Welcome

My hope is that you had a wonderful and happy holiday season and that this past year has been a successful one for you. I cannot believe that eighteen months has passed since I took the oath of office to represent you as President of the IAHSS. Thank you for this wonderful opportunity, personally and professionally. The experience of serving on the board is one that I will not soon forget. I am very humbled by the experience and grateful for the opportunity to have served you on the board for the past six years. The IAHSS has transitioned into being a recognized leader and source of information in the Healthcare security and safety arena. We have become the go to organization when it comes to healthcare security issues or concerns. This is just the beginning of our journey; you and I must continue to support this association as it continues on its journey.

There are many ways to support this organization and I encourage you to get involved. I was once told that you only get what you put in, when working or volunteering. This is a true statement; I sat on the sidelines as a member for several years. One day it occurred to me that I could get involved and represent the interests and concerns of my colleagues in a positive way. I hear from time to time that the IAHSS is a “Good ole Boys Club” and that we rehash the same old members through the various Board Positions, Council leadership, Task Forces and so on. When I hear this, it perplexes me as this is not the case with me and others. If you feel this way then get involved, vote during elections, volunteer, provide feedback on surveys, there are so many different opportunities for you to get involved. I was just a member who got involved. I worked for the best interests of the association and my profession of which I am so passionate about. So what is my point? Get involved and you will get back more than what you put in. Hold the board and staff accountable by getting involved. Yes, it means giving of your time and talents, but not overwhelming. The rewards - not monetary - developmentally with respect to personal and professional growth far and exceed anything I have experienced to date in my career. It is for that reason I thank you again. I appreciate all the opportunities that you have given me as your colleague in serving the IAHSS as a volunteer leader.

I look forward to seeing you all at the 2011 AGM in beautiful Toronto, Canada May 22-25, at The Fairmont Royal York hotel.

Best wishes

Joseph V. Bellino, CHPA, HEM
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Executive Director’s Letter

It is hard to believe 2010 has come and gone. What a year! I would like to express my gratitude to the hard working volunteer leaders of our Association. Without them we would not be able to push many initiatives forward. Welcome to the new Board members elected in November. 2011 promises to be an exciting year and we encourage our members to get involved. You can help make a difference for the profession.

Have you nominated anyone for the Awards and Recognition program? This is a fantastic opportunity to recognize someone deserving, please take the time to publicly recognize the outstanding work being done at the workplace. The award deadline is January 15, 2011.

As you know the 43rd AGM is in Toronto in May. Start planning now and get your passport so you are ready! Explore travel options such as flights, driving, train, or traveling with a group from your area. Porter Air has daily flights from several airports direct to Toronto Island airport, it is a great option and cost effective. We hope to see you in Toronto.

Concerns or questions? Email me at evelyn@iahss.org and I’ll get back to you.

Always,

Edyn A. Knauer  
CHPA, HEM
Entering into the millennium’s second decade, the IHSS Foundation will welcome two, as yet to be appointed, replacements on its Board of Directors. Having completed transitioning of programs from the IAHSS during the incumbency of the immediate past Board of Directors, the IHSS Foundation looks forward to strengthening presentation of those programs to the IAHSS membership worldwide.

Over the past year, by using the address (logo) reflected herein, subtle attempts have been made to distinguish the administration/operations/programs of the IHSS Foundation from those of the IAHSS.

The IHSS Foundation and the IAHSS are separately chartered as not for profit organizations by the State of Illinois. Each is administered by an independent Board of Directors under individual sets of bylaws.

The IHSS Foundation has sought to complement, support, and fortify the goals and objectives of the IAHSS through its programs:

1. the Commissions program,
2. the Grants program,
3. the Ken and Ellie Christian Scholarship (tuition assistance) program, and
4. the annual Recognitions program.

As cited in the footer to this article, brochures, applications and nomination forms for the various programs are readily available on the web site. Effective use of the brochures, applications and nominations relies upon user focus on the keywords and key phrases contained therein.

Just as in this article, keywords and key phrase are italicized for emphasis and to underscore their importance in proper completion of the specific brochure, application or nomination. Additionally, items on the application / nomination set forth in upper case, or which appear as shaded headers, should equally receive particular attention.

Page one of each application / nomination form is intended to be the face page for each submission, providing specific identification of the character of the individual submission and a comprehensive check list of the documentation required as exhibits (i.e., attachments/enclosures) providing support for the application / nomination.

All IHSS Foundation programs, without exception, are specific to, or focus on, healthcare security and safety, and as appropriate risk management.

IHSS Foundation Recognition Program

Lindberg Bell Outstanding Program - presented to a facility which has established and administered an outstanding … program

IAHSS Chapter of Distinction - presented to a chapter demonstrating the greatest initiative and/or innovation in promoting the … profession and the IAHSS

Philip A. Gaffney Faculty Chair - presented to individuals, institutions, organizations best exemplifying advancement of the purposes and aims of the IHSS Foundation through demonstrated achievements in

- promotion & development of educational research in ….
- acquisition, compilation, dissemination of resources, research materials & publications in the discipline of ….
- development and presentation of educational programs in ….
- publication of educational papers, texts, articles or treatises in ….
- recommendation of design, construction or retrofit of … facilities

Presented to an individual:

- … who, through his/her literary abilities, has made a significant contribution …
  - Russell L. Colling Medal for Literary Achievement
- … for a selfless and/or courageous act taken at the risk of his/her own life with full awareness of the danger involved
  - Medal of Valor
- … who distinguishes him/her self in performance of duty by an act of personal fortitude above and beyond to call of duty not taken at the risk of his/her own life
  - Medal of Merit
- … who, through individual action or initiative, has made a significant and lasting contribution to the … profession
  - Medal of Distinction
- … who has distinguished throughout a fulfilled professional career devoted to … purpose and aims of the IHSS
  - LifeWork Medal for Distinguished Achievement / Service
Australian Healthcare Security Conference Seen As First Step In Attaining Professionalism

The Third Annual Hospital & Healthcare Security & Safety Conference 2010 in Brisbane, Australia, on October 28 and 29, which covered a wide range of security issues, was a success, reports Bruce Irvine, Director/Adviser of BravoZulu Fire Safety & Security, and the regional chairperson for IAHSS. However, much hard work lies ahead to win over government and hospital management to the importance of training and professionalism for security officers.

The keynote address on “The Challenges of Security in Healthcare,” by Joseph V. Bellino, President of IAHSS, and System Executive for Security at Memorial Hermann Health System, Houston, TX, was very well received, Irvine says. Bellino also was featured on an Australian Broadcasting Commission telecast on attacks on doctors and nurses in hospitals in Australia and elsewhere and what trained security personnel can do to prevent them.

In Australia, Irvine points out, most of the government-run hospitals have proprietary security and seem stuck in a status quo of training and licensing with no real push for professionalism. On the other hand, contract security services have shown the most interest in the professional training of their security officers in order to be in a better position to obtain jobs.

Irvine says he will be working to form IAHSS chapters in Queensland and Victoria and to get IAHSS training recognized.

For Further Information, Contact: Bruce Irvine, Director/Adviser, BravoZulu Fire Safety & Security, 4 Barwin Court, Douglas Townsville, Queensland, Australia 4814. Phone: 01161-747752770. E-Mail: bruce@bravozulutsv.com
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PATIENT VIOLENCE

Hospital Psychiatric Patient Attacks, Beats Nurse
BUFFALO, NY. A psychiatric patient at Erie County Medical Center attacked and beat a registered nurse on the hospital’s psychiatric floor. According to news reports, the 22-year-old patient repeatedly punched the nurse in the head and face and then kicked her when she fell to the floor. He is also accused of choking her and hitting her with a telephone receiver. The alleged assailant was arrested and charged with second-degree assault. The hospital had recently contracted with Horizon Health to manage its psychiatric program. News reports noted the hospital also added more security to the floor, which is a locked unit. Following the incident, other nurses and associates of the New York State Nurses Association held a vigil in honor of the injured nurse.

Former Soldier Takes 3 Hostages at Georgia Hospital
SAVANNAH, GA. A former soldier seeking help for mental problems at Winn Army Community Hospital, Fort Stewart, took three hospital workers hostage at gunpoint before he could be persuaded to surrender. No one was injured and no shots were fired during the standoff. News reports say the man walked into the hospital’s emergency room armed with two handguns, a semiautomatic rifle and a submachine gun. He took a medic hostage and then proceeded to the third-floor behavioral treatment wing. Once there, he took a nurse and technician hostage as well. Military police alerted to the incident surrounded the hospital and Army investigators began negotiations that lasted less than two hours. Following the hostage incident, Fort Stewart stepped up its security, adding random visits by patrols to the hospital’s emergency room along with existing random inspections at the gates of Fort Stewart and Hunter Army Airfield.

NYC Hospitals Seeing More Drunken ER Visitors
NEW YORK, NY. Alcohol-related visits to the emergency rooms in New York City have tripled since 2003, according to the city’s Health Department. Newspaper accounts quoted that there were more than 74,000 alcohol-related visits among New Yorkers aged 21 to 64 in 2009, and that drinkers accounted for 3.4 percent of all ER patients. The rise in visits from underage drinkers leapt to 4,000 in 2009 from 1,000 in 2003. The demand for ER services between 2007 and 2008 also correlated with the concentration of bars and clubs in Manhattan neighborhoods.

TERRORISM

Two Canadian Hospital Technicians Tied to Terrorism Probe
OTTAWA, CANADA. Two hospital technicians employed by Ottawa area hospitals, a radiologist and a pathologist, are being held after a year-long terrorism probe by the Royal Canadian Mounted Police. The two hospital employees, along with two other suspects, are linked to an international terrorist cell, according to newspaper accounts. The cell is alleged to be plotting to make bombs and aid forces in Afghanistan. A sweep reportedly uncovered videos, schematics and manuals on bombing-building in their homes. In one home, police found some 50 remote-control detonators for improvised explosive devices, or IEDs. The radiologist was born in India and lived in Saudi Arabia before coming to Canada. The pathologist, who was recently hired by the hospital, grew up in Canada and graduated from McGill University.

continued on next page
Identity Theft Ring Hits Florida Hospital

FORT LAUDERDALE, FL. An identity theft ring breached emergency room files at Holy Cross Hospital and stole Social Security numbers and personal information pertaining to about 1,500 patients, according to newspaper reports. An emergency room employee was among four people arrested during an investigation by federal agents and postal inspectors. Hospital technicians tracked the employee's computer activity, which led to her firing. As a precaution, the hospital notified all 44,000 patients who visited the ER from April 2009 through September 2010. As a result of the data breach, Holy Cross has made procedural changes to limit the amount of personal data included in the types of documents involved in this case. It is also reviewing its systems, policies and procedures for additional improvements.

Surveillance Video Shows Computer Equipment Taken by Groundskeeper

SCOTTSDALE, AZ. Security officers at Scottsdale Healthcare Shea Medical Center used surveillance video to identify a contract groundskeeper as the alleged thief who took new and uninstalled computer equipment from a storage room at the hospital. News reports say the video showed the 37-year-old groundskeeper walking into a stairwell near the storage room with what is believed to be the computer equipment. The suspect allegedly took the equipment over several days. He was detained by hospital security and arrested by police. When Scottsdale police searched his home, they found stolen property and evidence related to the theft.

