Publication of the International Association for Healthcare Security & Safety

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Letter from the President:

In the last Directions it was noted that the Australian/New Zealand Chapter had been formed and they held their inaugural/charter meeting on July 8th, 2011. They recently held their first follow up regular chapter meeting on September 1, 2011 at the St. Andrew’s War Memorial Hospital hosted by the chapter chairperson Chris Rasmussen who is the Security Manager at the hospital. Congratulations to all the chapter officers and members and Bruce Irvine, Regional Chairperson for all their efforts as they move forward building this new International Chapter!

IAHSS and Reed Expo Services have entered into a strategic relationship. For those of you not familiar with Reed, they own the ISC West and ISC East Solutions conventions that are held each year in Las Vegas and New York City.

You may have read in the IAHSS E-Zine alert that IAHSS is jointly marketing the ISC Solutions program being held in NYC the first week in November. IAHSS will have a two day educational track at this event and ISC will promote our educational sessions to all attendees. IAHSS members will also be able to take advantage of discounted hotel room rates negotiated by Reed. If you have never been to NYC this might be your chance to attend a great healthcare security educational session and meet hundreds of security manufacturers and suppliers of goods and services at the exhibit hall. It will be held on November 2nd and 3rd, 2011 at the Jacob Javits Convention Center.

Complete information is posted on the IAHSS website and can also be found on the ISC Solutions website; it’s coming soon but you still have time to register. Special thanks to Marilyn Hollier, Ben Scaglione, Evelyn Meserve and all the members of the IAHSS Educational Council for their work on this educational program. If this event goes well IAHSS and ISC may do more joint programs in the future.

September 1st was the cut-off date for submitting interest to run for the IAHSS Board of Directors. There were three positions open, President –Elect, V.P./ Treasurer, and...
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Serving hospitals nationwide with local offices throughout the nation.
As the final quarter of 2011 approaches, IAHSS focuses on several upcoming events.

The election will be conducted to fill the vacancies for 2012 on the Board. Electronic ballets will be distributed to all members and we hope you will participate in the election.

IAHSS and ASIS Healthcare Council are teaming with Reed Expo to provide an educational program at the ISC Solutions in New York. This is an event that has been in progress for several years and we are excited it is coming together this year! We hope you will join us.

IAHSS will be exhibiting at ISC Solutions in New York in November as part of our outreach program to improve the visibility of IAHSS.

The 44th AGM will be held in Las Vegas in May, please start planning now to join us!

The Councils and the Commission remain hard at work and the volunteers are greatly appreciated. Without them, IAHSS would not be who we are!

Take a deep breath, the holidays are approaching.

Always,

Evelyn

Member-at-Large. There were three people that submitted applications, Lisa Pryse, Marilyn Hollier, and Martin Green; all are great candidates and deserve our thanks for stepping up. Please consider getting involved in the leadership of your chapter or putting your name forward for an IAHSS Council or Commission, or maybe the Foundation Board. The IAHSS membership has grown over the past few years and every member is encouraged to get involved in the leadership roles of IAHSS.

Hopefully you will make it to New York City the first week in November, see you there!
For members of the IAHSS, the fall of 2001 presented the stark realization that in the twenty-first century safety, and especially security, of healthcare facilities was entering a new era, one in which such entities were considered by gang member, disturbed individual and terrorist alike as desirable targets upon which to focus their personal societal agendas and vent their anger. From the morning of 9/11 the focus of security professionals became hardening the target.

Entering the century’s second decade it may be appropriate for IAHSS members to take time out to reflect upon the precepts of their chosen profession.

Webster is an appropriate starting point:
Webster’s New Collegiate Dictionary © 1959

Profession: the occupation, if not commercial, mechanical, or agricultural, or the like to which one devotes oneself; the learned professions of theology, law and medicine.

Ethics: The science of moral values and duties; the study of ideal human character, actions and ends. Moral principals, quality, or practice.

Integrity: Moral soundness; honesty; uprightness.

Webster’s New World Dictionary © 1978

Profession: a vocation or occupation requiring advanced education and training, and involving intellectual skills, as medicine, law, theology, engineering, teaching, etc.

Ethics: the study of standards of conduct and moral judgment

Integrity: the quality or state of being of sound moral principal; uprightness, honesty, and sincerity.

These principals are implicit in the charters and by-laws of the IAHSS and IHSS Foundation. There was little change in the definitions over the decade between granting of the two charters. In the years since what has changed is the lessened focus placed on those tenants.

The IAHSS expects the primary duties and responsibilities of its members are those of the security/safety profession. In turn the members anticipate the IAHSS leadership be equally dedicated to the security/safety profession.

Integrity and ethics provide the strength of the profession’s solid foundation. Throughout the daily fulfillment of their duties/responsibilities leaders are challenged to consistently exercise integrity and ethics, and in so doing set positive examples for peers, coworkers and subordinates.

The IHSSFoundation Recognition Program annually honors those whose individual acts or actions have reflected most favorably upon the profession while, at the same time highlighting the ethics of behavior and integrity of purpose both of the individual and the entity on behalf of which the acts or actions were executed.

Similarly the Scholarship Program encourages attainment of advanced professional competency through education - an intense endeavor for which ethics, integrity and honorable behavior are prerequisites.

The Grant Program provides for development of the knowledge and expertise essential to guiding the profession in fulfillment of the goals and the objectives incumbent upon its practitioners.

The Commission Program envisions promoting scientific investigation of fundamental issues encountered by healthcare security and safety professionals and in so doing establish certain universally recognized guidelines and standards.

Efforts during the past eighteen months include:

The IHSSF 2010 Crime Prevention Survey (www.iahss.org)
The IHSS 2011 Prisoner Escape Study
Journal of Healthcare Protection Mgmt
Volume 27, Number 2 (Pages 38 - 58)


In summary - ethics, integrity, professionalism are the driving forces of the mandate set forth in the charter and by laws of the IHSSFoundation.

As the IHSSFoundation continues its thirty-first year (2011), a call for Recognition Program nominations has been issued. Submissions may be forwarded at anytime subsequent to Monday, 30 May 2011, and continuing through Sunday, 15 January 2012. Nominations may be submitted by any IAHSS member in good standing, an executive of a healthcare facility/institution, or contract security provider employing an IAHSS member in good standing.
ED Metal Detector Becomes Hospital’s First Line of Defense Against Violence

Opened just last year, the new wing that houses the entrance to both the Tacoma General Hospital and Mary Bridge Children’s Hospital, Tacoma, WA, is also equipped with a metal detector meant to aid security in policing one of the most volatile areas of the facility.

In a recent series on workplace violence, Washington public radio station KUOW noted healthcare workers in the state are six times more likely to be the victim of violence than the state average. Gary Barth, CHPA, Director of Security, Safety, Grounds and Transportation for MultiCare Health System, says the statistics cited by the radio station’s report isn’t surprising. Hospitals, and especially emergency departments, are high-stress areas. Also, he says, healthcare workers are very comfortable with the reporting system for any kind of incident, and that may skew the numbers toward healthcare being a more dangerous profession.

With that in mind, Barth says his department has focused on making the ED one of the safest places in the hospital. Anyone who wants to enter the emergency department at either Tacoma General or Mary Bright must first pass through a metal detector and surrender guns, knives or any “edged” weapon.

Knives, Guns, Brass Knuckles

Installed for less than a year, Barth says when the metal detector was first put to use, security personnel allowed visitors to keep knives with a blade of less than 4 inches. “But now we don’t allow anything considered a weapon,” he explains. As a result, the hospital finds about 300 knives per month, along with other potential weapons such as guns, pepper spray, batons, brass knuckles and even the occasional baseball bat.

If someone does have a contraband item with them, they can either store it in their car until their visit or stay is over, or they can check it with security and have it locked up. Because the ED offers valet parking, Barth says sometimes a person’s car has already been moved by the time a knife or other item is discovered. In that case, it is put in a locker and returned upon exiting the building.

4.5 Full Time Officers Added to Man Detector

Adding the metal detector required adding 4.5 full-time employees to the security rolls, says Barth, because the machine and area needs to be manned 24 hours a day. This was the health system’s first experience with a metal detector, he says, and there aren’t any plans to add such units to the other hospitals in the MultiCare system. In addition to Tacoma General and Mary Bridge Children’s, MultiCare operates Allenmore Hospital in Tacoma and Good Samaritan Hospital in Puyallup. “This is a pilot project,” he says, noting that with the current economic situation and changes on the horizon for Medicare reimbursements, it isn’t likely the health system will have funds for equipping other facilities with metal detectors.

Having to go through a metal detector hasn’t been a problem for most visitors, says Barth. “We’ve gotten very little push back,” he says, adding that most people are used to experiencing metal detectors in government buildings and airports.

continued on next page
The other hospital entrances at Tacoma General are not monitored with detectors, nor does staff man them all. Barth says it was a matter of putting resources where they were most needed, which was in the emergency department. And within the ED, there are additional hurdles for visitors that are designed to ensure the safety of staff.

