Q. What can you tell us about the threat of terrorists on our soil?

A. Terrorism is asymmetric warfare. Some 80% of terrorists’ acts worldwide involve explosives. Terrorists’ weapons are more advanced; the way they deliver explosives is more creative. For example, they are now putting blood thinners in with explosives, making it harder to control bleeding of the injured. They have the ability to use chemicals like chlorine along with explosives. The sophistication of these people is growing. Also, there is a fifth column in the U.S. They use subtle sabotage, recruiting seemingly innocent people, and they recruit women as well as men. When you think about terrorists, you have to think outside the box. They’ll now threaten mothers and babies in the maternity ward, they’ll use the elderly and children as human shields. They will select their targets based on the high political, economic and human capital they can claim from the attack. So we have to look at our infrastructure with the same jaded eye and say OK, what’s high economic, high capital, high human and high political in terms of vulnerability? Beyond the panic created and the loss of life, look at all these other impacts.

Q. You’ve written about how physicians are able to infiltrate a hospital and enable terrorist acts. Can you elaborate?

A. There is a large influx of health care professionals from other cultures and countries, some of whom may be the fifth column. This isn’t profiling – it makes a lot of sense. In India, they arrested a physician who was part of the network. The #2 figure in Al Qaeda was a physician. In Glasgow, physicians were part of the bombing. They planned it and carried it out. A Palestinian responsible for the idea of blowing up a school bus was a pediatrician. Some of the top terrorists worldwide are doctors. When you see physicians who are masterminds of terrorist events in India, the Middle East, England and Scotland, why would we think they wouldn’t be in the U.S. too? Health care facilities need to do thorough background checks. Are doctors here on a visa? Is there an Interpol alert on them? Is there a Department of Homeland Security concern? Is there an ICE (U.S. Immigration and Customs Enforcement) issue?

Q. What can hospitals learn from the Mumbai attack?

A. First, hospital security and all healthcare professionals need to acknowledge the threat is there. Be aware threats can be quite real and quite clever. It’s not far-fetched. A healthcare facility is a critical infrastructure, and if it were attacked, the community would be greatly undermined. That’s exactly what terrorists want to happen. Healthcare facilities are usually part of a secondary attack. In the Israeli model, the Palestinian strategy is for the terrorist to strap on the explosives, blow up the target, and another IED (improvised explosive device) is ignited to take out the cops.

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and the ambulance. So we have to realize we may be the target. It’s time to start looking at this, planning for it and running drills for it. Many hospitals don’t have effective plans, and the plans are not well known by the people in the trenches. There needs to be a bottom-up, top-down approach. If done right, a plan can run smoothly. I consulted with one of the best squared-away hospitals I’ve seen, even though they were severely resource-contracted. They were the only healthcare facility within 20 miles in any direction – they knew they were the last line of defense in the community. Everyone from the janitor to the CEO was involved. Every department had a chance to review the plan and provide input. Everyone had a stake in the plan and knew exactly what role they were to play. At the other end of the spectrum, I worked with another hospital where we ran a drill for a biological incident. They forgot to lock the back door to the ER when they went on lockdown.

Q. You’ve written about hospital vulnerabilities and how terrorists see them as “low hanging fruit.” What are the kinds of vulnerabilities that terrorists could take advantage of?

A. The most important reason hospitals are low hanging fruit for terrorists is that an attack would so undermine the entire community. Beyond the loss of life and loss of a critical infrastructure, health care is an economic driver. Hospitals are huge employers. Look at the economic loss that would be suffered by employees, and how that would snowball. Look at the distrust it would create in the community. “What, you can’t even protect our hospital?” This would ultimately create loss of public confidence in the political structure, which is exactly what terrorists want. So let’s look at specific vulnerabilities. I’ll give you a few real-life examples. At one of the top universities – a high profile, well respected facility – there’s a big sign at their loading dock informing delivery services where to drop off radioactive materials. Talk about making it easy for a terrorist! When you go to the room, no one is there protecting the stuff, security is nowhere in sight. Someone could have stolen the materials and built a radiologic explosive device that could have caused havoc. At a hospital, there was a railroad track running right through it. Look how easy it would be for terrorists to run toxic chemicals or explosives through there. Or what if there was a derailment of a car carrying toxic materials? At another hospital, a highly explosive propane storage tank was sitting 30 feet from the ER.