Man Charged With Credit Card Thefts Inside Hospital

ALBANY, NY. Credits cards were stolen from purses at St. Peter’s Hospital on at least three occasions and used by the alleged thief to charge items, according to news reports. A 50-year-old man was charged with stealing the cards during incidents in May and June. Police made the arrest with the help of information from hospital security.

LONG TERM CARE CRIME

Security Officer Charged in Jewelry Theft From Residents

STUART, FL. A security officer at Ocean Palms Retirement Center faces six felony charges for the theft of jewelry from the tenants. The nighttime security officer had access to residents’ apartments via a master key and keys to each apartment. According to police reports, the man pawned the stolen jewelry. In the most recent incident, he allegedly took a ring appraised at $7,300 while a tenant was in the hospital and pawned it for $1,600. The security officer was also implicated in the theft of a ring and a necklace from two other tenants and for taking power tools from a maintenance area.

Woman Killed During Domestic Dispute In Nursing Home Parking Lot

WAUSAU, WI. A man who killed his girlfriend in the parking lot of the Wausau Manor Nursing Home during a domestic dispute in 2009 is going to prison for life. A state appeals court upheld the murder conviction for the man who shot his girlfriend, a nursing home worker, at point-blank range in the back and neck as she tried to escape from him during an altercation in the parking lot.

Man Linked to Care Home Burglaries Jailed Again on New Counts

CROSBY, UK. A man who was out of jail on parole is suspected of numerous thefts, including another one at a long-term care facility, according to newspaper reports. The man, who has been returned to prison, was charged with four counts of burglary involving thefts from the elderly. He was jailed prior to his parole for his alleged involvement in a string of burglaries at care homes here.
Nursing Home Chain Faces Lawsuits Linked to Employee Abuse Charges

ALBERT LEA, MN. A group of six teen-age employees allegedly poked residents in the breasts, rubbed their genitals, held them down until they screamed, hit them with canes and exposed their buttocks to other residents at the Albert Lea nursing home run by the Evangelical Good Samaritan Society—an action that has resulted in lawsuits from residents’ families against the South Dakota company that operates the home. The lawsuits claim the home’s ownership failed to properly monitor its employees and residents. Six teenagers who worked at the home in 2008 were charged with abusing residents during a five-month period. Two of them, now 20, were charged with assault, abuse of vulnerable adults, disorderly conduct by a caregiver and failure to report abuse. One of them has been sentenced to 180 days in jail, while another was waiting sentencing at press time. Four other women were charged as juveniles with failure to report.

VISITOR/OUTSIDER VIOLENCE

Hospital Roommate’s Visitor Attacks Elderly Patient

AURORA, IL. A 78-year-old patient was stabbed in her hospital bed, allegedly by a visitor of her roommate. In the incident at Provena Mercy Medical Center, the patient was stabbed with a butter knife after the son of the victim’s roommate became upset. According to news accounts, the 39-year-old man became distraught, left the room and when he returned he attacked the woman. Security and members of the suspect’s family were able to subdue him. The man was charged with aggravated battery to a senior citizen and aggravated battery.

Violence Prevention Program Planned In Wake of Attack at Hospital

ST. CROIX, VI. Officials at Luis Hospital have implemented a workplace safety and violence prevention program after the relative of a patient undergoing a Caesarian section threatened to kill a doctor. The man, who became disruptive during the operation and was asked to leave the room, then threatened to get a gun and shoot a doctor in the head because he had interceded. He also made racial and sexual slurs. The man was not arrested at the time, but was asked to leave the hospital, according to news reports. While both hospital security and local police responded, police aren’t empowered to make an arrest in such as case, reports noted, unless it involved domestic violence or a crime was witnessed. The man remained in the parking lot after the incident and the doctor felt threatened by his presence. Eventually the man was arrested on misdemeanor charges of disturbing the peace and a charge of intimidation. In putting together a violence prevention plan, Luis Hospital is planning to conduct a risk assessment and develop a reporting system for different types of incidents.

Nurse Killed By Former Boyfriend After Leaving Hospital

BLACKPOOL, UK. The former boyfriend of a 26-year-old nurse allegedly attacked and killed her after she left Blackpool Victoria Hospital and walked to her car in the employee lot just 100 yards away. According to news reports, the woman died of multiple stab wounds. Police were called to the staff parking lot and she was taken to the emergency department, where had worked, but colleagues were unable to save her. The 30-year-old man with whom she had once lived was arrested the following day.

Husband of Patient Rams Parking Gate, Confronts Security

PARK RIDGE, IL. A 47-year-old man who had come to visit his wife at Advocate Lutheran General Hospital allegedly drove through a parking garage gate, then parked illegally in a handicapped space and fire zone. When police arrived, they found the man to be uncooperative and abusive toward hospital security. He was ticketed for parking in a handicapped space and for double parking, but wasn’t charged for damage to the gate.

In Brief cont.
Threat Against Employee Results in Hospital Lockdown

LAFAYETTE, CO. Both Exempla Good Samaritan Medical Center and Kaiser Permanente’s Rock Creek offices were put in a lockdown after a threat was made against a Kaiser employee, according to news reports. Police accounts said the man making the threats had been a friend of the employee for 10 years and wanted to take their relationship to the next level, while she did not. When told that the man was on his way and could be dangerous, the lockdown went into effect. There was no arrest, however, because no crime was committed.

Security Finds New Father Lighting Joint to Celebrate Birth

UNIONTOWN, PA. Officers responding to a report about the smell of marijuana found a new father removing a bag of pot from his shoe, according to newspaper reports. A nurse taking a cigarette break reported to Uniontown Hospital security that she smelled marijuana. When police arrived, the man told them he was having a baby “and wanted to get a buzz.” He now faces possible drug possession charges.

Forensic Patients

Hospitals Consolidate Housing For Prisoners to Single Site

TEMPE, AZ. Tempe St. Luke’s Hospital has converted one floor exclusively for the care of prisoners requiring medical attention, consolidating services that were previously shared among three hospitals operated by IASIS Healthcare, according to news reports. IASIS earlier this year signed an agreement with the Arizona Department of Corrections to provide care for state prisoners. The action removes prisoners from care at Mountain Vista Medical Center in Mesa, AZ, and St. Luke’s Medical Center in Phoenix. Tempe St. Luke’s will handle a variety of medical cases for prisoners, including orthopedics, cardiac care and general medicine. The second floor of the 87-bed hospital is now secured and elevator key cards restrict access. Personnel have also been trained to deal with the inmate patients. The Department of Corrections typically assigns two officers per patient. The hospital also has its own security staff.

Security Breach Leads to Escape Of Prisoner in Custody at Hospital

ATLANTA, GA. A prisoner receiving medical care at Grady Memorial Hospital escaped during a security breach, but was recaptured at his home two days later. The 40-year-old inmate had been shackled to a hospital bed and was awaiting transfer to the jail when he escaped his restraints, according to news accounts. A private security contractor working on behalf of the city’s Police Department allegedly left the patient alone in his hospital room. The man was originally taken to the hospital after an altercation with police during an arrest for shoplifting. He had been sprayed with pepper spray and was taken to Grady Memorial for treatment. An ongoing investigation is under way to determine how he escaped.

Unfettered Prisoner’s Attack In Hospital Leads to Lawsuit

BROOKLYN, NY. A prisoner who was left uncuffed and unattended in Brookdale Hospital attacked a nursing assistant. The violent act has resulted in a lawsuit against the city. According to news accounts, the policeman who brought the prisoner in was at the nurse’s station when the attack occurred. The inmate hid his hands under a blanket and then attacked and punched the woman when she entered the room.

Prisoner Who Escaped Hospital Held in Strangling Death

NEWARK, NJ. A 30-year-old man, who escaped from The University Hospital, has been arrested for the strangling death of his former girlfriend. According to news reports, the man was taken to the hospital for treatment for a seizure. When he fled the hospital, he was being accompanied by an unarmed civilian employee from Logan Hall, a halfway house where he was staying. The treatment
facility does have armed parole officers on site, but they were not used to accompany the man. After fleeing the hospital, he arranged to meet a former girlfriend, who was later found dead in a car the man used while eluding police. After he was captured, the man was taken to Hackensack University Medical where he was treated under guard for self-inflicted wounds to his wrists.

**Inmate Attacks Security Guard During Hospital Visit**

**JACKSONVILLE, FL.** An inmate from the Duval County Jail attacked a private security guard at Shands Jacksonville Hospital and beat him with his own gun before other guards and hospital security stopped him. The 62-year-old security guard from GS4 Secure Solutions was under contract with the Sheriff’s Office to provide security for prisoners. The 19-year-old inmate was taken to the hospital after he claimed he swallowed pens and razor blades. The incident occurred as the inmate was returning from the bathroom. News reports say he allegedly managed to free his arm and began hitting the guard in the face. He then pulled the gun from the guard’s gun belt and pointed it at the older man’s head. Hospital security and corrections officers arriving on the scene used their weapons to get the inmate to drop his gun.

**New Medical, Mental Health Facility Planned for CA Inmates**

**STOCKTON, CA.** A new $900 million medical and mental health care facility for the state’s inmates will house 1,700 forensic patients when it is completed in a couple of years. According to news reports, the federal government decided to build a new prison hospital because of what were determined to be poor conditions in current medical centers. California Department of Corrections and Rehabilitation Director Matthew Cate said the facility would play a big role in solving some of the state’s prison problems. “It allows us to get sick and infirm inmates out of high security prisons and into more of a clinical setting. And we can fill those high security prisons with the inmates we should be worried about,” said Cate.

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**EMPLOYEE CRIME**

**Security Chief Ousted, Arrested For Lying About Credentials**

**BROOKLYN, NY.** The security chief at Kings County Hospital was arrested in September for lying about his credentials. John Perfetto, who supervised a staff of about 100 security officers, was fired September 8 and then arrested on felony charges a week later for allegedly falsifying information regarding a bachelor’s degree from John Jay College of Criminal Justice, according to news accounts. Perfetto was hired in January 2009 to the $87,000-a-year position following a purge of staff after allegations of patient abuse within the hospital’s psychiatric unit surfaced. The probe was linked to the death 49-year-old patient who collapsed in the psychiatric ER after a 23-hour wait.

**Officer Faces Felony Charges Related to Drug Theft**

**WARREN, OH.** A security officer at Trumbull Memorial Hospital was charged with a felony after police alleged he stole prescription drugs from a woman who was taken to the hospital after she died. According to news reports, the medication, Hydrocodone, was left in the security officer’s care at the hospital morgue, but was then allegedly sold to police in an undercover sting operation. Police tracked down the source of the drugs based on the woman’s name on the prescription, and the officer reportedly admitted to the theft.

**Former Security Head Charged With Stealing Tuition Reimbursements**

**PHILLIPSBURG, PA.** The former security director at Warren Hospital was behind a scheme to steal tuition reimbursements for courses taken at Lion Investigative Academy, news reports say. Robert Fulper, who was fired from the hospital in July 2009 for undisclosed reasons, allegedly worked with accomplices who would pretend to take courses at the academy, submit tuition reimbursement claims, and share the payments they received with Fulper.
Reports say Fulper would submit the claims to the hospital and, when employees were paid back, they would keep $300 and the rest would go to Fulper. According to police, the scam netted about $7,500 in stolen funds over a year’s time.