**ADDITIONAL ED SAFETY FEATURES**

To even get into a treatment area, a patient needs to be “buzzed in” or they must have a card for access. Within the individual treatment rooms, a large red panic button is positioned by the door so if a doctor, nurse or staff member has a problem, they can push it to summon security. Additionally, pushing the panic button will trigger a camera within the room to begin viewing and recording activity, says Barth, and cameras outside of the room become focused on the location in trouble, so security can see what is going on both inside and outside the space. An alarm is sounded as well within the dispatch center.

Barth says there are about 50 rooms within the ED that are equipped with the alarms. There are also two safe rooms that are used for high-risk patients. If a patient in one of these rooms becomes violent, staff can activate a security feature that brings a wall down to protect the cabinets and examination items so these fixtures and implements won’t become weapons. Even the card access unit mounted on the wall is protected so the person can’t remove it. There is also a decontamination room within the ED, he says.

MultiCare has 40 full-time security officers covering the four hospitals, says Barth, who are equipped with batons and handcuffs, but are not armed with guns, tasers or pepper spray. Barth says both tasers and pepper spray have issues associated with them. There is concern that use of a taser will cause a heart attack, he says, and as a cardiac care facility, Tacoma General doesn’t want to run the additional risk. With pepper spray, he says, once it is used, the entire area needs to be evacuated—something he has experienced when such products where brought into the ED previously and used by patients or visitors.

Rather than rely on use of weapons or force, Barth says his officers are all trained in non-violent crisis intervention techniques, as are many of the hospital staff members. “That’s one of the best tools we can give our employees,” he says.

Barth also sees the new ED, with its comfortable seating, big screen TVs and ample waiting rooms as a deterrent in itself. “If you put in a nice waiting area and make it comfortable, that helps,” he says. Most people coming to the ED are already stressed out and can benefit from a pleasant, calming atmosphere.

**BARTH: ‘UPGRADE CAMERAS AND CARD READERS’**

But seeing the metal detector and the presence of security at the entrance is also a disincentive to violence or unruly behavior, he says. Although it was too soon to give statistics on how the new ED and metal detector have impacted incidents, Barth says anecdotally he has seen a reduction.

Looking ahead, Barth says his department is constantly upgrading its cameras and card readers to improve security and lessen the reliance on individuals. “I can’t emphasize enough,” he says, “the importance of cameras and card readers. Because of the economy, we can’t hire more FTEs, so we have to look for other ways to provide coverage.”

Barth says he has a 24-hour dispatch center monitoring more than 2,000 cameras and card readers and several hundred panic alarms for protection of the 9,400 employees MultiCare has across five counties at all of its hospitals, clinics and outpatient facilities.

**FOR FURTHER INFORMATION, CONTACT:**

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Cleveland Clinic Police Department Wins CALEA Accreditation

The Commission on Accreditation for Law Enforcement Agencies Inc. (CALEA) has announced the accreditation of The Cleveland Clinic Police Department, making it only the second hospital in the country to earn this honor. The purpose of CALEA accreditation, according to the Commission, is to improve the delivery of public safety services, primarily by maintaining standards, developed by public safety practitioners, covering a wide range of up-to-date public safety initiatives.

Cleveland Clinic Police Department officials, who began the application process three years ago, made several changes and process improvements to comply with nearly 400 CALEA standards. The standards cover a broad range of topics including everything from recruitment to training, evaluation and record keeping. In addition, they developed more than 180 new policies and protocols.

“We are honored by this accreditation and it reinforces our goal, which is to provide the safest environment possible for anyone who comes to, or works at, Cleveland Clinic,” said Randy Stephan, Cleveland Clinic’s Chief of Protective Services. “By making this commitment and implementing the best practices in law enforcement, we have positioned our officers to have the highest and most comprehensive standards that help deter, detect and protect those who entrust us with their care.”

Commissioned in 1987, the Cleveland Clinic Police Department is the third largest police force in Northeast Ohio.
For nearly a decade, Rex Healthcare, Raleigh, NC, has offered its employees a multi-disciplinary plan for dealing with domestic violence. Over the years, Michael Hoke, Investigative Officer for Protective Services at Rex, has refined the program, basing his changes on the experience of dealing with more domestic violence cases.

“Statistically, this is the biggest security threat we face” says Hoke. “We owe a debt of gratitude to the 150-plus victims who have shared their needs with us because we have learned and improved with each of their experiences.” Although each case is unique, Hoke says the classic domestic violence situation is one in which a female victim has received a 10-day protective order, and then gone before a judge to increase that time to one year. “I can’t recall a case where a judge didn’t grant a one-year protective order,” he says. With that order in hand, the victim knows that if the person cited in the order violates it, they will be arrested. North Carolina’s law is stricter than some, says Hoke, and results in an arrest rather than a warning or a discussion with police.

From the healthcare systems standpoint, Hoke says communication is one of the most important elements. Sometimes victims don’t want anyone to know what is happening in their life, so they omit telling security, their supervisor or their co-workers what is happening until something occurs.

THE FIRST QUESTION TO ASK A THREATENED EMPLOYEE

If a woman does come forward, Hoke says the first question he asks is if the offender knows where they work, including the specifics of which facility and even which department or floor in the hospital. The less the offender knows, the easier it is to shield the victim.

Still, says Hoke, each case gets a file that now includes a photo of the offender as well as the victim. If the offender has a criminal history, it can be easy to get a photo through local law enforcement, he says. Putting the victim’s photo in the file means when officers respond, they know exactly who to look for and offer protection. There is also an extensive history about the offender, including his description, criminal history, ownership or use of weapons, alcohol or substance abuse information, job information, military background and physical strength or special martial arts training.

Hoke says while the information is shared among the security staff, he doesn’t bring in the person’s supervisor or co-workers unless she wants him to do so. “If you are in the safety plan business,” he says, “you have to keep the comfort level of the victim in mind.” Fortunately, says Hoke, about 75 percent of victims will share this information with co-workers and managers, and may even want one of those people to be the conduit between the victim and security. Because other employees could be in harm’s way if the offender shows up at work, Hoke prefers to keep as many people in the loop as possible.

In addition to putting the photos and offender profile in the file, Hoke also adds the victim’s work schedule and a copy of the protective order. He also asks if there is anything else security can do. Making a person feel comfortable means they are likely to continue to share information about their situation, he says. “The biggest lack of comfort on my part is that they (the victims) won’t contact us again,” he explains. In those instances, especially if nothing happens in the workplace, the case can move down the list from a priority to just an ongoing case.

TOP CASES ARE PART OF THE WEEKLY SECURITY BRIEFING

The top cases are part of a weekly briefing with the security staff, says Hoke. “We brief our staff on the three to six most serious threats,” he says, including reviewing the initial threat assessment and providing any new developments, such as if the abuser has returned to the area or come home from a military deployment.

In the nearly 10 years that he has been offering the program, Hoke says he has dealt with about 150 victims, mostly women but a handful of men as well. In addition to abuse, sometimes the victim is dealing with a stalker or someone who is paying unwanted attention to a staff member.

DEALING WITH STALKERS, LETTER-WRITERS

Hoke says often these offenders are “men of a certain age, who are alone and want to keep contact with the woman” who may have been their nurse or other caregiver during a hospital stay. Because stalkers can be unknown or unthreatening, Hoke says his department often deals with these types of incidents directly more often because there is no protection order involved and thus no threat of arrest. Stalking or abuse that happens via phone or computer can be dealt with if the offender is calling on the hospital line or using a hospital-issued email. But if they are
contacting the victim on her own cell phone, then the victim must bring in the local police, he says. “We can send him a caution” if it involves our office or business lines, he says.

“We have had several instances of convicted criminals seeing photos of or reading about our employees in on-line news media and then writing that person a letter,” says Hoke. In those cases, he says, “we research his criminal record and release date and brief the letter-recipient on that info.” Hoke recalls that one of these inmates wasn’t due for release until 2115.

While most victims remain in their job locations, in extreme cases, says Hoke, they will move someone to another Rex Healthcare facility. But that type of move is done only rarely because it can leave the co-workers in a vulnerable position if the offender shows up and makes demands or threats. Because there is no private security in the long-term care facilities or some of the outlying clinics, Hoke says victims will have to rely on local law enforcement for help, so he often briefs those departments about current cases.

**HOKE: ‘IF YOU DON’T PUBLICIZE YOUR PROGRAM, YOU DON’T HAVE A PROGRAM’**

While Rex Healthcare has had a program for a while, Hoke says he is always making sure to improve communication between his department and potential victims. “If you don’t publicize your program, you don’t have a program,” stresses Hoke. “Every time I hear of a domestic violence-related workplace attack, I question whether the victim asked for help ahead of time.”

In 2006, says Hoke, The Rex Hospital Foundation gathered grants and sponsors for a statewide Workplace Protection of Domestic Violence Victims Symposium. More than 130 businesspeople, law enforcement officers, human resources managers and risk managers attended the event. Hoke says he still gets calls from attendees asking about how Rex has handled certain security issues related to domestic violence.