Another example illustrates lack of communication and coordination: In the last four years there was a chlorine spill in a community, which had three hospitals. Hospital 1 was open to anyone from the outside – there was no mention of decontaminating victims. Hospital 2 was locked down – victims were not allowed in, to protect existing patients and staff. The last hospital de-contaminated everyone outside before they could come in the hospital. Now which playbook were they all reading from?

Another incident: A patient doused himself with a contaminant similar to nerve gas. If you touch it or breathe it in, you’ll get sick. EMS brought him into the ER, and three health care professionals were contaminated and passed out. It’s simple – they should have decontaminated the patient outside before treating him. This could have been so easily prevented. Pull out a garden hose if you have to. You don’t necessarily have to have expensive, fancy equipment to handle the situation. You need to look at your layout. If you have 15 doors and half of them are propped open, how good is your security? Are your security cameras operating, or are they for perception purposes only? Do you have the manpower to scrutinize them well? Do you have enough security in relation to your square footage? Do you do proper background checks on every employee and every doctor who practices in the hospital? Is your HVAC system secure? If terrorists wanted to poison a facility, using the HVAC system would be a good way to do it.

Q. What preparedness recommendations can you give security directors?

A. Number one, plan and train for a terrorist attack. In one survey of hospitals, 80% said they could not respond to a dirty bomb. I’d sleep at night if 12% or even 25% said that, but 80%? Have you thought through the details if a terrorist attack were to occur? You can’t just dust off an old disaster plan and hope it will be effective in a terrorist attack. You need to take an all-hazards approach, but with sections specific to WMD/terrorism as well as fire, pandemics, violence and other disruptive incidents. Say the community is exposed to a chemical, biological or radiological attack. A plane comes in with a delivery from the Strategic National Stockpile. First, you need a security escort to protect the supplies being transported from the airport to the community’s staging point. Does the hospital have enough manpower to break down pallets of supplies? Where is the stuff going to be stored? Who’s going to guard the drugs and supplies? You need people to organize and distribute them safely and securely.

If you’re responding to a biological attack, you’ll need to set up vaccine stations or antibiotic stations outside the facility to protect the people inside. You may be on a city street, working with law enforcement – this is a whole different thing than working routine facility security inside. Some of the plans I’ve seen are way too complicated. If it’s the size of a phone book, throw it out. They’ve got to be practical and easily understood. Also, if it’s only awareness training, it won’t be effective. Health care people want to know specifically what they, as an individual, must do. A good plan needs to empower everyone. They need to know the three steps they must do during an incident. What do I need to do if the people above me and below me are out sick? People should be able to cross cover if a role is absent or injured. Most people in the health care profession want to be part of the solution. They just don’t know how to do it. But if your plan is updated and role-dependent, it can work well.
Q. What else should we be concerned about?
A. How many people have read the plan? Where is it? How many actually contributed to the plan and have buy-in? A good plan gets health care professionals, support staff, law enforcement, fire and rescue – all organizations that will either rely on the hospital or the hospital will reply upon – working together and learning each others' responsibilities. A good plan lets everyone feel a sense of ownership, that preparedness is part of their job, just like infection control and preventing drug errors.

Another thing: How many times has the plan been practiced? At a recent presentation to about 200 doctors and nurses, we were talking about drills. I asked, “Would you let me intubate your loved one if I had only done it once in the last 12 months?” A doctor yelled out, “Only if you were the only doctor around who didn’t have broken arms.” That’s exactly the point: Why should anyone in the community trust that your hospital will protect them when it had only practiced its disaster plan once in the last year? Preparedness is very much like being pregnant – you either are or you’re not. If we don’t take care of the place that’s supposed to take care of the victims, then the game’s over.