LAWSUIT

Hospital Sued By Man Alleging Security Detained, Assaulted Him

CHERVERLY, MD. Alleging he was held against his will by two hospital security officers, a Maryland man has sued Prince George’s Hospital Center for $12 million. According to news reports of the incident, the man, who was admitted to the hospital following a car accident, was misidentified on his ID bracelet as a woman who was supposed to undergo surgery for a cancerous chest mass. When he tried to leave the hospital, a nurse called security to keep him from exiting. A complaint filed with Prince George’s County Circuit Court stated that the officers shoved him into a railing, then punched and verbally abused him. The man filed charges of assault and battery and false imprisonment. He eventually received treatment at St. Mary Hospital for broken ribs, a sprained shoulder, a ruptured spleen and a concussion.

Healthcare Security Officer “Boot Camp” is a Total Success

On Friday, August 27, 2010 the Central Florida Chapter with support from our North Florida Chapter colleagues, held our first ever “Basic Healthcare Security Officer “Boot Camp”. The attendance, funds raised for the chapter and most importantly the feedback of the attendees far exceeded our expectations.

When past Regional Chair, Mickey Watson, CHPA came up with the idea and presented it to the board, we got excited. This could give us a chance to provide training and boost morale for key employees that are rarely given an opportunity of this nature. We knew we weren’t re-inventing the wheel and that similar events have probably been held by other chapters in the past. But, with our intentions in the right place and the proper planning this could be one of our best achievements as a chapter.

We began planning immediately. Like most great teams, things seemed to just fall into place. Paul Mains, Chair-elect graciously agreed to host the event at Florida Hospital, Orlando Florida. This was very strategic because it enabled us to partner with our North Florida Chapter without the major headaches of travel expenses and coordination that could accompany an event of this type. It would be very important for us to make getting to and from the event as easy as possible for attendees and their employers.

The next thing we had going for us was our experience and diversity as a group. We wanted to ensure the training topics were current and specifically catered towards the Healthcare Security Officer. Trying to find volunteer speakers for conferences can be a real nightmare so we looked inward. For example:

- Basic Hospital Campus Patrol Tactics was presented by Vice Chair, Tony Venezia, and CHSS from Tampa General Hospital.
- Basic Security Officer Safety Techniques was presented by Chairman, Rich Miller, CHSS from Sarasota Memorial Hospital
- Fundamentals of Security Incident Report Writing were presented by Chair-elect Paul Mains, CPP, CHPA, CSC of Florida Hospital, Orlando.

New CHPA’s
David Guest Jr.
Dennis Merrill
Christopher Patin

CHPA Renewal:
If you received your CHPA in 2008 you must recertify in 2011. To obtain an application contact the IAHSS at 888-353-0900 or visit the website under certifications.

continued on next page
Infant Security System Basics was presented by Board Member Don Knowles of Niscayah, Inc.

Basic Healthcare Security Technology was presented by Chapter Secretary, Carl Stark of Qualified Systems Contracting, Inc.

With our core agenda in place we were then able to finalize the training topics with the help of other chapter membership and industry colleagues. Paul Ford, CHPA and Security Director from Tampa General Hospital presented on the “Patient Care Unit Research Project, Security Implications”. James C. Kendig, MS, HSM, CHSP, CHCM, LHRM and Vice President of Health First performed presentations on “A Line Officers Introduction to Emergency Management”, and discussed Color Codes, ILSM and Forensic Patient Management. We even conducted a round table “panel discussion” on Tobacco Free Campuses.

We charged a very reasonable fee of $50.00 for attendance. The event encompassed a full day with continental breakfast, lunch and snacks provided during breaks. We allowed plenty of time for morning registration giving the people who were driving significant distances enough time to arrive. In some cases, buses were donated by key hospitals or rented to reduce travel expenses for anyone needing assistance.

At the end of the conference everyone received a portable thumb drive with all the material presented, and a certificate of completion. All participants were asked to complete a feedback survey. The positive response was immediate and the attendees came from as far away as North Mississippi.

So how did we really do? What are the facts?

- We had a total of 101 students, from 26 different organizations in attendance, with an additional 14 board members, instructors and guests.
- Our expenses including food, location and supplies totaling $3,000.00 were covered by the Registration Fees.
- We presented gift cards to the support staff at Florida Hospital Orlando who did an amazing job.
- We donated $500.00 to the IAHSS North Florida Chapter in recognition of their support and participation in the seminar.
- We raised roughly $2,200.00 for the chapter to be placed towards future educational conferences.

Special thanks go to Paul Mains, CHPA from Florida Hospital and his support staff who hosted the event. It was nothing short of first class. Additionally, we are thankful to all the chapter vendors who donated their time and provided donations to help sponsor the event. This wouldn’t have been such a success without the key members and leadership our chapter is blessed with. Thank you all for the support. Look for our next event coming soon.

Rich Miller, CHSS
Sarasota Memorial Hospital
Chapter Chairman, Central Florida Chapter
An Interview With:
Connie Potter on Trauma Center Security Issues

Connie Potter, RN, is president of the Trauma Center Association of America. Las Cruces, NM. Within the United States, there were 1,675 trauma centers as designated by state and regional entities as of May 1, 2010, as well as the by the American College of Surgeons. The ACS ranks trauma centers by Levels I to III for both regular and pediatric-only facilities and also has a verification process. In this interview, Potter addresses the security challenges and needs at the nation’s trauma centers, and the results of the Association’s recent survey on “U.S. Trauma Center Preparedness for a Terrorist Attack in a Community.”

Q. What sets trauma centers apart from the regular emergency department?
A. Trauma centers are the epicenter of disaster response. Natural disasters, gang shootings, traumatic brain injury; all of these can have violent behaviors associated with them.

Q. In the event of a disaster, what are some of the security challenges that trauma centers face?
A. The things that are problematic about hospitals are the multiple access points, and the outside buildings that have been added over time that may not be as well policed. When there is a crisis, we expect lockdown to take place within five to 15 minutes with a single, controlled access point. There is a phenomenon called “convergers.” When there is a disaster, it brings out the “Looke Lous,” the worried will converge on the hospital. Some of it may even be other personnel from other hospitals who want to help. They may be well intentioned, but they aren’t credentialed and it causes problems.

We also frequently see a lack of relationship between the hospital command center and local police. There needs to be a system in place for controlling “convergers,” media, ambulances; and a place for workers to drop off their children when there is a crisis.

Q. Outside of a disaster, what are some of the day-to-day issues for trauma centers?
A. Psych patients are frequently brought in to trauma center EDs, especially because many hospitals don’t have psych departments. Psych patients can be a danger in the ED. They are already a danger to themselves. There are also inmate patients that are brought in. One way prisoners try to escape is by faking an illness. It’s not unknown for them to weapons from security or take hostages or try to escape from restraints. Even the general population can present security risks, especially in the current environment with people carrying firearms and some states having very few restrictions on weapons. I had two experiences when working in El Paso (TX) with patients that had shoulder holsters. Security had a video of me kicking a gun out of a room and pushing the (previously armed) patient against the wall—and I was just 110 pounds at the time. Since then, they got a metal detector and a weapons safe.

Patients under the influence of narcotics or alcohol will often perpetrate violence against doctors, nurses and other patients.

Q. What can be done about this?
A. The issues are that we have such an open policy in hospitals that are often overcrowded and understaffed that patients and families get frustrated. We don’t have enough security, and we don’t have enough gun-carrying security. Trauma center EDs are an open source for a variety of people. The best hospital I worked in (in Portland, OR) had off-duty, armed police officers. But too often the security in hospitals are like the security guard at Wal-Mart. So we’re seeing more and more concern about this.

Q. Are metal detectors a viable option for enhancing security?
A. I am an advocate for metal detectors. As a co-investigator for our study (“U.S. Trauma Center Preparedness for a Terrorist Attack in a Community”), I know you need to limit access very, very quickly, and you can’t stop everything. There are open carry laws and loosened handguns laws. I’m surprised that any facility wouldn’t use metal detectors, especially after an incident. They are used in airports and the hall of Congress, it shouldn’t be considered prohibitive anymore.

continued on next page
Interview cont.

Q. You mentioned the study, what were some of the findings related to security?
A. Nearly all (97 percent) had security in place, a lockdown plan and plans to control access. We also surveyed trauma centers about their perceived threat code, which is an indicator that they have an armed person on the grounds, or an escaped psychosis patient or inmate, or even a suspicious package. We found that people had plans (74 percent), but it hadn’t been practiced (66 percent). They should be practicing how long it takes to do a lockdown, get the police there, set up a perimeter. I also think a universal code system should be accepted for the security of workers, patients and staff to alert them to danger.

Q. What is the role of the Trauma Center Association of America in improving security?
A. Our part is education, through disaster preparedness communications and through things like our study. Education is very necessary, especially at the executive level. The Joint Commission looks at disaster plans, we look at them, but mostly they are a big book on a shelf that no one looks at.

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To download a copy of the Association’s report on disaster preparedness, go to http://www.traumafoundation.org/disaster_preparedness.htm.

IAHSS Healthcare Metrics Working Group

For the past few months several of our Association colleagues and George Campbell, a member of the Emeritus Faculty of the Security Executive Council (SEC), have been meeting monthly to focus on developing a set of performance measures and metrics for healthcare security and safety. This IAHSS initiative has now boiled down to about 20 potential indicators with the objective of gaining consensus on a smaller set we can test among ourselves and then roll out to the membership for wider data input. Our intent is to build a body of measures that will be useful for identifying Security’s value proposition, reporting up, internal trend analysis as well as for benchmarking among similar institutions. This initial test period has been supported by the SEC and the balance of the 12 month demonstration will be supported by the IAHSS. Upon completion of this initial survey phase in January, we will be soliciting active participation by members in a variety of approaches to building actionable metrics for your organization.

Jack Connelly, Mike Tabeek, Connie Packard, Bonnie Michelman, and John Driscoll were honored for their service to the chapter at the Boston Chapter holiday meeting.

Ken Close, Don MacAlister, Martin Green at the awards ceremony where Don MacAlister was presented Security Director of the Year for Canada.
Johns Hopkins and Other Recent Hospital Shootings Spur Concerns About Hospital Security

When a patient at Johns Hopkins Hospital, Baltimore, MD, was killed and her doctor critically injured by a shooter who took his own life, the issue of in-hospital violence has become a key part of national media concern.

For Anthony Potter, CHPA-F, CPP, Director of Public Safety, Greater Winston-Salem (NC) Markets, Forsyth Medical Center and Novant Health, this incident was one of many that he has tracked over the past several years. From 2008 until early November 2010, Potter says there have been 65 deaths from incidents involving firearms at the nation’s hospitals, from Maine to Alaska. Of those incidents that involved security officers, in just three cases were the officers armed, he says, while 45 events involved unarmed security. Potter has also broken down the events by location and motivation, with the emergency department as the site of 15 incidents, followed by the parking lot with 10 and patient’s rooms and other accounting for eight incidents each. Domestic violence is the leading cause of shootings, outweighing other categories such as suicide by officer and unknown at seven each and murder-suicide and gang violence, at five each.

Joint Commission Reacts To Johns Hopkins Security Plans

The event at Johns Hopkins, which is currently under review by the Joint Commission, shined a spotlight on this issue in part because Johns Hopkins is historically one of the leading hospitals in the country. Security officers there are not armed, says Potter, although off-duty police who serve there do carry firearms.