Hoke says Rex continues to have a domestic violence awareness program each year and publicizes its program through meetings with new employees and volunteers, brochures, signage, training and the hospital’s website. “We think we are doing an ‘A’ job on publicity,” he says, but we would like it to be an ‘A+’ program.”

**FOR FURTHER INFORMATION, CONTACT:** Michael Hoke, Investigative Officer for Protective Services, Rex Healthcare, 4420 Lake Boone Trail, Raleigh, NC 27607. Phone: 919-784-2065. E-mail: michael.hoke@rexhealth.com

Additional details on Rex Healthcare’s domestic violence program can be found in the article, “One Hospital System’s Safety Plan for Domestic Violence Victims beginning on page 56 of the Journal of Healthcare Protection Management, Volume 21, No. 2, Summer 2005.”
IN BRIEF:

GUNS IN HOSPITALS

CITRUS MEMORIAL STAFF THREATENED BY GUNMAN
INVERNESS, FL. Security and staff at Citrus Memorial Health Systems were able to barricade and subdue an armed, agitated patient who was threatening people with a gun he pulled from his wife’s purse, according to news reports. The 71-year-old man, who was a patient on the critical care unit, became agitated and wanted to leave. When he pushed a nurse as he walked toward the doorway, she called a code, which alerted a co-worker. As the co-worker tried to get the patient back to bed, he pulled the gun from his wife’s purse and pointed it at the man’s head. He then began pacing the hallway, while still armed. After 20 minutes, staff and security were able to corner the man in the critical care unit and the individual initially called by the nurse was able to disarm the man and bring him to the ground. A plain-clothed deputy, who took the man into custody, assisted him. The wife said she always carried a firearm for safety and had a concealed weapon permit. The patient was charged with aggravated battery with a firearm and aggravated assault with a firearm.

MAN SHOOTS ESTRANGED WIFE AT HOSPITAL
NAPLES, FL. Before security was able to respond, a 54-year-old man killed his estranged wife and then turned the gun on himself in an incident on July 5. The man entered Physicians Regional Healthcare System–Pine Ridge carrying two loaded guns and an extra pistol magazine, according to news accounts. His estranged wife was visiting a male friend when her husband entered the room and, after cordial greetings, an argument ensued. The male patient told a nurse to summon security, but the man shot and killed his wife and seriously injured himself before anyone could intervene. The shooting was attributed to an ongoing domestic dispute. The woman had filed for divorce a few weeks earlier to end their 37-year marriage. According to the couple’s son, the man had spoken before about suicide and killing family members and had fired a gun into the air during an argument involving his son. In that shooting incident in August 2009, no charges were filed because the wife told a judge her husband wasn’t a threat. Physicians Regional, in a statement issued after the event, said it was reviewing its emergency protocols and credited security personnel and emergency management preparation for actions taken in the aftermath of the event.

DOMESTIC DISPUTE LEADS TO SHOOTING IN HOSPITAL PARKING LOT
WHITEVILLE, NC. A 51-year-old woman who had been under police protection at her job because she had received threats from her estranged husband, was shot in the head and killed by him as she was leaving Columbus Regional Healthcare System in Whiteville after visiting her mother, who was a patient there, according to TV news accounts. The shooting, which took place in the hospital’s visitors parking lot, occurred at 7 a.m. Also injured was the woman’s boyfriend, who was shot in the leg and taken into the hospital for treatment. After the incident, the shooter drove to the Columbus County Sheriff’s Office and surrendered.

SECURITY OFFICER SHOOTING REMAINS UNSOLVED
PORTLAND, ME. More than three years after it occurred, the shooting death of a 27-year-old security officer at Mercy Hospital remains unsolved, according to newspaper accounts. The officer, who was unarmed, was on patrol at 4 a.m. around the exterior of the hospital when he was shot in the back of the neck in the hospital parking lot. Police have attributed the shooting to a nearby drug transaction and say the security officer was a random victim of a confrontation during the drug sale. A $30,000 reward, posted by Mercy and Portland’s other hospital, Maine Medical Center, has been set as an incentive to get more information about what occurred that evening. A surveillance photo from a nearby business captured grainy images of two people in the vicinity when the shooting occurred.

MED CENTER SECURITY, POLICE APPREHEND MEN SEEN WITH GUN
SPRINGFIELD, MA. Security and local police acted quickly to arrest three suspects after a witness sighted a man with a handgun at Baystate Medical Center. The three were each charged with being a disorderly person and carrying a firearm without a license. According to news report, the suspects entered the hospital to visit someone and were spotted with a handgun. Security was notified and officers in turn contacted local police, who arrived within minutes. Witnesses provided security and police with descriptions of the three men and they were encountered and arrested leaving one of the buildings at Baystate. Although the weapon wasn’t initially found, a search continued and state police became involved in the investigation.
HOSPITAL CAMERAS PROVIDE INFO ON ARMED WOMAN

MARTINSBURG, WV. Using security surveillance cameras, officers were able to view and track the movements of an armed 51-year-old woman outside of City Hospital. According to news reports, security officers first spotted the woman, who was distraught and intoxicated, as she was sitting in a vehicle in the parking lot, holding a gun to her head. As she exited the vehicle, she began to walk around the exterior of the hospital, and her movements were viewed on the security cameras. At one point, reports state, she fired a round into the air. She then put the gun into her purse and entered the hospital’s outpatient waiting room. The woman, who passed out at the police station after her arrest and was returned to the hospital for treatment and psychiatric care, was eventually charged with discharging a firearm within city limits and carrying a concealed deadly weapon.

ER STAFFERS PREVENT ARMED WOMAN FROM ENTERING

WINCHESTER, TN. Staff members in the Emergency Department at Southern Tennessee Medical Center denied access to the hospital via its secured entrance to a woman who was carrying a gun and fired shots into one of the hospital’s exterior walls. The woman, whose actions were captured on hospital surveillance video, rode up to the hospital ED and tried to gain access through a secured, sliding ambulance door that required a key code or swipe card for entry. Hospital staffers denied her access when she approached. After shots were fired into the building, she left in a pick up truck, according to TV news reports.

HOSPITAL ED SITE OF MAN’S SUICIDE BY HANDGUN

PITTSBURGH, PA. An armed 88-year-old man from a nearby assisted living facility killed himself in the Emergency Department at St. Clair Hospital. The hospital doesn’t have metal detectors but does have a policy against bringing handguns onto the premises. According to news reports, the man drove to the hospital for treatment and after entering an examination room, excused himself to use the bathroom. While in the bathroom, which was being monitored by a nurse outside of the door, the man shot himself in the head and died from his wounds. The hospital’s spokesman Rich Sieber told the newspaper that St. Clair does have security on hand in the ED, and will check out anyone who seems suspicious. But he added that the elderly man showed no such tendencies, nor did he threaten other patients or staff.

BASE SECURITY HANDLES ARMED MAN IN ED

WRIGHT-PATTERSON AFB, OH. Specially trained security forces responded when a retired Army sergeant major attempted to kill himself with a 9mm handgun in the Emergency Department at Wright-Patterson Medical Center on the Wright-Patterson Air Force Base. The retired officer, who reports said appeared intoxicated and distraught, fired the single shot at his own body, but was not hit by the bullet. Members of the 88th Security Forces apprehended the man and secured the medical center.

SPRINKLER SYSTEM TRIGGERED AS MAN SPRAYS EXTINGUISHER

HOUMA, LA. A man disturbed by the use of a vacuum cleaner in the Emergency Department at Leonard J. Chabert Memorial Medical Center caused the sprinkler system to go off when he grabbed a fire extinguisher and began spraying it around the room. According to news reports, a security officer witnessed the 30-year-old man take the fire extinguisher and begin spraying it at the maintenance man who was vacuuming. The deployment triggered five fire sprinkler heads and sent at least one person to the ED because of severe coughing. The man, who was homeless, was arrested on various charges.

HOSPITAL VIOLENCE

ADDED SECURITY FOLLOWS SEXUAL ASSAULT ALLEGATION

DORCHESTER, MA. As the result of a hospital response plan following an alleged sexual assault on its adolescent psychiatry unit, Carney Hospital has hired 24-hour security and instituted hourly checks to make sure staff are appropriately engaged with patients, according to newspaper reports. Carney sent its plan to the Massachusetts Department of Mental Health following allegations that an employee sexually assaulted a young patient. The hospital also fired the entire staff on the 14-bed unit as well as some administrators. All hospital staff is undergoing training pertaining to mandatory reporting. The alleged assault wasn’t reported to law enforcement because the hospital’s policy is to leave that decision to patients and their families.
SECURITY OFFICER THREATENED, ASSAULTED IN HOSPITAL ED

MIDLAND, TX. A man who was “trying to get a rise” out of a security officer, assaulted the officer and police who came to the officer’s assistance at Midland Memorial Hospital’s Emergency Department. The man allegedly began yelling at and threatening to kill the security officer and then resisted arrest when police tried to put him in handcuffs. As he was being escorted from the ED, he kicked the security officer and continued to call him derogatory names, according to newspaper reports.