Q. What other factors are key to successful training?
A. Building awareness. In the anthrax incident after 9-11, it wasn’t Public Health that saved the day – it was an infectious disease practitioner in a small community who had a patient with certain symptoms. He and an astute lab technician who had just gone through training on anthrax suspected this could be anthrax. They were the ones who called Public Health. If you do the right kind of training, you actually help people develop their sense of observation and acumen. If it’s one thing we can take from 9-11, Katrina, Mumbai and other disasters, it’s that we need to have an index of suspicion – we should be liberated from the fear of saying that something just doesn’t feel right.

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Nurses Seek Ways to Curb Growing Violence Directed At Them By Patients

A growing number of violent incidents involving nurses is resulting in demands for legislation criminalizing patient or visitor attacks against healthcare workers, lawsuits by assaulted nurses, and other actions. At the same time there is growing concern about conditions and practices that encourage violence and the fear that less rather than more security will be available.

MNA Mounts Campaign To Criminalize Attacks On Healthcare Workers

In Massachusetts, the Massachusetts Nurses Association is promoting a proposed state law to criminalize assaults on health care workers. According to David Schildmier, spokesman for the Association, the MNA is mounting a legislative campaign to criminalize assaults on health care workers in the line of duty, similar to a state law that protects ambulance crews, firefighters, and other public employees. It is also pushing a proposal that would require hospitals to identify factors that contribute to violent incidents and minimize them.

An Association study found that half of all members surveyed reported being punched at least once in the previous two years, and more than 25 percent said they had been frequently pinched, scratched, and spit on, or had hands or wrists twisted.

This action coincides with press reports of violent attacks on nurses, like a December 31, incident at the UMass Memorial Health Alliance Hospital, Leominster, where police said a man punched a triage nurse in the face, pulled her off her chair and threw her against the wall in the emergency department. The attack was said to be the second on an emergency room employee at the hospital in the past month. According to court documents, Joseph Murphy, 26, was already agitated when his name was called by a 57-year-old female nurse to be seen for treatment. He is alleged to have told the nurse it took too long to call his name and started punching the computer in front of her. He picked it up and tried to throw it at her, but the wires on the computer prevented him from doing so. He then lunged at the nurse and started punching her in the face. Murphy then allegedly picked her up off her chair and threw her against the wall, and the attacks began anew. By this time staff and members of the security team were able to get Murphy off of her and handcuff him.

The hospital, it was reported, had already deployed security cameras in parking lots and at all entrances. Security personnel are already working in the emergency room at the hospital, but the dedicated presence in the waiting room is a change initiated by a December 1 incident in which a 43-year-old female greeter was allegedly punched in the face and body by Victor Jiminez, 30, after she asked him if he needed help. He allegedly knocked her to the floor and kicked her. When a patient came to assist the woman, Jiminez allegedly attacked him. After the December 1 incident, a hospital spokesman said security was beefed up at the emergency department. Additionally, a security presence is maintained in the emergency department’s waiting room 12 hours a day and a plan is in place to increase that presence to 24 hours a day.

Nurses Seen Concerned About Cutbacks In ED Security

Schildmier sees a number of factors contributing to this growing violence. Besides the closing of mental facilities and sending of mental patients to hospital emergency rooms, he cites the police practice of not arresting drunks. “Today, the old practice of locking up drunks is not practiced by the police department. Instead of locking them up and watching them themselves, they take them to the ED dump them there. Those are folks more prone to violence.”

Nurses are also concerned with cutbacks in law enforcement and hospital security, he says. “In hospital assessments we’ve done, we have usually included putting pressure on the hospitals to beef up security. For example, one hospital used to have an armed police detail at night because of gang violence. They took that away, and in one year we had over a thousand 911 calls to come to the ED.” Schildmier adds that ‘we’re finding in tough financial times the people that get cut right away are security details. They are asked to cover larger areas with fewer resources and less training. The nurses see that as having less support.”