In its planned review of the shootings, which took place on September 16, the Joint Commission has asked Johns Hopkins to review its security plan and suggest possible improvements, according to news reports. The commission has identified the shootings as a “sentinel event,” which it defines as “an unexpected occurrence involving the death or serious physical or psychological injury or the risk thereof.” Johns Hopkins had 45 days from the date of the shooting to submit a report to the commission. The hospital public relations declined an interview on behalf of security personnel, citing the need to focus on the report.

Several Other Hospital Shootings Since The Johns Hopkins Incident

While Johns Hopkins has made the major headlines, there have been several hospital-related shootings since then, including a shooting outside the emergency department at Chester Regional Medical Center, Chester, SC, that took the life of a 20-year-old man; another shooting near the entrance of the Highland Hospital emergency department in Oakland, CA, in which a man was shot in the abdomen; the wounding of two Omaha police officers during a gun battle in the lobby of Creighton University Medical Center; the death by suicide of a former Palm Bay Hospital, FL, employee, who barricaded himself in the cafeteria and fired shots, though he didn’t injury anyone; and the attempted suicide by shooting at INOVA Mt. Vernon Hospital, VA.

Conflicting Rules About Use of Force

Hospitals, says Potter, operate under conflicting rules. If someone who isn’t a patient causes a problem, officers can

continued on next page
use force to control the situation. “But when dealing with patients, law enforcement implements aren’t approved for use,” he says.

As a result, says Potter, “we have never had an officer injured when dealing with a criminal. All the injuries have happened during altercations with patients.” At his medical center, Potter says officers aren’t armed, although they do carry pepper foam and collapsible batons. In some hospitals where guns aren’t allowed, tasers are used, he says. “But a taser isn’t a substitute for a firearm,” he notes, adding it is most useful in non-deadly force incidents.

**Things To Consider If You Plan Installing Metal Detectors Or Arming Security Officers**

Metal detectors have also been put forth as a deterrent to the use of firearms by those entering a hospital. And Potter acknowledges “this is becoming quite a trend.” His own issues with them, he says, are that they need to be used in conjunction with an X-ray machine to screen handbags, backpacks and packages brought into the hospital. And if officers are looking for and dealing with people with guns, Potter says, he would want the officers doing the screening to be armed.

For those hospitals considering arming their security officers, Potter cites three primary reasons why this is necessary. First, it acts as a deterrent. A visibly armed officer is an effective deterrent to armed violence, he says. The second reason is defense. Only an armed officer can effectively defend himself or herself and others against an armed attacker. Finally, says Potter, there is the need to provide immediate response. Only armed officers can provide an immediate response to an armed attack without waiting for law enforcement to mount a rapid response in accordance with current tactical doctrine.

He also adds that if hospitals are going to arm their security staff, they need to do proper background checks and psychological evaluations. Even his unarmed officers, because they have the capability of using force with batons or sprays, undergo the same testing that is given to police. And they are trained similarly as well.

**Drilling With Police Essential Part Of Active Shooter Policy**

Because Forsyth Medical Center doesn’t arm its officers, Potter says in the event of an active shooter, they would rely on police to handle the rapid response, with one of his officers, wearing a bullet-proof vest, acting as the person who would guide the four police officers through the facility to the site of the shooter. Typically rapid response personnel approach in a diamond-shaped formation, using four armed police. The security officer would be behind the lead officer in the role of guide. Potter strongly advocates training for active shooter incidents. “For our Code Zero (active shooter), we do drills with the police,” he says. “It’s important to write a policy, but you also need to know what to do. If you don’t drill it, it’s worthless.”

Potter adds that while most hospitals have done a good job of working with local police, it can be irrelevant when an incident occurs because of the response time. The bottom line, says Potter, is if you arm officers “at one point one them (the guns) will go off. So you need to make sure it’s justified.” And that means hiring the right officers who receive the proper training under the dictates of appropriate policies and procedures.

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Potter is the author of “Considerations When Arming Hospital Security Officers,” available by accessing Educational Materials on the IAHSS members website.
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In August 2005, Hurricane Katrina devastated the city of New Orleans and many of the surrounding communities, destroying homes, taking lives and forcing people to seek shelter wherever they could find it. Hospitals throughout the area were stretched to the limit because of extended power outages, food and personnel shortages and the overwhelming need to continue to provide care for their patients. Now five years later, we've asked some of the people who were involved in events at that time to reflect on the security-related lessons they learned and how they are applying them to hospitals and emergency management programs of today.

Participating in this article are Kenneth Alexander, Vice President of Quality & Regulatory Activities for the Louisiana Hospital Association, Baton Rouge, LA; Lisa Pryse, CHPA, CPP, Chief of Campus Police & Public Safety, Eastern Virginia Medical Center, Norfolk, VA; Norris Yarbrough, Assistant Vice President-Emergency Preparedness & Response, Ochsner Health Systems, and Mike Mitchell, director of security at Ochsner Health Systems, New Orleans.

ALEXANDER: RETHINKING SHELTERING IN PLACE

While Katrina may be the most remembered of the major storms that hit Louisiana, Alexander says hurricanes Rita, Gustav and Ike have also influenced how the state’s hospitals look at and prepare for such disasters.

With Katrina, he says, “we found that historically hospitals are looked at as a place of rescue and shelter. But this situation belied that.” The extended loss of power and the inability in many instances to provide adequate security taxed hospitals and brought forward the need for mass evacuation plans.

Since 2005, hospitals have developed comprehensive evacuation plans, he says, and are continuing to refine the process of patient tracking. “We have to reconsider the idea of sheltering in place,” says Alexander. When it comes to security, many hospitals are underprepared, he notes.

The Need For Increased Security

At the time that Katrina hit, Alexander was a CEO at a hospital in Baton Rouge. “We took in special needs patients,” he says, but couldn’t get armed security because everything was focused on New Orleans. Hospitals everywhere were inundated with people, looking toward the facilities as population shelters, adds Alexander: “So it becomes a situation of balancing community needs with what resources you have to handle them.”

After Katrina and the other storms, he says, the state revised its protocols and processes related to certain areas such as pharmacy security. If there is an event, does there need to be a secondary site for protecting the drugs, or is it just a matter of adding more security features, such as locks on the doors? “In Baton Rouge, we looked at surveillance, doors and the like. And afterwards we rekeyed all the doors, realizing we needed to step up security.”

The Need For Redundant Communications

Communications during a major event is another area where hard lessons were learned. Alexander notes that cell phone towers have a back-up life of only 24 hours. Communications trunk lines were lost to storm surge, impacting landlines and the Internet, he says. Back-up power in all situations was compromised as power went out and generators failed.

Even in communities that weren’t directly impacted by the storm, the sheer numbers of people taxed communications, he says. In Baton Rouge, the metropolitan population doubled in 48 hours, he notes, and the existing cell phone towers were overtaxed. “Even though we got back on line, the system was inundated,” he says. As a result, hospitals are now exploring redundant communications with radios and back-up radios.

Shelter, Generators, Supplies, and Delivery Issues

Using hospitals as shelters calls for hardening supplies, pre-planning and intensive drills, says Alexander. The hospital
association helps coordinate with state and federal agencies, as well as putting regional coordinators into place.

On the issue of sheltering, Alexander says there are now better processes in place to identify potential shelters and gain access to law enforcement for security purposes, “but we are still competing for them.” Still, he says, having an enhanced level of communication and better deployment of resources, while making security an integral part of the plan, will help.

Looking at the multiple storms that Louisiana dealt with, Alexander says each brought forward new challenges for hospitals. Gustav required a major evacuation, with 20,000 to 30,000 people in shelters. About 1,000 hospital patients were moved: half to other state facilities and the rest out of state.

The power outages that resulted for all the storms focused people on not only the need for generators, but also on how they would gain access to diesel fuel. The loss of 10 percent of the state’s tree canopy during Gustav resulted in downed power lines and limited access to roads. Alexander recalls taking two hours to drive eight miles. “It was a major problem for medical personnel and ambulances to get to the hospital because of the excess traffic,” he says.

While getting personnel to the hospital is critical, so is getting supplies. After Katrina, he notes, there were problems with getting trucks filled with supplies to the hospitals. Even with the later storm Gustav, there were still supply issues “because we didn’t do enough post-Katrina.”

The hospital association has a task force that is working on identifying and credentialing the supply chain, so trucks with medical supplies and oxygen and even personnel can get where they need to go more quickly. “There is now more awareness and a critical eye placed on who and what is important,” he explains.

The Need For A Liability Waiver

Although there are many changes taking place post-Katrina, Alexander says not much of it is because of new regulations. “By nature, Southerners are independent, so we don’t have as much regulation” as some states. Where the exception lies, he says, is in the area of liability for medical personnel. Termed the Anna Pou legislation after Dr. Anna Pou who was charged in the deaths of some Katrina victims, Alexander says without a liability waiver, it would be difficult to mandate that personnel come to the hospital during a natural disaster or other event.

There are some reporting mandates, he says, such as whether a hospital has a working generator; how many patients it can shelter; and the like. “And there is lots of voluntary self-analysis to improve the process,” he says.

As a state, Alexander says they are better prepared for a major hurricane and its aftermath. “But that being said, there are always outliers who haven’t put the urgency to it. But that is a rarer and rarer event.”

**YARBROUGH: THE ALL-HAZARD APPROACH**

Begun before Katrina, but finalized since then, Yarbrough literally wrote the book on dealing with the types of hazards, disasters and threats faced by Ochsner Health Systems. “We needed to get away from the traditional mode of a compartmentalized approach to disasters,” he says. “That’s just too fragmented to follow. 9/11 showed you do similar things in all types of disasters, so we created an all-hazard approach.”

Where previously manuals on disasters had separate chapters for each hazard and often repeated the information contained therein, Yarbrough says a better approach is to take common elements such as evacuations, finding outside resources or dealing with utilities and linking that information with the different disasters. Yarborough also rated the top disasters for the area covered by Ochsner. Hurricanes, of course, are one of those natural events that gets major billing in Yarbrough’s tome. “We put in hurricane specific information,” he explains, “but we just linked it back to other areas in the book for some information, such as how to get outside assistance.”

“That really makes it very easy to keep it current,” he adds, because they are just revising one plan.

**The Column A, Column B Approach**

When it comes to lessons learned from Katrina, Yarbrough says he takes the two-column approach: In column A, he lists all the resources the facilities needed to respond to the disaster; such as personnel, supplies, and so forth. In column B, he makes a list of all the state and federal resources available. “Then the challenge is to figure out how to make column A cover all the column B resources for at least three days. How do you fill those gaps?”

In the case of Ochsner, Yarbrough says, the health system has developed a plan that would cover seven days without access to fire, police, utilities and other resources. For continued on next page
example, he says, to cover the possible loss of potable water; another well has been sunk. To cover power loss, three more generators on tractor trailers have been purchased. “We have enough power now for all the power needs of the hospital and beyond,” he says.

If the normal communications becomes “unplugged,” Yarbrough the system has a plan in place to get to people by relationships established with parish, state and federal entities in the incident command system. Not only do they have the relationships, he says, but they have also done drills to make sure the process will work.