OFFICER, NURSE, POLICEMAN ASSAULTED BY PATIENT

WILKES-BARRE, PA. A security officer, nurse and policeman were all allegedly assaulted by a man brought to Wilkes-Barre General Hospital for blood alcohol testing. The 25-year-old man, who was arrested for driving under the influence after failing a breath test, was brought to the hospital for further testing. While there, he became abusive and claimed he was assaulted during his arrest and asked to be checked by hospital staff. While waiting for an X-ray, he became agitated and allegedly hit the arresting police officer in the abdomen and then pushed him down, resulting in the officer getting a cut on his arm. When security and a nurse stepped in to help, the man allegedly kicked the security officer in the thigh and spit on the nurse’s cheek. He was arrested on assault and harassment charges in addition to those related to driving under the influence.

MAN ATTACKS NURSE, SECURITY AFTER TRYING TO KILL FATHER

EASTBOURNE, UK. A man who was trying to smother his elderly father allegedly attacked a nurse, a security officer and police when they tried to deal with him. The 49-year-old man, who was recently sentenced for attempted murder and assault related to the incident, became upset when a nurse at Eastbourne District General Hospital caught him with his hand over his father’s mouth and the other pinching the 79-year-old’s nose. He allegedly punched the nurse and then hit a security officer who responded. When police came, he punched one officer and supposedly bit another, according to news accounts. Officers equipped with firearms were dispatched to the hospital and used a taser and Captor spray to finally subdue the man.

ASSAULT ON NURSES SPURS MOVE TO PANIC ALARMS

BRANDON, MANITOBA. After a man cornered and assaulted a pair of nurses at Hamiota District Health Centre, new security measures, including the use of personal panic alarms, were instituted. The extra security is designed to bring rural hospitals in line with new health and workplace safety regulations in the province. In addition to the pilot program involving the alarms, other changes include improved violence prevention policies that allow for employees to get immediate help when threatened. The Rural Health Authority is working with a security company to facilitate calls for help and assessment of buildings for security improvements, including better locks and means to secure items so they don’t become weapons, according to newspaper reports. Nurses will be asked to comment on the effectiveness of the panic alarm system before the RHA considers stationing security officers at its sites.

HOSPITAL REVIEWS SECURITY AFTER SECOND NURSE IS ATTACKED

SAN ANTONIO, TX. Christus Santa Rose Hospital is reviewing its security measures after a second nurse was attacked in less than 10 months. In the most recent incident, a nurse was walking alone to her car in the visitor parking lot when a naked man attempted to sexually assault her. According to news reports, the nurse managed to fight back and escape and returned to the hospital. In the previous incident, a nurse was walking through the employee parking garage when she was assaulted. As a result of that event, the hospital added more security cameras and lights and offered to escort employees to their cars.

HEAVILY MEDITATED PATIENT RAPED AT HOSPITAL

GASTON COUNTY, NC. A male patient at Gaston Memorial Hospital allegedly raped a female patient who was heavily medicated at the time. In news accounts of the incident, police said the 35-year-old woman didn’t know her attacker and wasn’t in a state to fight back. When asked about security measures, hospital officials declined to comment to the TV station, but acknowledged it was “a serious matter” and they were cooperating with authorities in the investigation. The man involved had a prior record for assaulting a female.
HOSPITAL DEFENDS SECURITY DESPITE ATTACKS ON NURSES
BLACKTOWN, NEW SOUTH WALES. Officials at Blacktown Hospital are defending their security measures, even though a patient wielding a butter knife stabbed a 48-year-old nurse repeatedly. According to news reports, the hospital’s general manager said security is high, staff is aware of what to do and there exist sufficient alarms. According to police, the patient had been pacing the halls and demanded to leave. When the nurse told him that a doctor would see him soon, the patient went into a kitchen area and removed the knife. When he returned and made his demands again, he then punched the nurse in the face and stabbed her in the arms and back. Another nurse who witnessed the attack subdued the patient and secured the knife. After nurses threatened to walk off the job over the incident, the hospital placed a security officer in Blacktown’s Emergency Department from 10 p.m. to 6 a.m. under orders from the Health Minister, but nurses are requesting 24-hour security. Nurses told a newspaper that it can take up to 10 minutes for officers to respond to a Code Black, which signals someone is being assaulted. Blacktown’s security is being reviewed, under request of the Health Minister, as is the possible removal of metal cutlery from the ED.

EMPLOYEE THEFT

SECURITY POLICIES CHANGE FOLLOWING JEWELRY THEFT
PALMER, MA. Security policies at Wing Memorial Hospital have been changed after a former nursing assistant was accused of taking jewelry from elderly patients. According to news reports, from November 2010 to July 2011, the hospital worker took money and jewelry from patients, mostly those in their 80s and 90s. A hospital spokesman said security policies have been revised and as soon as the incidents were brought to staff attention, appropriate action was taken. The 31-year-old woman who is accused of the thefts is no longer employed at Wing.

CAMERAS USED TO CATCH DOCTOR STEALING EQUIPMENT
MIAMI, FL. Security cameras at Jackson Memorial Hospital showed a surgeon taking medical equipment from a storage room on at least three occasions. The doctor, who is on administrative leave from his work in the critical care division of the surgical department, was stopped on at least one occasion by a security officer who confronted him as he walked out of a storage room with surgical instruments. The doctor told the officer he needed the equipment to perform surgery, even though none was scheduled. On another occasion, cameras showed him entering a storage room with an empty duffle bag and exiting with a full bag and equipment in his hands, news reports said. When confronted by investigators, the doctor did return 34 items.

EX-HOUSEKEEPING HEAD INVESTIGATED FOR FRAUD SCHEME
CHILLICOTHE, OH. After employees, including security, began asking questions, an investigation was launched into the actions of the former head of housekeeping at Adena Health System. According to news accounts, the woman allegedly signed a contract on behalf of Adena to do external cleaning. But it was discovered the woman had ties to the contractor and had been approving payments on invoices for services never provided. Although the theft was still being investigated, it was believed to involve a large amount of money.

BILLING ISSUES TURN UP COUNSEL’S EMBEZZLEMENT SCHEME
PHILADELPHIA, PA. An investigation into billing inconsistencies led to a former Children’s Hospital of Pennsylvania executive who embezzled $1.7 million from the hospital. The 46-year-old former general counsel pleaded guilty to charges of mail fraud, money laundering and filing a false tax return. According to news reports, the man created a system to pay non-existent expert witnesses, while sending the checks to himself. In addition, he created seven bogus consulting firms and fake entities that billed the hospital $1.4 million. The scheme, which started in 1999, began to unravel in 2010 when the hospital found billing problems and began an investigation. Although the man was using a friend’s identity to pose as a consultant, he accidentally left his own email address on some correspondence.

BRIBERY, KICKBACK SCHEME TIED TO FORMER HOSPITAL EXEC
BEVERLY, MA. More than $500,000 was taken from Northeast Health System under a bribery and kickback scheme tied to a former vice president. According to news accounts of the

continued on next page
In Brief cont.

Incident, the 59-year-old man paid off contractors who did work on his home. The man is also accused of taking art that formerly hung at Addison Gilbert Hospital in Gloucester, MA, and taking antiques from the hospital for use in his home. He faces three counts of bribing a business and four counts of felony larceny. Three contractors who took a plea deal, admitted performing work at the man’s former house and paying his personal bills with money paid to them by the hospital from project funds.

LONG-TERM CARE

KENTUCKY TO FINGERPRINT POTENTIAL CARE WORKERS
LEXINGTON, KY. Under a $3 million federal grant, Kentucky’s Cabinet for Health and Family Services will be able to purchase equipment so long-term care facilities and similar agencies will be able to conduct digital fingerprint background checks on potential hires. Users will be able to check fingerprints against both in-state and FBI criminal databases. Current state law only requires long-term care facilities to conduct name-based background checks, although some facilities have added FBI background checks as well.

PHONY DOCTORS IMPOSTER USES FAKE ID TO POSE AS HOSPITAL RESIDENT
BEAVERTON, OR. A phony plastic surgeon used bogus identification, scrubs and a vest with the hospital’s logo purchased from the bookstore to get into Oregon Health and Sciences Hospital and pass himself off as a doctor to at least one person. The 21-year-old, who claimed to be a second year resident, was finally caught when a woman who had paid him to perform gastric bypass surgery went looking for him. Although he had access to the hospital, officials told reporters he couldn’t have entered the emergency room or operating room without an electronic badge. Hospital surveillance video showed the man wheeling the woman out of the hospital. The man listed OHSH as his employer on his Facebook page, along with several other jobs that were discovered to be false.