Nurse Injured By Forensic Patient Sues County

Claims that a forensic patient at Shasta Regional Medical Center, Redding, CA, assaulted a nurse and bit off the tip of her finger in the process have resulted in a civil suit filed against Shasta County in late December. Nurse Joyce Lynn Green’s attorney, Art Morgan, a personal injury lawyer, says his client is still employed at the hospital, although she did miss work because of her injury and the counseling she required afterwards. Green isn’t suing the hospital, he said, because any issues associated with the hospital would be a worker’s compensation case. Green’s suit is pro

continued on next page
personnel brought Buckner into the hospital. While Buckner was transported in a secure vehicle and shackled during the transfer, the suit alleges that she was then left unsupervised and in the care of hospital staff. “This is a common problem in hospitals,” claims Morgan. “And often security can’t do anything. They may even be instructed not to touch anyone. So in this case they bring her (Buckner) in shackled and handcuffed and then they kind of dump her off.”

Morgan says Green wants both the sheriff’s department and the hospital to review their policies and procedures regarding how forensic patients are handled. Green’s injury happened as Buckner began fighting with hospital staff. Green, who was pushed into Buckner, tried to steady herself by placing her hand on Buckner, and Buckner turned and bit off the tip of Green’s index finger.

Richard Sem, a hospital security consultant and president of Sem Security Management, Trevor, WI, agrees with Morgan that such incidents “are all too typical.”

“It is a significant frustration for hospital security personnel,” says Sem, referring to the disconnect between law enforcement and hospital security supervising forensic patients. “(Law enforcement) just assumes it’s the hospital’s responsibility,” said Sem.

In an interview with The Record Searchlight, Shasta County Sheriff’s Captain Don Van Buskirk said once a patient transport by his department enters the hospital, “they’re the hospital’s responsibility. We’re there to facilitate a safe and secure handoff.” The problem, Sem says, is that there is a wide range of security measures provided by different hospitals. Some employ off-duty police, while others rely on unarmed, non-police personnel.

Shasta Regional Medical Center officials would not comment on the type of security in place at the time of the incident, or what changes were made in security following this event.

Sem says that in working with hospitals on their security plans, he strongly encourages them to liaise with law enforcement. Of the hospitals with which he has consulted, Sem reports about half of them have a policy in place regarding forensic patients that spells out what the hospital will and won’t do in handling these patients. In at least one instance, he said, during a hospital’s security assessment, police and sheriff’s department representatives were brought in to talk through the possible policies and procedures.

Addressing A Policy On Patients With Restraining Orders

The attack on a nurse at Sutter Amador Hospital, Jackson, CA, by an individual who was under a restraining order from the patient he was visiting, raises the issue of how hospitals should be addressing these types of workplace violence incidents. In the situation that occurred on November 29, Michael Holloman entered the hospital with other family members to visit his mother on the medical/surgical floor. After being there just a short time, Holloman became combative, throwing food, shouting and using a lighter in a room in which the patient was on oxygen. Holloman attacked the nurse who tried to intervene, slamming her hand in a door and throwing her into a table. Two other nurses were also attacked before police could subdue Holloman.

Bryan Warren, director corporate security for Carolinas Healthcare System, Charlotte, N.C., says many hospitals have procedures in place to assist employees who are having domestic difficulties, which can include the issuance of a restraining order. For patients, however, the system isn’t typically as clear-cut. With staff, Warren says, the hospital will keep a copy of the restraining order on file and also encourages the staff member to keep a copy on them. Often they can work with the person’s manager to change their schedule, although the person whom they want to avoid still knows where they work. Security will ask for a recent photo of the individual on whom the restraining order is issued and can make it part of the BOLO (be on the lookout) file. If an incident has occurred or is likely to happen, security can issue alerts to look for the individual at key checkpoints.