Creating A Redundant Incident Command Center

Depending on the situation at the hospital itself, Yarbrough and his group have created an incident command plan that works outside the command center: “We created a room with dedicated computers, monitors and satellite phones” all with card-restricted access, he says. Additionally, he notes, “we made it redundant. There is a back-up system using a stand alone satellite to operate the Internet.” The backup for landline phones is a cell phone with out-of-state area codes. The command center is run by emergency power, but it also has a back-up generator.

Going Beyond Arming of Officers

On the physical security front, Yarbrough says his group relies on in-house security to oversee the eight hospitals and 40 clinics in the Ochsner system. “Officers are already armed, but we took it to the next level and gave members on each shift riot training,” he says.

He recalls that during Katrina, there was a period when no local law enforcement was available. “Fortunately, they (our security officers) were armed, but we saw a need to upgrade that.” He says one of the major challenges during those post-hurricane days was dealing with rumors about marauding gangs. “One way to deal with that was by having armed guards,” he says.

Ochsner also had and still has a memorandum of understanding with local law enforcement so they can bivouac on the premises. “It helps them to get law enforcement into the community, and it helps us in terms of protection,” says Yarbrough.

A Hospital With Its Own Fleet of Boats

Although evacuating a hospital “is the last thing you want to do,” in the event it is necessary, Yarbrough says it should be done via the national disaster planning system and in conjunction with the military.

Because New Orleans and the surrounding area is subject to flooding, Ochsner has its own navy: a fleet of 10 flat-bottom boats that can carry up to 24 people. There is also an airboat and two personnel carriers available for use.

“We had several boats custom built that can move 60 patients on stretchers,” says Yarbrough. A hospital with a typical population can be evacuated in less than 10 hours, he adds.

While it may seem as if Ochsner has all its bases covered—and then some—Yarbrough says there are still problems yet to be solved.

“I wish I could go home at night and lay down and think I have everything done,” he says. “But I still go home and think about the other scenarios. Katrina taught us there’s something round every corner that you haven’t thought about.”

MITCHELL: IMPROVING UPON WHAT WORKED

With disaster plans already in place, Mitchell says Ochsner successfully survived Hurricane Katrina because it was prepared. But even with that, he says, the security department continues to become more organized and better trained to deal with future events. Like Yarbrough, he says rumors about gangs and wide-scale violence, rape and even murder “were the biggest things we fought at the time. Fortunately, we were one of the few facilities that was armed.”

Special Training of Security Officers

Since Katrina, he says, the hospitals have increased their weapons availability and added tactical gear for some officers. The size of the force hasn’t grown, he says, remaining at about 95 officers. But about half of them have gone through in-house SWAT training. During the height of Katrina, Mitchell says he used his contacts with ex-law enforcement personnel to bring in an additional 30 officers to secure the property before the National Guard could arrive on the scene.
Upgrading Physical Security Equipment

On the physical security equipment front, Ochsner has installed hurricane-proof pan-tilt-zoom cameras on the roof that can see for up to a mile. Those cameras are tied into the incident command center, but can also be pulled up on devices from remote locations.

“As we continue to grow, (having a central command center) is more on everybody’s mind,” says Mitchell, noting it can be used for both natural disasters and terrorist attacks. He also notes that while they had memos of understanding before, they have increased these so they can house other groups of police, firefighters and the like during future storms. “We coordinate with them pretty deeply,” he says.

Finding The Right People For The Job

Finding the right people for the job is always a challenge, and situations such as Katrina point that out. When the hurricane hit, Mitchell says “we lost about one-third of our (security) personnel pretty quickly. Some went AWOL on us; some came in and then had to leave, but we couldn’t guarantee them they’d keep their jobs.”

Mitchell and others stayed on site for 40 days. He says he was surprised by his people’s reactions to the situation. “Some people who you’d think would be in control, fell apart, while others were outstanding.”

As a result of this, Mitchell says the department now discusses contingency planning in its interviews with potential security officers. Security is seen as part of essential personnel, he explains, “and they know that and that is the business they are in.” Officers have to plan to be away from their families in an emergency, he says, but he will make some exceptions, such as for those caring for an elderly parent. Mitchell adds that many of the officers applying for jobs today have a background in Gulf War service and have been in combat situations and understand the principles of command and control.

Despite the volatile nature of the hurricane aftermath, Mitchell recalls that none of his officers had to draw a weapon. “Because our folks were armed, it gave reassurance to the people working here,” he says. The armed officers went on outside patrols, showing that they could use force if necessary, and likely garnering respect from those in the area, he says. Within the facility, personnel wore armbands as part of a recognition system instituted by human resources, he says. There was also an internal curfew of 10 p.m., so security could monitor who was moving throughout the building.

Looking ahead for the next possible Katrina, Mitchell says his wish list is endless. “I’d like to see more people, and we can always use more equipment for first-responder work.” Training is also critical, he says, with some officers training as much as 200 hours a year to hone specific skills. “My concern is with people thrown into something very difficult and they’ve never had to draw their weapon,” he says. That’s why it’s important for security officers to get training similar to what police officers know.

Of course, he says, it all comes down to funding. While there have been grants to fund some items in the emergency response plan, most of security’s needs are covered by budgeted money, he says. “Security is always looked at as overhead,” he says. “They (management) don’t see the cost savings because it is hard to measure.”

Likewise, says Mitchell, with Katrina five years in the past, memories become a bit fuzzy. “As time goes on, people forget. If everything is OK, people don’t see the need to grow security.”

PRYSE: EXPERIENCE CARRIES OVER TO EVERY DAY POLICING

In the days immediately following Hurricane Katrina, Pryse participated in the recovery process as a member of the North Carolina State Medical Assistance Team in Waveland, MS. The team set up a mobile hospital in a Wal-Mart parking lot and Pryse and a maximum of four officers from her police force assisted in the security of the operation.

“With Katrina, necessity was the mother of invention,” says Pryse. “What we did was in response to that disaster.”

At the time, Pryse was chief of campus police and director of public safety for WakeMed Health & Hospitals in Raleigh, NC. At WakeMed, Pryse oversaw a 16-member tactical team, and since coming to Eastern Virginia Medical Center in January 2010, she has been revamping the emergency response program, calling on the lessons learned from her Katrina experience and that of WakeMed.

No Electricity, No Police

“I learned a tremendous amount (in Mississippi),” says Pryse. “Even when I first arrived there, and we worked under the federal marshals. I was surprised that they were continued on next page
all dressed in jungle fatigues, but then I realized we were under martial law. There was no electricity and people were just wandering around.” That situation, she says, made her aware that in a healthcare situation, there will be times when you need people who can flex to that level. “There were no police, so we were it,” she says. Even in a hospital, she says, “you need individuals who are trained to do SWAT. But for this kind of environment, you have to be careful not to create a monster. This training is helpful, but you have to ensure they don’t walk around at all times in tactical attire or with that attitude.”

Developing An Emergency Response Plan

While EVMS had an emergency operations plan in place, Pryse says she set to work on an emergency response plan. After putting in a police and public safety department with public safety and police officers properly outfitted and badged, the focus turned to training.

Among the programs offered are FEMA Incident Command System training, rape aggression defense training and, through the Homeland Security Department, free chemical weapons training at a former military base in Alabama. Using an outside consultant who is a former FEMA director, Pryse conducted a hazard vulnerability assessment. “I knew I was out of my league within Virginia to have a certain continuity of operation plan. We have 13 military bases, plus ports here.”

She also has instituted a threat assessment team involving students on the EVMS campus. The group meets biweekly and initially many of the concerns centered on response to another Virginia Tech-type shooting incident. “We had about 20 issues the first time we met,” she says, noting students who participate “are able to bring their concerns to a safe haven.”

Changing The Emergency Notification System

One outcome from the student meetings has been a change in the emergency notification system. Previously, participants had to opt-in to receive alerts via phone or text. Now, says Pryse, her department has partnered with an alert system that is opt-out only. One feature of the system is that it can act as a panic alarm. This is useful for students on campus, she says, who may be studying late and want to ensure they arrive home safely.

Students set a timer on their phone through the alert system, and unless they undo it when they arrive at their destination, it sends an alarm to EVMS police with a photo of the person and GPS coordinates. Pryse says they know it works, because one overly sleepy student who forgot to remove the alarm setting upon returning home was visited by police who were unable to reach her by phone.

Building A Sworn Police Force

With all the technology and programs she has added, Pryse says she has learned from her WakeMed experience that she needs to build a team of internal trainers. She is also following her WakeMed example by slowly building her sworn police force. Of the 38 officers she has now, 14 are sworn police. “I have a program that I had a WakeMed where I send one or two public safety officers to the academy to become police officers,” she explains.

Because of her experience with post-Katrina policing and the programs she has created at the hospitals at which she has worked, Pryse says she has heard from several individuals who are interested in building a similar emergency response program. “Usually those I hear from are very progressive,” says Pryse. “A lot of what we do is still considered cutting edge, not mainstream.”

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LEAVING AMBULANCE GENERATOR RUNNING WHILE PARKED

One emergency medical technician died and two co-workers were hospitalized after being overcome by carbon monoxide while on duty for an EMS service operated by Good Shepherd Medical Center, Longview, TX. Hospital officials said that the carbon monoxide apparently was from a generator left running on an ambulance parked in a bay with all of the doors closed at one of 22 EMS stations located across East Texas. The two hospitalized employees were on a different side of the building, which did not have carbon monoxide detectors. Because of the circumstances of this accident, hospital officials said, carbon monoxide detectors have been installed in all of its EMS stations.

FAILURE TO REPORT TASER ‘USE’ TO POLICE, CMS

In an incident involving a violent mental patient who was assaulting a doctor, a hospital security director reports that the painting of the patient with a Taser laser beam -- without emitting an electrical charge -- was successful in getting him to stop, retreat and be restrained without further incident. The situation met all requirements for CMS guidelines for the deployment of the Taser -- the officer used clear, loud, direct commands in response to a criminal event, the security director said. This question then arose. Is reporting only required when the officer actually Tases the patient or does painting a patient constitute deployment and therefore require that the police are notified? The answer, after a conversation with CMS, is that deployment occurs when the officer removes the Taser from the holster and uses it to alter a patient’s behavior, whether an electrical charge is employed or not. “If we paint someone, we are required to call the police and do all necessary documentation indicating the same.”

PRANKSTERS IMPERSONATING FIRE DEPARTMENT DISPATCHERS

Prank calls by disturbed or uncaring teenagers have become a fact of life for hospitals. Mostly such calls are for false bomb threats. In Stoughton, MA, two teenagers were arrested for allegedly making more than a dozen bomb threats against a Stoughton hospital and forcing an evacuation of the hospital’s patients. In Columbus, OH, however, a teenager took prank calls to a new level. According to police, the boy allegedly called Nationwide Children’s Hospital, and, posing as a member of the Columbus Division of Fire, told the hospital to start evacuating patients. According to media reports, hospital security complied with the caller’s request and started wheeling patients outside, including disrupting more than 12 surgeries that were in progress. A fire investigator reported that it is believed the caller was listening to department radio transmissions and pulled off an impersonation. “He had our lingo down,” the investigator said. “He’s obviously been listening long enough to know what kind of wording we use. He did sound like our dispatchers, and he convinced Children’s Hospital to evacuate the building.” The hospital reportedly has changed its procedures and will no longer evacuate until the head of security and the battalion chief talk face to face.