SECURITY INCREASED AFTER PATIENT DEATHS

STOCKPORT, GREATER MANCHESTER, UK.
Private security officers and vehicle checks have been instituted after a 27-year-old nurse, Rebecca Leighton, who was later freed, was accused of killing five patients at Stepping Hill Hospital. According to news accounts, the nurse supposedly tampered with medical products, including saline ampoules and saline bags, in which pinpricks were discovered. The saline was allegedly contaminated with insulin. After her release from prison she reportedly said she plans to sue police for a six figure sum, claiming wrongful arrest, or will try to gain compensation worth up to £1 million. Meanwhile police have said they will continue their investigation into the deaths of seven hospital patients and there are plans to interview at least another 500 potential witnesses. Detectives investigating the poisoning of the patients at Stepping Hill Hospital were quoted as saying they now believe that two killers may have been working at the premises. Officers found evidence of two different sets of fingerprints on tampered stock. The police say that investigation was hampered over the past two months by the difficulty of establishing who had access to medical supplies at the hospital and because of lack of security over where they were stored. Police believe they are close to apprehending one of the two people they believe sabotaged the saline solutions. According to a police source: “One of the huge hurdles the investigation has faced so far is that there was virtually no security or checks for access to the medicine stores. Almost anyone could gain access, including nurses, patients and even visitors. Some were taking medicines for personal use or for use at home with their families while others were even selling it.”

continued on next page
SECURITY'S ROLE IN DEALING WITH PUBLIC DURING C. DIFFICILE OUTBREAK IN ONTARIO

Responsible for more than 30 deaths and impacting 10 hospitals, the Clostridium difficile outbreak in greater Ontario has meant stepped up efforts by hospital security personnel to limit the spread of the infection by managing visitation hours and hygiene rules.

According to Sue Matthews, Interim President and CEO of Niagara Health System, additional security officers have been provided with a script that they use when encountering visitors and patients who enter the hospital. The extra officers are also equipped with two-way radios to communicate with regular, on-site security in case there are any problems with enforcing the protocols established for hand washing and hygiene.

“There are more security personnel on duty during the outbreaks, and the main entrances at each of the larger sites are covered with security staff,” explains Matthews.

The C. difficile outbreak began in late May and continued throughout the summer months, affecting more than 90 patients, 31 of whom died. The Niagara Health System’s facilities serve 434,000 residents and include Greater Niagara General in Niagara Falls, St. Catharines General Hospital, Welland Hospital, Douglas Memorial in Fort Erie, Niagara-on-the-Lake, Port Colborne General and the Ontario Street site in St. Catharines. C. difficile causes severe diarrhea and may damage the colon; it is spread most usually through contact with fecal matter.

A More Direct Role In Dealing With The Public

Matthews says during the outbreak, security has a more direct role in dealing with the public. “Previous to the outbreaks, nursing staff on the floors would call security to help with situations that arise with visitors on the units. Now, security has direct contact with visitors when they enter the hospital. This enables (them) to communicate directly with visitors when they arrive and help educate them about the various restrictions in place and avoid potential conflict.”

Among the greatest challenges for security, says Matthews, is enforcing the restricted visiting hours. “Many of the visitors are unaware the hours have been reduced,” she says. “Some drive in from out of town and others want to visit during off hours. In these cases, the nursing staff is contacted (by security) to authorize the visits or decline for reasons explained.”

Security is working closely with administration at each of the affected hospitals, she says. “As well, there is daily communication between the security site supervisors at each of the sites to ensure practices are standardized across all sites of the Niagara Health System.”

While there have been reports of visitors becoming angry and even combative regarding the hand-washing and limited visitation rules, Matthews says most members of the public have been cooperative. “There are specific guidelines, protocols and training to follow in the event visitors are uncooperative, in particular with requests to wash their hands,” she says.

“To date, each of the situations has been successfully resolved by the security officers or nursing staff, all of whom are trained to de-escalate in conflict situations,” says Matthews. “Most effective is communicating with the person on the importance of regular hand washing for everyone’s safety.” As of mid-August, there had been no arrests related to enforcement of the health rules, she adds.

Keeping Lines Of Communications Open

Once the crisis is over, says Matthews, security personnel will be part of the extensive debriefing “to confirm our strengths and identify areas where we can improve,” she says. “New guidelines and protocols will be adopted as identified, just as we have done before.”

The main lesson learned during a situation such as the C. difficile outbreak, says Matthews, “is to keep the lines of communications open throughout the hospital and to take each new challenge seriously. Open lines of communication result in responsible and reasonable decision making.”

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An Interview With:

Leslie Porth And Walter Kowalczyk
On Emergency Preparedness

(The Missouri Hospital Association is one of the primary subcontractors to the Missouri Department of Health for the state’s hospital preparedness program. With 152 member hospitals, the MHA covers all but two hospitals in the state. Working under a grant received in 1002, the MHA has been facilitating emergency preparedness and strengthening regional and local partnerships among hospitals. It has also purchased equipment that hospitals are using for evacuation or surge purposes during a crisis. MHA also plans exercises that prepare the medical facilities for major events, such as a tornado. In conjunction with Strategic Emergency Group, an East Northport, NY, disaster preparedness consulting firm, MHA and SAG drilled hospitals through tabletop exercises and larger scale ones for scenarios similar to the one that occurred in Joplin, MO, on May 22, when St. John’s Regional Hospital suffered a direct hit from an F-5 tornado.)

Leslie Porth, Vice President-Health Planning for MHA, and Walter Kowalczyk, Vice President-Operations for SGA, were interviewed for IAHSS directions about the importance of emergency preparedness and how such training played a role during the events in Joplin.

Q. Tell us about how MHA’s efforts on disaster response were evident in Joplin.

A. (Porth) Planning on the front end was the most critical component. We had covered medical surge and mass fatalities, and all of those plans came together that evening, even when things didn’t go perfectly. What has been pivotal in the past few years is that we have done exercises. We did an extensive tornado exercise in which the scenario was a tornado taking out a hospital in Springfield. During that exercise we tested communications systems and pushing out patients to other hospitals in other areas. We also tested bed capacity. The lessons learned from that exercise really helped us.

(Kowalczyk) The exercise took place at St. John’s in Springfield, which is in the same system as St. John’s in Joplin. As part of the exercise, they used chairs and sleds to physically practice bringing people down the stairs, which is what happened at St. John’s (in Joplin). Also, prior to May of last year, we did a statewide tabletop exercise with 200 participants and did a tornado scenario for that as well.

(Porth) And separate from the tornado exercises, about six to eight months beforehand, St. John’s Joplin did its own testing of its emergency equipment.

Q. What have you heard about what happened that night and how the response went?

A. (Porth) We’re still in the data collection mode for the after-action report. But they were able to evacuate more than 180 patients from St. John’s in a little over an hour. There were some challenges because of all the debris, so they had to do some critical thinking on the fly that evening. They lost all communications and some of the surge equipment in the disaster, so that was one of the biggest challenges. They didn’t even have paper and pencil to write a plan. But their resiliency through their partnerships helped. One thing that went very well was the statewide mutual aid agreement. Every hospital knew its role, including how to handle payments and so on. One of the great assets in Joplin was the partnership with other hospitals in the region and across the state. The equipment is now standardized and the training is similar, so people were able to get their feet on the ground pretty quickly.

Q. How were SAG’s effort on training evident that night?

A. (Kowalczyk) One of the most important things to recognize about our work is that we help the hospitals test their plans. I’m a retired EMS planner for the New York City Fire Department and a former hospital emergency planner. So I’ve been in their shoes. We don’t look at ourselves just as a contractor, we look at ourselves as part of the (MHA) organization. Although we immediately felt a lot of sorrow for what happened, after the fact we recognized that the exercises helped them and now what happened and what they learned from it will help them to modify their plans.

(Porth) Both SAG and another of our partners, the Imagine Team, reached out to us that night. It was very comforting and reassuring to hear from people.

Q. Why are the hospitals in Missouri so focused on preparedness?

A. (Porth) In Missouri, there is a lot of interest and commitment. We’ve had several tornados on the ground this year, plus floods and heavy snow.
Interview cont.

(Kowalczyk) We just finished an exercise (not on tornados), and we see the dedication from the people at all levels. These people live with tornados every day, along with other potential disastrous events.

Q. So what is the next step for MHA and SAG?

A. (Porth) We are both exercise and disaster fatigued right now. So we want to review our after-action plans and make necessary changes. The next six to nine months will be a time for reflection. But that doesn’t mean we’re not already planning for what’s next.

(Kowalczyk) We do work across the country, and we’re working with FEMA now. But the fiscal reality is that as federal dollars are trimmed, we still hope that first responders and the medical folks can continue to sustain their (training) plans.

(Porth) We have been fortunate to have the resources to do the exercises. But there is some fear that a successful response, like we had in Joplin, will have some people saying that our preparedness plans all worked and we don’t need any more training. We recognize that the exercises are just one of the components and that the overall planning is important. We also know that the exercises aren’t always easy to do, but they are critical for a successful response.

(Kowalcyzk) We believe success begins at the community level, and you need to have exercises be a part of the planning. And just as there is evaluation of the exercises, there needs to be evaluation of the real world response to be successful overall.

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HOSPITAL’S BOARD APPROVES GUNS, TASERS FOR SECURITY OFFICERS

Security officers at Blount Memorial Hospital, Maryville, TN, have added tasers to their defensive options, and at least five of the supervisors are now also equipped with firearms.

This new policy began in July, following approval by the hospital’s board of directors. Mike Steele, Assistant Security Director at Blount, says there was no one incident that sparked the change, but rather it was part of an ongoing plan to improve response times and make officers better equipped to handle certain situations, especially in the hospital’s safe room and decontamination room.