In the case of a patient, said Warren, their name can be taken out of the hospital register and they can be identified by an alias. “We can do a BOLO on folks, just as we do for staff,” he says, “and educate the switchboard if someone calls for that person and to record the phone number.” On the floor, staff at the nurse’s desk can use coded safety words to inform security that the person named in the restraining order has come onto the floor without tipping off that person.

In the Sutter Amador incident, the event occurred late at night, on a weekend. Warren says that while hospitals go to great lengths to ensure patient safety, they also must balance that with the opportunity for families to provide support and care during critical times for patients. “In our locations, we try to limit the visiting hours,” he reports. His facilities also use self-expiring visitors passes that are good for just 12 hours at a time. After that period, the color-changing badges show that they have expired.

Often the nurses and other on-floor staff are the first ones to learn that a patient doesn’t want a particular person to visit. It’s important, Warren says, for that information to be passed along to security so they can put the proper policies into place. Seldom, he said, does this information emerge as a patient is being admitted.

continued on next page
Stressed Nurses Turn Prostitutes, Australian Newspaper Reports

In an article that years ago would only have run in a supermarket tabloid, the Courier Mail, Brisbane, Australia, a daily newspaper, reported in December that several Queensland hospital nurses have left their profession for the world’s oldest. In the article, the nurses’ decision to quit their work in hospitals for prostitution was confirmed by Beth Mohle, Assistant Secretary of the Queensland Nurses Union, and Stephen Robertson, Queensland’s Health Minister. Robertson said it was disappointing that some nurses were seeking alternative careers. He claimed that “Queensland nurses are now among the highest paid in Australia, having benefited from a 26 per cent wage increase since 2006. This is one of the factors which has helped us to recruit an extra 5,834 nurses since June 2005.” He also claimed that the government had created a “safe and supporting working environment for nurses.”

Mohle said the union was aware that there is an exodus of nurses due to workloads and burnout. Nurses, she claimed, are also experiencing record levels of frustration. “A survey of nurses’ attitudes undertaken last year found most nurses love nursing but hate their jobs,” she said. “There’s a tension there that nurses feel they can’t deliver the quality of nursing they want to.” In the same survey, according to Mohle, 45 percent of nurses said they had experienced workplace violence, which is more prevalent in the public and aged-care sectors than in the private sector.

The newspaper quoted one former registered nurse with 10 years’ experience, who said that she and at least four of her colleagues found new jobs working in brothels. “We could no longer work in such an understaffed and stressful environment.” The nurse said violence was more of a concern in hospitals than in the sex industry. “The security (at the brothel) is wonderful. We have buzzers in our room. There are (alarm) bracelets we can request if you have a client you’re a bit suspicious of.”

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Disaster Preparedness Helps Hospital Survive ‘Worst Case’ Fire Scenario

What happens when there is a raging fire at your doors, smoke has entered the building, most of your patients have not been evacuated, power is out, and your emergency generators have failed? The support and clinical staffs of Olive View-UCLA Medical Center, Sylmar, CA, found out when the Sayre fire roared through the area in late November. They credit their disaster preparedness training with helping them and their patients survive.

With fire at its doors, and smoke entering the building, the hospital went into full disaster mode. When the fire burned the power lines coming into the facility, the two emergency generators kicked in. “But a fuel pump in one generator failed, and it went down,” spokesperson Carla Nino relates. “A short time later the other generator failed, and we were plunged into complete darkness.”

The darkness lasted for 3-1/2 hours. During that time, staff had to use hand-cranked ventilators to keep some two dozen critical patients breathing. All this time, with smoke in the building, most staff themselves were wearing smoke masks. Nurses roamed the rooms with battery powered breathing equipment to minister to any patients affected by the smoke. Those not requiring that level of care but still having difficulty, were given smoke masks.

Nino says security knew the fire was going to be on them quickly about 10:30 PM. “We could see the flames on the hill behind the hospital, and the wind, at 60 miles an hour, was blowing directly towards us.” Security immediately initiated lock down and evacuation procedures. Eighteen infants and nine adults were quickly evacuated. But, after the evacuations, 185 patients remained in the hospital. By midnight, the flames were at the gates. According to the Los Angeles Times, “the hospital was surrounded by tall cyclonic walls of flames, as embers showered on the grounds and smoke seeped into the hospital’s lower floors.”