PHONE SCAMMERS MISREPRESENTING HOSPITAL TO GET PERSONAL INFORMATION

St. Mary’s Hospital at Amsterdam, NY, according to press reports, is being misrepresented by unknown callers offering community members free health information, including items such as a free diabetic kit and monitor. Callers reportedly asked for an individual’s Social Security number or Medicaid card number as well as a date of birth.

A hostage training exercise at St. Rose Dominican Hospital, Henderson, NV, has resulted in the firing of the hospital’s security director. During the exercise, a man walked into the ICU with a handgun and ordered staff members into a break room and kept them there as hostages, according to press reports. The situation was similar to a March 2009 incident where a man walked into the hospital’s emergency room with a loaded weapon. Playing the assailant was an off-duty police officer. Staff members, including two nurses, two doctors, a respiratory therapist, the director of the ICU, the charge nurse and a house supervisor were held in the break room for 15 to 20 minutes, leaving patients unattended, with some staff members reportedly suffering traumatic effects.

The emergency drill was planned by the hospital’s heads of security, emergency management and the environmental care committee, she said. Hospital employees had criticized
previous drills as not being realistic, she reported, so the three
had “the best intentions” to make the drill worthwhile. She
said the hospital has revised its training policy and will require
announcements, signs and other communication with staff to
ensure the mistake does not happen again. The other two
employees involved in planning the drill were suspended and
then stripped of their positions.

SUICIDE ATTRACTION OF
MULTI-LEVEL GARAGES
The second suicide in four years at the four-deck garage of
Berkshire Medical Center, Pittsfield, MA, has prompted hospital
officials to seek further safety improvements, according to
press reports. Following the first suicide in 2006, when a
52-year old man, a psychiatric patient at BMC, jumped to his
death from the top story of the garage, the hospital added
security fencing to the garage’s third and fourth floors. (The
hospital had been sued by his family for wrongful death. The
case was settled out of court.) In August 2010, a 39-year-
old man, who was not a patient or employee of the hospital,
reportedly jumped to his death from the unfenced second
level.

GIVING ACCESS TO PHONY
DOCTORS
Delaware State Police are investigating three separate reports
of unlawful sexual contact at Christiana Hospital, Newark,
DE, over a two-week period, according to press reports. A
police official said the hospital waited two weeks to report
the incidents. The victims, all female patients admitted to the
hospital, claim that a man entered their rooms, in a white lab
care, posing as a doctor. The suspect then allegedly performed
a physical exam on the women and improperly touched and
fondled them before leaving. According to the hospital’s COO,
the three patients were in rooms on open-patient floors
where there was no need for a badge or credentials to visit or
gain access to the women, who were in different units of the
building when the incidents took place. Among area hospitals
reacting to the news of the imposter was a statement issued
internally by John J. Jordan, Security Manager, Shriners Hospital
For Children, Philadelphia, PA, which said: “There was a man,
posing as a doctor - entering rooms in the hospital and
inappropriately touching three patients. He wore a lab coat in
order to fit in with others on the unit. The Joint Commission
and PADOH mandate that hospital staff and physicians be
clearly identified in order for patients to be aware of who is
entering their room and what role that person plays in their
care. Identification badges should be worn at all times while
on duty and in a prominent place so the patient can easily see
it. Please be extremely conscientious about wearing your ID
badge when on the hospital campus, as well as asking anyone
who is unfamiliar - whether they are in “street” clothes or lab
carets/scrubs- where their hospital ID is.
Letter to the Editor:

Dear Editor:

I received the latest edition of “Directions” yesterday, and have to admit the best article, from my perspective, was that regarding the “Australian Healthcare Security Conference. The article is entirely correct and did hit upon some critical key points as well as observations by myself:

Healthcare security must have the ability, educational resources, training and professionalism to rise above other forms of security (be it contract or proprietary). And I believe that this writing addresses some serious key issues that warrant consideration in order for our profession and our organization to be able to provide to our many and varied members and associates.

In addition to the courses of instruction and certifications offered by IAHSS, serious consideration should be given to the designing and implementation of a Hospital Security Officer Pre-assignment Training course (to often officers are hired and thrown into the Healthcare environment without any education or training and are provided only limited OJT at best). The course should be no less than 8 hours in length and, at the very least, provide the newly assigned/hired officer a window into the arena of Healthcare Safety and Security.

Individuals providing training specialized Healthcare Training to both newly assigned and season personnel need to meet specific minimal requirements, be qualified, certified and periodically reviewed in order to teach Healthcare Related - Specific courses (just because an individual is a “manager or a trainer” doesn’t necessarily make that individual qualified to present courses or subject matter on Healthcare Safety and Security - perhaps, in fact, just the opposite).

Once the training has been conducted, as Mr. Irvine indicates, “the issue of training trace ability as well as drills and monitoring and reviewing procedures” MUST be adhered to in order to ensure all officers are trained, the training is so indicated in their personnel files and that he training is consistent and ongoing. In his closing sentence, Mr. Irvine states the causation for this need to foster professionalism and training in the Healthcare Security Professional when he says - “Significant responsibility is being mitigated toward the healthcare security personnel, but there is a need to ensure appropriate training is delivered to both the security officers AND the healthcare professional.”

If these factors were in place profession wide, perhaps (just perhaps) some of the incidents eluded to in the publication could have been prevented or at least minimized had the Healthcare Security Personnel involved received the proper “professional” training by QUALIFIED AND CERTIFIED Healthcare Safety and Security Professionals.

It was a great article and does reflect some of own personal and professional opinions. I would like to see some the suggested precepts at least considered if not put into action and would be willing to offer my services to assist in that venture.

Thank you,

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UPCOMING EVENTS

January 15, 2011
Nomination deadline for awards

May 22-25, 2011
43rd Annual General Meeting
The Fairmont Royal York,
Toronto, Canada
The shooting death of a gunman and his mother and the wounding of her doctor in mid-September brought the issue of hospital metal detectors to the fore once again. Although Johns Hopkins Hospital, Baltimore, MD, site of the shooting incident, has no immediate plans to add metal detectors to its entrances, other hospitals have taken this measure, either in response to or in advance of in-facility violence.

**Antelope Valley Hospital, Lancaster, CA**

Kawika Feltman, Director of Safety and Security at Antelope Valley Hospital, Lancaster, CA, has two metal detectors in place in the facility he oversees—one in the emergency department that was first installed in 2001 and a second in the women's and infant's pavilion, which is a separate facility with a single entry point. “Our emergency department is the second busiest in Los Angeles County,” he notes, second only to the University of Southern California. The 420-bed acute care hospital serves a 3,600 square mile area, says Feltman, and is the site of some gang activity.

Like all hospitals, Feltman says Antelope Valley has weighed the issue of keeping the hospital visitor and patient friendly with the need to provide adequate security. In fact, he says, hospital administrators have been looking at the idea of allowing 24/7 visitation, “but we would have to add more metal detectors.”

“If we did modify visiting hours, we would have those entrances staffed and it would change the staffing plan,” says Feltman. Currently, the hospital closes its doors to visitors at 8 p.m. and routes anyone coming in through the ED. “So it would have to be a whole re-education process,” he says.

**Dividing The Cost of Detectors**

The addition of metal detectors has been a cost borne by the hospital, while Feltman's department has picked up the cost of the additional personnel need to operate and monitor the equipment. The second metal detector in the birthing center in 2009 came about as the result of staff requests, says Feltman. The hospital handles 5,500 births a year.

The cost of one machine is about $3,000, he says, but there is also the ongoing cost of additional personnel to run it and training and competency issues so officers can troubleshoot any problems and better understand what they are dealing with.

**Conducting A Search**

Visitors and non-critical patients entering the ED pass through the metal detector and also have the bags visually checked. “It’s non-invasive,” he explains, “we ask people to open their bags.” Feltman says officers aren’t allowed to reach into bags, but rather they ask visitors to move items around as they look for obvious contraband, such as weapons or mace.

Every officer at Antelope Valley is trained on how to work at the two metal detectors. There are 10 to 12 officers per shift, he says, and they rotate responsibility. Everyone is also instructed periodically to maintain their competency on the equipment, which is calibrated quarterly, the use of handheld scanning wands. If officers do find a firearm or knife, they ask the person to secure the weapon in their vehicle before re-entering the hospital. “In our area, we find a lot of knives,” he explains, “but rarely do we confiscate items.” The ED isn’t equipped with an evidence locker, but
they do have weapons lockers for off-duty law enforcement personnel.

Feltman, who is the vice chairman for the Los Angeles chapter of the IAHSS, says he has spoken with other hospital security directors about the metal detectors at Antelope Valley and their policy. “Most hospital don’t have them,” he acknowledges, “but for me, I don’t want to take that chance.”

**Henry Ford Health System, Detroit, MI**

Nick Radu, CHPA, Director of Security for the Police Department at Henry Ford Health System, Detroit, MI, says the metal detector installed there was added in response to a shooting in the late 1980s. “We thought it was one measure we could deploy,” while renovating the ED. While Radu expected such a move to be met with some resistance from patients who often come from both urban and suburban areas to receive medical care at the city-based facility, that wasn’t the case.

During the pilot program, visitors had the option of storing items in lockers before heading into the triage area. But that proved to be ineffective, he says, because the lockers filled up and often people forgot to claim their belongings. Now, says Radu, everyone is screened before entering the waiting room. Incoming pedestrians have to go through the metal detector, which is staffed by two officers. One handles the belongings, which are placed in a basket, and the other monitors the person passing through the detector. If the alarm sounds, the officer uses a wand to do an additional scan.

**Radu: Why Metal Detectors Work In ED**

The types of items they look for, says Radu, are anything that could be used as a weapon: from the obvious guns and knives to the more subtle nail clippers and knitting needles. Anything illegal, like pepper spray, is confiscated. Legal items, such as guns carried with permits, are stored and the person receives a claim check. Bringing illegal firearms into the hospital can lead to prosecution, says Radu. His officers would make and process the arrest, while the city police would handle transportation. About 400 items are detected each month, says Radu, of which just a small number are illegal. In January, for example, they detected 427 items and eight were illegal knives. Between January and October 2010, security officers recovered six illegal handguns.

Radu says while violence within the hospital isn’t typically weapons related, the ED can be the site of conflicts, with heightened anxiety as people get upset over long waits or from those who are brought in because of mental health issues. Having a metal detector at the ED works, says Radu, because it doesn’t bring in the volume of visitors that the rest of the facility does. “It’s not practical to have it at other entrances,” he says, adding “the hospital is an open and welcoming-type environment.” Hospitals can’t expect people to wait in lines the way they do at the airports, he says. But fortunately, the wait times at the ED are minimal.

**Needed: A Second Person Round The Clock**

Metal detectors, says Radu, have become a standard for urban hospitals, noting all the ones in Detroit now use them. It’s common in trauma centers where EDs receive both the victim and the shooter; he says. “But we have seven other hospitals (in the system) and they don’t have it.” As to the cost and personnel requirements, Radu acknowledges running the detector requires a second person around the clock. The ED at Henry Ford already has two officers working; one at the entrance and the other at the ambulance entry.

Since installing the metal detector in 1987, it has been replaced three times, says Radu, and hand wands have also been replaced. “When we first did it, we also had an X-ray machine (to scan belongings). But it was so sensitive and we had to train our people to detect certain shapes when looking for objects.” It turned out not to be cost effective, says Radu, so they now rely on visual detection.