“We were the last hospital in the region to introduction weapons,” explains Steele. With certain managerial changes in the security department over the past two-and-a-half years, he notes, the board felt a new level of trust that the department could handle this change while keeping liability low for the hospital.

Under the new scenario, Steele and the security director carry .40-caliber Glock pistols. The other three supervisors carry Glock 23 .40-caliber pistols along with the Taser X26, Sabre Red Foam, an expandable baton and cuffs. The remaining officers have been approved to carry the tasers. At this point, says Blount, there is no specific date by which additional officers will be allowed to carry guns. Officers were already approved to carry the pepper foam and batons, and the tasers are being added to their belts, says Steele.

CUTTING DOWN ON RESPONSE TIMES IN CERTAIN SITUATIONS

One of the advantages of having armed officers on site, he says, is that is will cut down the response time in the case of certain incidents, such as an armed shooter on the premises. “We used to have police posted in the Emergency Department waiting room,” says Steele. Part of the presentation to the board was that although Blount’s security has a great relationship with area responding agencies such as police and the sheriff’s department, “we wanted to cut the response time from two minutes to zero.”

Steele says the supervisory staff has all had experience carrying weapons in the past as former police or military. They are currently undergoing a bonding process through the sheriff’s department, which requires 40 hours of in-service training. Security staff has participated in active shooter training in the past,
Adventist GlenOaks Hospital, Glendale Heights, IL, has been awarded the President’s Award from the DuPage County Senior Police Management Association for its hospital wide services to the community. Contributions of the hospital cited include:

- Support of drug and gang prevention programs, including D.A.R.E. and G.R.E.A.T., helping supply various promotional products to give students. The hospital has been purchasing T-shirts for every D.A.R.E. program graduate since the mid-1990s.

- Financial support for Glendale Heights' Safety Town, a summer program that teaches pedestrian safety, railroad safety, fire safety, stranger danger, 911, first aid, poison prevention, bicycle safety and seat belt safety. Adventist GlenOaks Hospital also has provided an instructor for the program every year since it began in 1991. The hospital also donates funds for Halloween and Easter programs at Safety Town.

- Participating in a Community Emergency Response Team (CERT) program instituted two years ago to educate and train residents in disaster response. Adventist GlenOaks Hospital appointed an employee to serve on the team’s Citizen Corp Council, provided a certified first-aid trainer for the program and donated medical supplies for the unit’s kits.

Adventist Glen Oaks Hospital is part of the Adventist Health System, the largest not-for-profit Protestant healthcare provider in the country. The DuPage County Senior Police Management Association, incorporated in 1993, is a nonprofit group comprised of 70 high-ranking police officers from DuPage County below the rank of chief. The hospital was nominated for the award by Glendale Heights Police Chief Michael Marron.

MAINTAINING A CLOSE WORKING RELATIONSHIP WITH LAW ENFORCEMENT

Serving as a community leader in volunteerism while maintaining a close working relationship with local law enforcement is part of the health system’s ministry mission statement, says Richard Roehr, Glen Oaks Hospital Administrative Director, Support Services. One of the most important relationships, he reports, is the relationship the hospital enjoys with local law enforcement. “We think of our law enforcement as partners in all we do,” says Roehr. “We have an unarmed security force here at the hospital. If anything gets out of our control it’s always good to have our external support at the same table. They know us and we are aware of each other’s emergency plans.

We attend the same governmental agency partnership meetings. If there are events going on in the village, they know who to contact, just like we know who to contact if we need assistance. Maintaining that relationship is of the utmost importance to us.”

Getting employees excited about fostering a relationship with the community — and, in particular, with the local law enforcement agencies — is not difficult if the right people are involved, Roehr adds. “It isn’t hard to find employees who want to get involved because there are so many employees who are naturally motivated and you just have to find the right ones.” The award from the county Police Management Association was unexpected, he says. “Every day we do things without thinking about awards or recognition. We are honored to receive the award, especially since it was police chiefs, retired police chiefs, and commanders from all over the county who decided upon the award recipient.”

The close relationship between the hospital and local law enforcement is of great benefit to the hospital, he says, which sometimes encounters law enforcement throughout the course of normal day. Patients are sometimes brought to the hospital in police custody, and once in a while there is a need for a police guard for a patient. If a patient slips out of the hospital unnoticed, the hospital may turn to local law enforcement for aid in tracking the patient down. It is times like these that the existing relationship between the hospital and local law enforcement proves to be quite beneficial. Instead of working as two separate entities, everyone is able to work together to the benefit of everyone involved, Roehr says.

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says Steele, and some have participated in shooting courses with the sheriff’s department as well.

To be able to carry and use tasers, officers had to take a six-hour training course that covered topics such as when they are allowed to use tasers, how to fire the taser and remove the probes, statistics on the rate of death and injury from taser usage and an inventory of the weapon. “Our department adheres to a strict use-of-force policy and force continuum policy, which outlines under what circumstances an officer may deploy available defensive weapons,” explains Steele. “We also have a separate taser policy, and all officers receive training on all three policies.”

“ANOTHER LEVEL OF DETERRENT”

The reaction among hospital staff to having armed or taser-equipped officers has been positive so far, says Steele. “This is the first time since 1947 that we’ve had this, so trust was the biggest factor that we had to gain; he says.

Steele says Blount's officers are trained in de-escalation techniques to deal with volatile situations, and haven’t had to use their chemical weapons or batons yet. Adding tasers is just another level of deterrent, he says. He recalled how one patient, who was taken to a safe room for treatment, pointed out upon seeing the taser that he had a heart condition and didn’t want the officer to have to use the taser on him.

Like the hospital staff, Steele says the officers also supported the addition of tasers as a means of protection. “We sleep a little better at night now that our staff have these and have some additional options to protect themselves,” he says.

What is the best part, says Steele, “we had goals and they have been met or exceeded through the bonding process. We are always looking for ways to be innovative. Now it’s just a matter of being successful at maintaining this.”

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Special Report:
IP Video: It’s Coming to a Hospital Near You

IMS Research, a U.K.-based market research company, recently announced that its research shows sales of IP and network-based security equipment is likely to surpass that of analog equipment by 2014. “Whilst the global analog video surveillance equipment market was relatively depressed in 2010, the network video surveillance market has continued grow almost three times as fast as the total market in 2010, over 30 percent,” IMS Research Senior Analyst Gary Wong wrote in a prepared statement. “If the Chinese analog video surveillance equipment market was removed from the equation, both the EMEA and the Americas analog markets contracted in 2010.”

Network video surveillance’s growth is being aided by government stimulus-funded projects, Wong’s report says, as well as market penetration by higher-value IP video products such as HD cameras.

With IP video on the minds and in the budgets for many organizations, this report will focus IP projects from the point of view of suppliers, installers or end users.

Bessegado: Ready for More

It has been about 10 years since St. Joseph’s Health Care, London, Ontario, first entered the world of IP video technology through a project with IndigoVision. Mike Bessegato, Director of Fire and Security Services at St. Joseph’s, says that initial investment allowed security personnel to view real time video at the four campuses in two cities that make up the St. Joseph’s Health Care system.

The campuses in London and St. Thomas include about 50 buildings and more than 300 cameras, says Bessegato. Included in the coverage area are St. Joseph’s Hospital, Mount Hope Centre for Long-Term Care, Parkwood Hospital, Regional Mental Health Care London and Regional Mental Health Care St. Thomas. The latter, says Bessegato, is a forensic hospital for which it was especially critical to view incidents as they happened.

“We couldn’t afford a time delay,” especially at the mental health units. When the system was first installed, it handled fewer than 200 cameras. About half of the 300 cameras installed today are IP versions, and all new cameras will be IP ones, says Bessegato.

Viewing of the images from the live feeds can take place at each site or from the health systems central control station at Parkwood. At that location, he says, two dispatchers handle all the incoming phone calls and monitor the cameras from all the sites. There are monitors that can view 16 images at a time, he says, and most cameras have pan-tilt-zoom capability so officers can bring up a single image on a larger screen and focus in on whatever is going on.

Part of making that case is stressing the importance of monitoring the mental health centers, especially the forensic patients at the St. Thomas location. “When you are dealing with a Code White (violent incident) at the mental health center, being able to see what is going on and react quickly could save someone’s life,” he says.

With the camera feeds, the dispatcher can see everything that is going on. Officers on site have a similar...
camera feed in their office, but if they are on patrol, they aren’t there to catch the action as it happens.

Within the mental health facility, Bessegato says they recently added help buttons that are provides audio within 100 feet of the button that is pushed. Dispatchers can hear the distress call or argument and use that to zoom in a camera to see the situation firsthand.

Bessegato says they have also incorporated some video analytic tools to set perimeters on some locations that when breached will sound an alarm and bring up a camera image in dispatch. This is used for high-risk areas, he says, but also for remote locations where activity isn’t expected. All of the exterior, roof-mounted cameras have PTZ capability, he says, as do the ones in high traffic areas.