Fortunately, disaster drills are a frequent occurrence for Olive View. Nino says. It is on an earthquake zone, and had completed an earthquake drill just a month before. “While there is a difference in the earthquake drill and a fire situation, many of the preparations and the disaster operations are similar,” Nino notes.

As the fire reached the property, the entrance gates were closed, cutting off all access. “We didn’t want refugees trying to find shelter here and getting hurt… or worse.” While the hospital building itself suffered only interior smoke damage, a good portion of the outlying buildings were destroyed. These included the IT facility, the child care facility, the financial records center, and several others. Firefighters stationed themselves around the hospital building and kept the flames from encroaching onto the facility. However, the planters in the front of the building were burned.

One destroyed building stored medical wastes. That required a HazMat team be called in after the fire to clean up the area. “We also had a few staff members who suffered minor smoke inhalation problems,” Nino says. “They didn’t require hospitalization, just a little oxygen.”

Olive View has a consulting team looking into why both generators failed. There’s also the long road ahead of rebuilding the facilities that were destroyed. Nino has no estimate on that time frame. That’s not a totally new experience for Olive View. The current hospital was opened in 1987 to replace the original facility that was destroyed by an earthquake.

PRODUCT UPDATE:

Communications Device Speeds Security Response

When a psychiatric nurse at Toronto East General & Orthopedics Hospital (TEGH), Toronto, Canada, was in a dangerous situation with an angry patient and needed immediate help, she didn’t have to fumble with a phone or get to her desk in order to send out a distress call. Instead, she clicked her Vocera communications device twice and the security team immediately knew not only that she was in need of help, but they also knew exactly where to find her and could hear everything going on in the room until they reached her.

“We’re able to talk directly to the individual who’s activated the communication device and determine how serious the incident is,” says Rocky S. Prosser, Manager of Protection/Emergency Planning, TEGH. “If the individual is unable to talk we have the ability to locate them using the device.”

The panic button is one of the many features with the Vocera communications device designed for use healthcare personnel. The device is lightweight enough to not be cumbersome to the personnel carrying it, but it’s effective enough to summon immediate assistance when necessary. In addition to functioning as a panic button, Vocera also offers users instant access to other users by voice recognition. The voice recognition system uses simple verb/noun combinations to contact other users, such as “Call Dr. Smith” or “Broadcast Security,” which would send out a simultaneous broadcast to everyone on the security team.

“As opposed to a traditional telephone system where you’d be dialing an extension or dialing a phone number, with the Vocera system there’s a button on the front of the badge that you press, and when you press it you’re speaking to what we refer to as “The Genie,” says Brent Lang, President of Vocera Communications. “You can issue commands and it will set up different kinds of calls. The beauty of using speech recognition is that it is not limited to calling someone by name. The user could also say, ‘Call security’ and what our system would do is find the first available person of that group and connect them.”

Over 600 hospitals around the world are currently using the Vocera device - including hospitals in The United States, Canada, The United Kingdom and New Zealand, the manufacturer reports. “One of our Canadian customers did a survey in their surgical unit regarding safety before and after the installation of the Vocera system and found that 80% of the staff believed the environment was safer for them and their patients after they began using the badges;” says Lang. “It was a substantial increase in the number of people who felt more at ease working in the clinical environment.”

Prosser agrees. “From a security perspective we find it immensely satisfactory, both from a front line office, management, and response perspective.” He says that before the Vocera was installed the average response time of security personnel at the hospital to a distress call averaged two or three minutes, but now the average response time is only one minute. “We’ve consistently been tracking the response times month-by-month. All the calls and all the averages have come in between 58 to 62 seconds. This makes a big difference when a person perceives they are in danger so each minute can seem like hours.”