Radu says he and his staff find the metal detector useful, but acknowledges it’s not the answer for every hospital in every setting. “It’s common in urban settings,” he says, “and its one tool in our toolbox.”

**FOR FURTHER INFORMATION, CONTACT:**

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Contract Officers Trained in Threatening Behavior Identification Techniques

With more than 50 percent of its business focused on hospital and healthcare system security, Old Dominion Security (ODS), Richmond, VA, has instituted threatening behavior protection training as part of its program for hospital security officers. The security contractor's 700 employees serve clients in the Middle Atlantic States.

Rafe Wilkinson, Owner of ODS, says with the growing awareness that hospitals can be the site of violent acts by staff, patients and visitors, the company wanted to improve officers' observation and recognition skills. The training is delivered through several methods, he says, including classroom work and demonstrations, in-the-field practical use skills and routine written assessments of staff. “But it gets started with the clients recognizing the major threats and concerns,” he says. These can range from routine domestic incidents to those involving mass casualties and terrorist attacks.

Adding An Observational Component

Dan Schultheis, a member of the ODS management team, says while typically post orders for officers were limited to how to handle specific security-related tasks, “we believe in adding an observational component where they look at certain behaviors so they know what to look for and how to react.”

This type of security work, he adds, doesn’t typically come naturally, so it requires training and orientation on the types of behaviors for which they should look. Hospitals, especially emergency departments, are at risk from violent behavior that can result in verbal or physical violence. Wilkinson points out that training is handled both internally and through the use of outside resources. Modeled on Israeli-style bomb threat training, the skills learned by ODS officers can detect the threats more common to U.S. hospitals, such as gang violence.

A challenge with this and any type of training, says Schultheis, is marrying the family-oriented customer service aspect of hospital security with detecting and reacting to suspicious behavior. At one client, ODS moved its officers from inside to outside the entrance, having them nod to and acknowledge people coming into the hospital. By moving security to a more visible location and having them make eye contact, officers changed the perception of security, increasing their visibility and reducing incidents.

Among the actions that officers are trained on include the assailant mindset, gathering intelligence, counterintelligence, suspicious sign recognition, questioning and security procedure, knowing how to recognize a suicide bomber, identifying an explosive devise and emergency situation behavior. There is no recognized certification for this type of training, but having completed the coursework, which takes 1.5 to four days in the classroom with ongoing follow up, is noted in officers’ personnel files and can impact their pay grade.

Following Up Training With On-Site Testing

Although training is at the heart of the program, Wilkinson says officers can’t be trained once and then be expected to retain what they’ve learned. So teams from the organization go into facilities to test what the officers by having them respond to potential incidents. The response so far has been positive, says Schultheis, and plans are to roll out the training for officers in the company’s other security situations such as education, manufacturing and industrial, real estate, corporate, financial institutions, government services and construction. “Violent acts aren’t predictable,” he says, “so we want it to go systemwide.”

Making security officers better prepared is an asset to law enforcement as well, says Schultheis, noting that hospitals may have both private security and police on site. “We have a high regard for law enforcement,” he says, “but they are there mostly to detain. Our role is observing what might happen.”

Both Wilkinson and Schultheis acknowledged that training officers in behavioral observation skills give them a new skill set, while heightening the level of security they provide to the client. And it can be cost effective for the client, as they make better use of the officers they have on location.

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Elopement in Long Term Care Facilities:

Who Is Most Likely to Do It? When? What Can You Do to Prevent It?

In long-term care facilities, one of the greatest risks to elderly residents is their ability to leave the facility unseen and put themselves in harm's way. Called elopement, this is often associated with wandering, an act whereby the person is disoriented or unengaged in their environment and goes about seeking someone or something, or just wanders randomly.

Be Especially On The Alert In the First 48 Hours After Admission

Elizabeth Gould, MSW, Director of State Programs at the Alzheimer's Association, Chicago, report that people who wander persistently are the source of 80 percent of elopement cases. Additionally, she notes that 45 percent of these incidents occur with the first 48 hours of admission to the residence. For those in the role of protecting residents, including administrators, staff and security at long-term care facilities, Gould stresses it is important to understand why a person wanders so the necessary safeguards can be anticipated. For the elderly, especially those with cognitive issues, wandering may serve as a form of communication for both physical and psychological needs. Wandering may indicate something as elemental as needing to use the bathroom or wanting a glass of water, or it may be a reaction to something in the environment that is irritating to the resident. Other factors behind wandering include medical or emotional conditions or the desire for physical stimulation, such as wanting to feel the warmth of the sun. By understanding someone’s needs, says Gould, security and others may be able to anticipate what is necessary before the wandering or elopement takes place. Staff should be especially aware of these issues when a resident first enters a facility, because a new environment often triggers a desire to return home.

Have A ‘Lost Person’ Plan In Place

Gould says all staff involved with residents should be trained on the risks of wandering and the approaches for prevention. In its Dementia Care Practice Recommendations, the Alzheimer’s Association outlines several effective staff approaches, such as developing a care plan based on a resident assessment that allows mobility, but takes into consideration wandering patterns; working with residents to develop a feeling of safety and familiarity with staff; alerting staff about those who have a tendency to wander and under what conditions it may occur; and providing additional staff assistance as new residents adjust to the environment.

Facilities also should have a “lost person” plan in place that can be activated in the event of an elopement, says Gould. The plan begins with regular accounting for residents, such as at meal times and shift changes. Another component is developing a sign-in/sign-out policy for family and visitors who take residents out of the facility.

If an elopement does occur, having recent photos of residents and their former address is important so police can look for and follow up on exiting seniors. Management as well as family, law enforcement and state agencies as required should be notified when someone elopes from the residence and police should be provided with a description of what they were wearing. Within and around the facility, staff should carry out an organized search, keeping in mind that the person, especially if they have dementia, may not respond to their name.

Electronic Alarms: Staff Training Is Essential For Effectiveness

For some facilities, using electronic devices to track patients with memory or wandering issues provides an extra layer of prevention and protection. Al Arzola, Facilities Director at the 250-resident TLC Care Center, Henderson, NV, has used a cut band system from Accutech since March for the 20 residents of the facility’s Alzheimer’s unit. Residents in that part of the building wear wristbands with transmitters. The bands can set off different sounding alarms depending on the situation, he says. If someone is playing with the band, one alarm will sound, while a much louder, persistent one sounds if the band is cut. A softer alarm is triggered if a resident loiters in one spot for an extended period. And there is yet another alarm if they exit through the unit’s doorway.
Arzola says for staff, one of the biggest learning curves is recognizing the different alarms and responding accordingly. For those wearing the bands, the transition has been quite easy.

**Other Precautions To Reduce Elopement**

In addition to the alarm system, Arzola says TLC has taken other precautions to reduce elopement, such as having windows that only partially open and closing doors at 8 p.m. each evening so anyone leaving the building has to go through the front doors. All staff, from nurses and aides to housekeeping personnel is also trained on the signs of wandering and elopement, he says. Arzola notes that making sure the right residents are assigned to the proper units also helps with security procedures.

If a facility is going to use an electronic monitoring system, Arzola says there needs to be a review of the facility to see how easily it can be fitted for the system and if it continues to meet local and state regulations for fire and patient safety.

Even if a facility has an electronic monitoring system or uses wrist, bed or chair alarms for individual patients, Gould says it may be beneficial to enroll the person in the association’s Safe Return program—a nationwide program that helps identify, locate and return dementia patients to their homes.

**FOR FURTHER INFORMATION, CONTACT:**

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Al Arzola, Facilities Director, TLC Care Center, 1500 Warm Springs Rd., Henderson, NV 89014. Phone: 702-547-6700.
New Addition Spurs Five Hospital Integrated Access Control Upgrade

The building of the newest addition to Christus Santa Rosa Health System, San Antonio, TX, (CSRH-Westover Hills) has served as the impetus for the security department to install an integrated access control system.

“We were looking for new access control software that was expandable, web-based and not proprietary,” explains Mark Hart, CHPA, System Director for Security and Environmental Safety. “Westover Hills (opening) was the catalyst to go with a new access control system.”

Under its new system, five hospital campuses in South Central Texas are linked by the OnSite Se/XE access control system from Brivo Systems. The five hospitals represent 210 doors, along with 1,128 beds, about 3,900 employees and 2,000 physicians. “Before we had too many data bases,” says Hart, “but now we could use access control card throughout the system.”

Hart says it took between nine months and a year to coordinate the move to a new platform. Areas with special access control needs such as the pharmacy, medical records, and infant nursery all had to be switched over as well as all personnel. “Once we received all the information, we had to build the database,” explained Hart. Profiles were set up for new hires as well, giving them access to necessary areas such as the parking garage or one of the 126 other groups into which all employee access is organized based on privileges for various locations, days and time periods.

No Need To Hire Additional FTEs Thanks To Redeployment of Personnel

The process began with the new hospital, says Hart, because it was easier to build a database from scratch and then use that as the model at the existing facilities: CSRH-City Centre, CSR-Children’s Hospital, CSRH-Medical Center and CSRH-New Braunfels. The servers that support the system are located at Westover Hills. Although the software and access cards were updated, Hart says they were able to use some of the existing infrastructure at the doors.

“We were able to purchase and justify the software,” he says, and then looked at the age and connectivity of the existing hardware, such as the badge readers. The proposal presented to management showed that the technology could reduce physical security needs in some areas and allow for the redeployment of personnel. “We didn’t need to hire additional FTEs,” says Hart.

Exploring Tying System To Cameras, System Wide Lockdowns, Smart Card program

Hart says he is still exploring the different features and options provided by the access control system. The system isn’t tied into the surveillance cameras yet, “but that is the next phase.” Currently, he says, the department is mapping all the camera sites by facility to determine how to tie in cameras with access control. Because of the high number of doors, Hart says limiting the camera links to sensitive areas is being considered.

The new system also allows CSRH to move forward with its deployment of the FIPS-201-compliant smart card program. Hart has been involved with the Southwest Texas Regional Advisory Council, which is creating a universal ID card for its physicians. Brivo has programmed the HID badges used by doctors to be FIPS-201 compliant, he says, “which is a big convenience for doctors” who often move among hospitals in the system.
Another feature that is being explored, says Hart, is the ability to do individual hospital or system wide lockdowns from a single location. “We’re building that now,” he says, setting up icons that can be used to secure a hospital or the entire region.

As with any major security project, Hart says it’s important to have a plan, looking at how will the system be used, how will it integrate with what is already in place, and how best to transition employees from one system to the next. Fortunately, he says, for the end users of the system there wasn’t much for them to do. And for his own staff, it is a matter of learning to use all the features that the access control software provides.

Hart says although they haven’t used it yet, he is interested in tapping into the guard tour feature, which will allow him to audit where officers have been by having them access different doors. With so many options, it becomes a matter of prioritizing. “We have to take small bites for right now,” he says.