With several new projects under way, including a new parking structure with 40 cameras, a new mental health building set to be completed in 2013 or 2014, and a new dispatch center opening in the next year and a half, Bessegato says it’s important that the system is scalable to handle the additional cameras, digital recorders and servers.

“I’m told this system is quite flexible,” he says, noting they haven’t had a problem thus far with bandwidth for all of the video they are currently watching and recording. “We have some room to move forward,” he notes. Bessegato credits internal IT with helping him keep on top of what he needs and how to make it work.

He also has worked with a preferred provider throughout the transition to IP and finds that staying with one company cuts down on problems. “I oversee the plans and the equipment and work closely with the IT department,” he says. “They understand what we need and work at the table with us and our vendor.”

WOODBERY: WHEN ONE BECOMES THREE

When Haywood Regional Medical Center, Haywood, NC, merged with hospitals in Harris and Swain in early 2010 to form Medwest Health System as part of Carolinas Health Care, it provided an opportunity to bring the two additional facilities up-to-date on surveillance technology. Jason Woodbery, Medwest Director of Security, says Haywood had been working on a conversion to IP video since 2000 and now saw the similar needs at Harris and Swain.

Harris only had local cameras, he says, “and we saw this as a good opportunity to bring in IP” using a converter from March Networks. Swain, which has a March DVR box that is used with existing cameras, is also in line for an IP conversion and will be replacing its cameras as they die out. Adding cameras at Harris and Swain now means bringing the video back to a switch, rather than pulling miles of cable, says Woodbery. And picture quality is also improved over the old analog images.

MedWest deployed a video management solution that integrates server platforms with the pre-configured VMS software and IP camera connection licenses to ensure faster installation and better performance. It also installed March VideoSphere Edge encoders and 4000 C Series hybrid recorders to bring its existing analog cameras onto the IP network and to support new IP cameras in some locations.

While security doesn’t have someone dedicated to watching camera images all day, Woodbery says they are able to view images as needed on monitors or on computers. Security in Haywood’s ED and on the behavior health unit can get access to the cameras in their specific units, while not having to deal with video from elsewhere in the hospital.

Woodbery says with any system that is installed these days, it’s important to have a good relationship with the hospital’s IT department. “I don’t speak the IT language,” he acknowledges, “so it’s handy to have them on board during any discussion.” Woodbery recalls a recent visit by an integrator “and IT stopped what they were doing to help us.” That kind of cooperation is critical, he says, if the goal is to be cost effective as well. Paying an integrator to wait until IT is available doesn’t work for any of the parties involved, he says.

“With us being a very small hospital, they (IT) know us and our installers and we have a good relationship with them,” he says. “I think that’s really the key today—you have to have them on board and bring them in at the beginning so they will know how any new products you want will effect their systems.”

Woodbery says in 2002, he drew up a five-year plan for Haywood, covering cameras, building security and access control, and has completed the elements of that plan. At

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Haywood, he notes, access control is tied in with video, while at Harris and Swain, they are still converting to new AC ID cards.

“They still have an older system,” he says, but a new one was expected to come online within two to three months. At Haywood, if an alarm is sounded through the AC system, the video can be tied in. “I think when we get more uniform (at Harris and Swain), then we can do more,” he says.

Woodbery notes that in such a merger there needs to be integration of systems, policies and procedures throughout the system. “And one of the first departments that integrated was security, with our policies and procedures being adopted.” The three hospital have 25 officers among them, says Woodbery. Any training that needed to be done on software related to the IP video system was accomplished without having to go into a classroom setting, he says.

March sent someone down to help set up the server and to train Woodbery on the software, he says. From there, it was a matter of getting officers to test out the system to see what they could do in terms of viewing the video and manipulating the images. “There’s not a lot of damage they can do,” he says. “We just tell them to try it and see what happens.”

If officers are looking at recorded video, Woodbery says he advises them to report activity as quickly as possible, so they can pinpoint the date and time. From there, he says, there are features that can help, such as showing when there is motion on the video so they know they can skip over anything without activity.

Woodbery notes that his video management solution is also scalable. As it is currently configured, they can have up to 64 cameras on the server. “But adding more cameras to the system is easy,” he says.

CREMINS: MAKING A CASE FOR IP

Healthcare is one of the top groups transitioning to IP video, and Dan Cremins, Director of Product Line Management for March Networks, can understand why.

“They (hospitals) need to see video everywhere,” he says, because there is so much public access in a hospital. As the need grows to cover more ground, so does the need to add cameras, he says. “And that’s an advantage of IP: Anywhere there is a need, you can add a camera.”

Once limited by where coaxial cable could reach, Cremins says IP gives hospitals the freedom to place cameras where they are needed the most. Pointing to the Medwest project, which uses March technology, Cremins says, “When a hospital is taking over an older facility, the last thing they want to do is dig up concrete or go into the plaster to run cable.”

He noted Medwest was able to combine three systems into one and make the move to IP. “If things work the right way,” he says, “it should really be seamless.”

Storage, even for cameras across several facilities, is less of an issue, he says, with some servers able to handle up to 128 cameras. “If they (a hospital) adds more sites, they can add IP cameras to the VMS,” he says. “That’s really the key point behind it.”

And because most healthcare organizations are already big bandwidth users, they usually have a network that is robust enough to take on what security needs for its video. “Hospitals are already sending video for other reasons, such as sending x-rays and medical images,” he explains. So the important factor there is to keep IT in the loop, so security can be just another part of the infrastructure.

Another selling point these days, says Cremins, is that the cost of IP video cameras has come more in line with the cost of analog ones. And the issues of resolution have also been addressed, he says, with the creation of high-resolution cameras. These are especially useful when covering large areas, such as parking lots, and needing to focus in on a license plate or other smaller area of interest, he says.

PACE: PLANNING PREVENTS PROBLEMS

When Greater Ormond Street Hospital for Children (GOSH) upgraded its video system this year to one that deployed analog, high-definition and IP cameras on an IP video management backbone, it began by undergoing an Enterprise Audit Report (EAR) conducted by its integrator,
Check Your Security.

Carl Pace, Managing Director, says it's important to focus and clearly understand the "why?" behind the need for a change. "Only after understanding this simple question can you start to look at if what they have in place addresses this," he says.

"An EAR is a way to start the ball rolling by finding out exactly what the client has in place, its condition, value and upgradeability, and if its fits with their long-term goals and objectives. Once we have this in place, it is easy to see if anything offered is forward progress rather than just an expensive detour in achieving their objectives," he says.

What the EAR also does, he says, is put on paper problems that exist, such as poor maintenance, mismatched upgrades, missing equipment or networking issues and help to address them with any changes made.

Pace says converting GOSH, which needed coverage of its entire campus and critical patient areas, to an IP-based system was more evolutionary rather than revolutionary. "No one is going to throw out equipment if it is still usable," he says. "And remember that a lot of analog cameras with expensive lenses can, in a lot of instances, give a very clear picture and are still fit for the purpose." In GOSH’s case, the 160 cameras on site were a combination of analog and 70 percent new IP cameras.

Pace says the advantage of the new system is that is very good at finding data and pictures, especially when complemented with analytics. "Getting forensic data on incidences is quicker and passing these incidents to corrective agencies to follow up is easy," he explains. In addition, he says, many of the newest products coming into the market require digital images as a starting point.

The GOSH system can grow with the hospital’s needs, adds Pace, noting it is scalable to 5,000 cameras. "More than the hospital would ever need, I dare say," he says.

From a user standpoint, the system is easy to understand, he says, "but key personnel have been trained to ensure that the best use is made of the system. With

continued on next page
Staff changes and additions, this is an ongoing project based on the customer’s requirements and we are there for the long term, not just to install the equipment, explains Pace.

The GOSH VMS system uses technology from DVTel as the central platform. DVTel’s Intelligent Security Operations Center works on the existing network infrastructure and with many of the existing analog cameras. In areas where facial and vehicle recognition was critical, GOSH invested in some DVTel cameras as well as some megapixel ones.

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Mercy Health Systems, which operates St. John’s Regional Hospital, Joplin, MO, destroyed in the May 22 tornado, has announced plans to build a new hospital about 1.5 miles away from the old one. Groundbreaking for the 327-bed hospital is scheduled for January 2012, with the opening sometime in 2014. Previously Mercy had announced the opening in October of a new mental health facility, as well as new office space.

“We’re in the process of hiring 12 new officers to work exclusively on the new mental health facility,” reports Spencer Dobbs, who heads security for the hospital. The security staff already has grown to 18 officers, plus Dobbs, another supervisor, and the office staff, he says. The hospital has also contracted with a third-party security firm to handle security around the old hospital, former medical office building and rehabilitation facility and do daily patrols to keep in contact with them.

Dobbs says having to act quickly and to rebuild the security department has given him ideas on what he would like to do differently with the new buildings. Already, he says, they have separated security dispatch from the general switchboard. Improvements with dispatch mean that a fire alarm sounding at one of the new buildings won’t just go to the fire station, but will also sound at the dispatch center so security can send an officer to the site. And cameras are being used at the MMU and new ones placed in the new mental health center that can be accessed easily, even via cell phone, he says. “We plan more improvements like that,” says Dobbs, who notes that security is involved in the early discussion about camera placements, access control systems and the like for the new St. John’s.