Vocera is sold as a system including the communication badges and the accompanying software. It uses a Wi-Fi infrastructure, so the range the device covers depends largely on the needs of the medical facility. “Most hospitals are covering every place on the campus, including the parking structures,” says Lang. “In fact, one of our hospitals put access points out in the parking structure because of the concern with clinicians being assaulted in the parking structure. This allows the clinicians to get help even if they are sitting in their car in the parking structure.” Vocera is functional beyond security uses, as many medical personnel use it to summon additional help or to dictate information for medical records.

Vocera Communications has plans for enhancements to the system as well as some new products in the future. A device that is held up to the ear like a cell phone - instead of worn like a badge - is expected to be released later this year. The company is also working to add a function to the badges which allows users to access medical records from an automated system using the Vocera.

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Costly Fires In Unguarded Locations

Most hospital fires are in-room or bathroom affairs caused by smoking patients or employees. They are usually prevented from spreading by the actions of the facility’s sprinkler system, although water damage may run into the tens of thousands of dollars. However, three recent fires, two in one hospital, in ventilation system areas, may be a reminder that such areas should be better secured because of the much greater potential life safety risks, as well as the physical damage caused, which can run into the millions.

Cincinatni’s Jewish Hospital: Two Rooftop Fires In One Month

Two fires in one month at the 200-bed Jewish Hospital, Kenwood, OH, required partial evacuations, according to local media reports. The first Jewish hospital in the United States, established in 1850, the hospital moved to its new Kenwood location in Cincinnati’s northeast suburbs in 1997. The first fire took place at 4 a.m. on Thanksgiving Day when the cooling towers on the roof went up in smoke. The three-alarm fire forced 40 patients to be moved from the fifth and sixth floors, it was reported. There were no injuries, but damage was estimated at two million dollars. Administrators credited a well-executed and recently practiced disaster plan with keeping the situation from getting out of hand.

One month later, on Saturday, December 27, at 12:46 p.m., rooftop mechanical equipment at the hospital caught fire and blew smoke into the hospital’s emergency room, forcing the evacuation of a third floor wing for several hours. Firefighters said that fire was caused by a broken motor in the ventilation system. Hospital security was able to put the fire out quickly, but the halls were still clogged with smoke. Fire crews were able to air out the floors quickly, administrators said. No one was reported injured. Sycamore, OH Fire Chief, B.J. Jetter was quoted as saying that the wing is the oldest part of the building, constructed in 1960. “The building’s getting old,” the chief said, chalking up the fires’ timing to coincidence. It was only the third fire he can remember in 14 years as chief, he said. The first came when a patient smoking in his room caught himself on fire.

New York’s Mount Sinai: Mechanical Room Fire Forces Evacuation of 600 Patients

On Wednesday, January 20, at 6:30 p.m. a three-alarm fire in a second-floor mechanical room at the Mount Sinai Medical Center, New York, NY, forced the evacuation of 600 patients to other buildings of the 1200-bed complex. The fire was confined to the mechanical room, but smoke spread to nine floors of the hospital’s East Wing. There were no reported injuries to patients. Six firefighters reportedly suffered minor injuries. The cause of the blaze, sparked in the storage area of the second floor mechanical equipment room, full of paint and cardboard, is under investigation, said a fire official.

Warning: Check Vulnerability of HVAC Systems

While there is no indication or proof that the above fires were deliberately caused, Robin McFee, in her interview in this issue, points out that if terrorists wanted to poison a facility, using the HVAC system would be a good way to do it. In the 1980 fire at the MGM Grand Hotel and Casino, Las Vegas, NV, a fire caused by an electrical ground fault inside a wall soffit, spread smoke through the building, killing 87 people and injuring 650, including guests, employees and 14 firefighters. While the fire primarily damaged the second floor casino and adjacent restaurants, most of the deaths were caused by smoke inhalation on the upper floors of the hotel. Openings in vertical shafts (elevators and stairwells) and seismic joints allowed toxic smoke to spread to the top floor. The disaster led to the general publicizing of the fact that during a building fire, smoke inhalation is a more serious threat than the flames.

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