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U.S. Hospitals are key targets of the Global Threat Reduction Initiative (GTRI), part of the Department of Energy’s National Nuclear Security Administration (DOE/NNSA) worldwide mission to reduce and protect vulnerable nuclear and radiological material located at civilian sites worldwide. Hospitals, according to Kenneth Sheely, Deputy Director of NNSA’s GTRI program, can also be targets of terrorists seeking to acquire materials which can be used in a weapon of mass destruction, a crude nuclear bomb, or other acts of terrorism. To prevent this, NNSA’s efforts are aimed at removing unneeded nuclear and radiological materials or securing these materials still in use, Sheely says. Cooperation with GTRI is voluntary and federally-funded. These efforts include:

- Detection — installation of remote monitoring systems, access control devices, motion detection sensors, and cameras.
- Delay — deployment of in-device delay (IDD) mechanisms, tie downs, and hardened doors/rooms.
- Response — delivery of alarm response training and table top exercises for first responders.

Radiological Dispersal Services Commonly Used In Hospitals

There are thousands of civilian sites where nuclear and radiological materials are used for legitimate and beneficial commercial, medical and research purposes, the agency reports, including hospitals which are open environments. A Radiological Dispersal Device (RDD), deployed with amounts of material found in normal use, could result in radioactive contamination that could require relocation, prohibit the use of that area pending cleanup, and cause economic impacts in the billions of dollars.

Common examples of high priority sources located at hospitals, the agency reports, include devices with Cesium-137, Cobalt-60, and Iridium192 in quantities greater than 10 curies (Ci). Typical devices include:

--Blood Irradiators (commonly found in blood bank facilities) — thousands of Ci of Cs-137
--Research Irradiators (commonly found in cancer research facilities) — thousands of Ci of Cs-137 or Co-60
Cancer treatment devices such as:
Gamma Knives — thousands of Ci of Co-60,
Teletherapy devices – thousands of Ci of Co-60,
High-Dose Rate Brachytherapy devices — tens of Ci of Ir-192 or Cs-137

The Terrorist Threat To Hospitals

The United States domestic territory continues to be a target of terrorists. Terrorist tactics are constantly evolving and have recently included the use of U.S. citizens and facility insiders. These adversaries are often self-radicalized and extremely difficult to detect. In addition, adversaries around the world continue to be interested in “dirty bomb” materials, Sheely warns. Since 9/11 there have been several global incidents of lost or stolen radioactive materials and disrupted plots to deploy RDDs, he says. This presents a potential threat to research facilities, hospitals, and universities that house high-activity radioactive sources or nuclear materials.

NNSA’s GTRI Domestic Security Enhancement Program

DETECTION

Through GTRI, NNSA offers voluntary security enhancements to prevent and detect unauthorized actions. Detection upgrades include biometric access control device, door alarms, motion sensors, cameras, radiation sensors, electronic tamper indicating seals, area radiation monitors, and remote monitoring systems.

NNSA provides support to regional, state, and local organizations that are interested in monitoring the nuclear and high-activity radioactive materials within its boundaries. This enables first responders to have additional situational awareness about any attempted attack at nuclear or continued on next page
radiological material sites. GTRI Remote Monitoring Systems (RMS) are critical to addressing the insider threat and improving alarm communication and local law enforcement response. The RMS integrates critical alarms (e.g., irradiator tampering, radiation, communication/power loss) with video images in a tamper-indicating housing with battery back-up. The RMS encrypts the video and alarm data and sends it simultaneously to on-site security and off-site local law enforcement to prevent single-point failure in alerting armed responders to a potential theft. The RMS can also be monitored by off-site commercial monitoring companies.

**DELAY**

Through GTRI, NNSA provides delay enhancements that impede an adversary’s progress to access nuclear materials and radiological sources. By increasing delay, first responders have more time to interrupt the adversary before they can remove and then steal these materials. These delay systems include:

- Device tie downs and security cages
- Security grating
- Hardened doors/rooms
- Bullet proof glass
- In-Device Delay kits

In cooperation with NRC and the Department of Homeland Security, NNSA partnered with cesium irradiator manufacturers to develop In-Device Delay (IDD) kits for the most widely used models of cesium chloride (CsCl) blood and research irradiators. Through GTRI, NNSA currently funds the installation of IDD kits for Best Therotronics (Nordion) Gammacell 40, 1000, 3000; JL Sheppard Mark I 68, 68A; and Pharmalence (CIS) IBL473 at volunteer facilities. IDD enhancements add a set of protection hardware, including hardened security plates and tamper resistant fasteners to the irradiator which greatly increases delay times without affecting normal operation, use, and maintenance.

**RESPONSE**

NNSA provides site personnel and first responders with specialized tools and training to respond to a security incident at civilian sites with radiological materials. This response support includes enhanced radio systems and repeaters, personal radiation detectors (PRDs), central alarm station hardening, RMS alarm review stations, Alarm Response Training, and Table Top Exercises.

**Three-Day Course At Oak Ridge, TN**

GTRI offers a three-day course, which is held at the NNSA Y-12 National Security Complex in Oak Ridge, TN. This training:

- Teaches site security and local law enforcement how to protect themselves and their communities when responding to alarms indicating possible theft of civilian nuclear and radioactive materials. Includes realistic scenarios using radioactive sources, irradiators and security equipment.
- Provides classroom instruction and hands-on exercises.
- The course is certified by the Department of Homeland Security. Through GTRI, NNSA pays for all attendee costs except for salary (e.g., travel, lodging, car rental, and per diem).

**NNSA/FBI One-Day Exercise**

NNSA and the Federal Bureau of Investigations (FBI) sponsor no-fault, site specific scenarios where officials can exercise their response to terrorist acts involving nuclear and radioactive materials. The exercises:

- Promote cross-sector communication, cooperation, and team building among federal, state, local, and private sector first responders.
- Examine newly developed tactics, techniques, and procedures resulting from GTRI voluntary security enhancements.
- Offers a one-day exercise conducted in near-real time game play customized to the site-specific realistic events based on FBI threat information, and video injections with mock-media involvement for fast paced action.

**Costs And Commitments**

NNSA voluntary security enhancements are federally-funded, Sheely explains. The security assessments, equipment procurement and equipment installation are all paid for by GTRI. A 3 – 5 year maintenance and warranty contract is also funded by GTRI for all equipment. GTRI also pays for the travel related expenses (airfare, car rental, hotels, and meals) associated with the 3-day Alarm Response Training course outside of Knoxville, TN. The only expense to the institution not covered by GTRI is the salary cost of the people from these institutions (Radiation Safety and Hospital Security staff) that are attending the training courses or assisting with the coordination of the voluntary security enhancement effort on behalf of the institution.

In addition, he says, GTRI does require a good faith commitment from the site to operate and maintain the installed equipment after the GTRI-funded maintenance and warranty period expires – this annual expense should be minimal for most hospitals (however, GTRI will consider funding extended maintenance and warranty contracts on a case-by-case basis).

**FOR FURTHER INFORMATION, CONTACT:**

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Q & A – IAHSS Healthcare Security: Basic Industry Guidelines

Q- Why does IAHSS produce industry guidelines?
A- The guidelines are intended to assist healthcare administrators fulfill their obligation to provide a safe, secure and welcoming environment; while carrying out the mission of their healthcare organization.

Q- How do the guidelines get produced?
A- In support of the IAHSS strategic plan and its members, the Association has established a Council on guidelines responsible for researching topics and developing and implementing healthcare security basic industry guidelines.

Q- Who are the members of the Council on Guidelines?
A- The Chair of the Council is appointed by the IAHSS Board of Directors for a two year term and the chair is responsible for the membership of the Council. The six to eight Council members are diverse in the geographic areas and healthcare business models they represent and all are IAHSS members in good standing.

Q- What process does the Council follow to write and produce a guideline?
A- A Council member is appointed to lead the production of a particular guideline and is responsible to manage the guideline through production to implementation. The following process is followed:

- A first draft is produced by the designated Guidelines Council member—the draft may be written with other subject matter experts with an interest in a particular subject.
- The draft is closely reviewed by all Council members, individually and collectively. Multiple iterations of this process occurs until a draft is initially approved by the Council for IAHSS membership review.
- The revised draft guideline is distributed to the IAHSS membership via Survey Monkey. The membership is asked to review the guideline, rate their acceptance of the individual guideline as presented and provide additional comments.
- Survey feedback from the IAHSS membership is invaluable. This feedback is closely reviewed by the designated Council member responsible for production and the entire Guidelines Council. Additional iterations of the Guideline are made to reflect membership input and again vetted within the Council until a draft is submitted for approval by the IAHSS Board of Directors.
- The final step in the approval process of a new Guideline is the approval by the IAHSS Board of Directors.
- Approved guidelines appear on the IAHSS website – Members Only section under “guidelines”.
- A booklet containing all the IAHSS guidelines is sent to IAHSS members each year – usually at the beginning of each calendar year.

Q – Why don’t the guidelines provide more detail, they seem very general in the way they are written?
A- At present the guidelines are intended to provide a framework or higher level guidance to security leaders in healthcare. The Council works to ensure each Guideline is as applicable to a 10 bed rural hospital with no security personnel as it is to a 700-bed inner-city hospital with a security director and a comprehensive security program.

Q – There seem to be general references like “accreditation” and “regulatory body” and so on in the content of many of the guidelines. Why is the Council not using terms like “The Joint Commission” and other broadly recognized entities in the guidelines?

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A – In addition to ensuring that all guidelines can apply to any size facility and in all US jurisdictions, the Council must also apply an international “lens” to each guideline and ensure the guidelines have utility in all of IAHSS partner countries including Canada, the UK, Australia and others.

Q – How can I become involved and support the work of the Guidelines Council?

A – First by using the guidelines in your organization and ensuring they are made available to your key internal and external stakeholders. The process also benefits greatly if you respond to the Survey Monkey and provides the Guidelines Council with needed feedback on new guidelines – you can help shape the guidelines but we really do want and need your input each and every time! Finally you can actually help write the guidelines and allow the Council to benefit from the tremendous knowledge base we all have access to through the IAHSS membership.

Q – If I wanted to help write a guideline, how would I do that?

A – Contact the Chair or any member of the Guidelines Council and express a willingness to help produce a guideline you are interested in. Contact information is available in your guidelines booklet or on the IAHSS website in the members- only guidelines section.

Q – How will I know how the Council wants a draft guideline written – is it in a specific format?

A – In addition to receiving information from the Council when you contact them, there is a reference document “How to Write a Draft Guideline” in the annual guidelines booklet and in the members-only section of the IAHSS website under “guidelines”.

Q – How does the Council decide which guidelines are written?

A – First through the feedback from the membership on the Survey Monkey response to individual guidelines – a section there allows the members to request specific guidelines be produced and these requests are tracked by the Council. As well, the Council maintains a master list of guidelines still to be produced and prioritizes these guidelines each year, based on member input and industry requirements.

Q – How many guidelines does the Council produce?

A – The Council typically produces six guidelines each year as a part of their commitment to the IAHSS Strategic Plan.

Q – I’ve submitted specific comments and suggestions in the Survey Monkey response in the past but not seen the final product reflect my input. Why is that?

A – Keep in mind the previous comments on the need for the guidelines to be applicable to all facility types and sizes and in other countries – sometimes member comments relate specifically to their facility or state. If you want to speak to a Council member about your comments on the Survey Monkey please ensure you indicate that in the last section of the survey and provide your contact information. A Council member will contact you.

Q – I notice some of the guidelines date back to 2006 – how does the Council make sure these guidelines are current?

A – The Council is responsible to ensure each Guideline is reviewed for accuracy and currency annually. The Council has established a process to ensure this commitment is met and the most current revision date appears on each guideline.

Website

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