The Mobile Medical Unit (MMU) was set up in a nearby parking lot within days of the tornado. The MMU covers 10,000 square feet and offers 20 emergency room beds, 40 inpatient beds, two operating rooms and nine modular patient care units, along with some warehouses. Dobbs says officers are there 24 hours a day to assist with security and help patients and visitors find their way around the unfamiliar surroundings.

With all the work related to old and new structure, the job of security is one that changes constantly, says Dobbs. At last count, he says security was responsible for eight facilities, with two more coming on line in October.

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When a disaster happens, many organizations rely on mass notification systems to alert people as to what is happening. But while the ability to communicate quickly and efficiently is paramount, so too is the ability to continue to carry on a virtual dialog with those involved and to also access where they are and what has happened to them once the initial crisis passes.

Guy Miasnik, President and CEO of AtHoc, San Mateo, CA, says companies such as his are taking advantage of the investment in telecommunications and computing infrastructure to produce a robust system for mass notification, especially within agencies, including healthcare systems, operated by the federal government.

As a major player in the mass notification for the Defense Department and Veteran’s Administration, Miasnik says investment in infrastructure are paying off on the security and safety side. With three major phases of communication at work—initial communication, ongoing communication during an event and post-event accountability—each one can tap into various forms of communication that are available today.

**THE INITIAL PHASE: ALERTING EVERYONE ABOUT AN EVENT**

In the initial phase, when alerting a hospital or medical campus about an event, the communication should be as robust as possible, says Miasnik, meaning it should go out in various forms to reach as many people in as quick a time as can be accomplished. This can include personal communications via email, phone or text, but also through a public address system or on scrolling message boards within the facility. It’s a combination of public and personal messaging, he says, but the message should be a simple, direct one to avoid confusion.

For example, says Miasnik, at one VA facility, the mass notification system is connected to a digital media player so as the message is activated to appear on desktops and phones, it is also going out over public devices.

One of AtHoc’s most recent installations is at the R.W. Bliss Army Health Center, Fort Huachuca, AZ, which like many defense facilities and VA hospitals, has installed mass notification systems.

**VoIP, Cloud Computing Expand Mass Notification’s Reach**

R.W. Bliss Army Health Center, Fort Huachuca, AZ, which like many defense facilities and VA hospitals, has installed mass notification systems.

meaning messages pop up immediately on all PCs. There is also the capability for combined PC and phone messages and electronic acknowledgement capability.

“Being able to send the alerts with the click of a key to hundreds of users saves vital time in emergencies,” she says. And using PCs, phones and text messages increases the probability of reaching all personnel, she adds.

Scott says sending emergency codes is the most frequent use of the system at RW Bliss. All healthcare systems use codes to alert staff of various incidents such as a medical emergency (Code Blue) or a violent situation, she says. Additionally, she says, “We plan to use these for environmental announcements such as network outages and generator testing. Being in a 50-year-old building, we don’t want users to have 50-page documents open during generator testing.”

Scott notes that AtHoc provided training on site for personnel in the operations section, which includes the security manager. “And they have been in contact with AtHoc regularly as we have fine-tuned the system.”

Some users are also exploring additional features of mass notification. If a message needs to be sent beyond the campus, Miasnik says, this can be achieved by integrating GPS to identify the location of a personal computer or phone to get the message, or a specific one for that person, to them where they are.

**THE NEXT PHASE: COMMUNICATIONS DURING AN EVENT**

In the next phase, while the event is in progress, the messaging becomes about original content, says Miasnik. If the event is a shooter within the hospital, personnel can now receive maps that they can use to evacuate the building based on where they are. Miasnik says the continued migration to voice-over-IP (VoIP) adds a level of richness that regular phones lack. The IP phone has a larger display that can be used to displays the evacuation map, a message or even a video.

“Suddenly the IP phone is a great enhancing device,” says
Miasnik. And most organizations, he notes, are either in the process of moving to IP or have done so. As the organization shifts its telecommunications backbone, so too does AtHoc. While AtHoc works heavily with federal government clients, such as Army medical centers and the VA, he says even public hospitals are putting together plans to convert to VoIP.

This can even be a cost savings in the long run, says Miasnik, because the VoIP devices take the place of more traditional mass notification tools such as speakers and message displays.

Mobile applications, or apps, are also being deployed, he says, but not to the same degree as VoIP. Not everyone has a smart phone, he says, so relying solely on that means of communication doesn’t work. But he says his company is providing some mobile apps, such as GPS-related ones that can help track individuals during a crisis.

This information can be provided to first responder teams, he says, to emergency managers can know where certain personnel are.

As events unfold, says Miasnik, part of the importance of the mass notification system is to establish two-way communication. Security personnel in particular want the ability to be able to report to managers and others about what is occurring. This communication isn’t for the public part of the system, says Miasnik, but is designed for first responders and managers to be aware of what is going on. This type of communication, called inbound information flow, can even include video as well as text messages, he says, using the communications vehicles of today, such as smart phones.

**THE POST-EVENT PHASE**

During the post-event phase, Miasnik says communications are all about accountability—finding out what is the status of the facility and the people involved. This helps to expedite the recovery process, he says.

Of course, notes Miasnik, all of this communication needs a place to go and organizations are increasingly looking to cloud storage as a solution. Rather than investing in onsite servers to handle all the data, operations people are relying on external sources for IT.

**‘GOING TO THE CLOUD’**

Going to the cloud for basic emergency notification makes sense especially among larger organizations, he says, such as chains of hospital or government groups such as the VA. “As the organization grows, suddenly the enterprise understands that each facility having its own mass notification system isn’t efficient,” he says. Instead, they can put basic mass notification for telephony, text or email in a private cloud that will provide service to all of the different hospitals in the chain.

A private cloud, explains Miasnik, is stored within an organization’s own facility vs. the public cloud where it is somewhere offsite. “Many healthcare organizations are reluctant to put information in the public cloud,” he says, because of privacy issues. A private cloud is more expensive, he says, but still provides about 90 percent of the savings that using a public one would for an enterprise.

Public or private, the idea is to put information in a central location that can be used by each hospital as needed. Many hospitals, says Miasnik, want to integrate personnel information with mass notification, so this often leads to the use of a private cloud, just because it is easier to integrate the information side by side, rather than having to move it, he says.

Miasnik says the Coast Guard has combined 150 locations into a single private cloud and his company is currently working with the VA on such an enterprisewide deployment. “When we look at our customers, about 80 to 85 percent of operation centers are under a cloud deployment,” he says.

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Book Review

Deadly Neglect: Apathy & Denial vs. Act of God
By Dr. Jim Blair, DPA, MHA, FACHE, FABCHS, CMAS

In his new book voicing concern about lack of all-hazard preparedness by the country’s healthcare sector, Dr. James “Jim” Blair, president of the Center for Healthcare Emergency Readiness (CHCER), focuses on what happened in hospitals during and after Hurricane Katrina and the embarrassment that disaster continues to cause those in high places responsible for protecting patients and staff against natural and manmade threats.

Quoting at length from a study which interviewed nurses who provided care in flooded New Orleans hospitals during and after Katrina, Dr. Blair maintains that the resulting deaths and suffering and massive litigation which followed would have not happened had hospitals and healthcare systems there heeded the conclusions of reports that followed tropical storm Allison. That storm devastated Houston hospitals four years before Katrina. Exercise PAM, a New Orleans simulation a year earlier of the impact of a hurricane much like Katrina--also concluded that the correct action would have been to evacuate in advance and not protect in place, and to move switchgear and backup generators out of basements to upper floors. Nor has the industry chosen to learn from Katrina since 2005, the book relates, despite hours of Congressional testimony, legislation, and new enforcement responsibilities given to the entities like the Joint Commission and CMS. Citing chapter and verse, Dr. Blair explains the failures of Congress, the various agencies, sometimes overlapping, assigned to carry out legislation, as well as the states, and accreditation agencies to prepare for natural disasters like the “all-hazards perfect storm” which engulfed Japan’s nuclear facility in March or the very real threat of a “dirty” bomb in the radiological materials found in over 1,000 hospitals in the US.

In the end, Dr. Blair, concludes the fault lies with critical components of the public health and healthcare sector--from the design and construction community, to the human resources community, to the healthcare professional and popular media, to the hospital trustees, and finally to the C-suite--who “have turned a blind eye to the known all-hazard threats to the healthcare workplace or serve as passive enablers.” The result, he says, has been and will be unfair burdens on clinicians such as the Katrina nurses or saddling of security personnel with additional responsibilities without the resources to carry them out.

“Twenty years of guidance, Federal all-hazards and response planning evolved into a comprehensive National preparedness and response plan for known natural and manmade threats went largely unheeded by the hospital community,” Dr. Blair concludes. In his book, he details how and why this has occurred and what may be the consequences of such neglect.

“Deadly Neglect” is available from Amazon for $16.

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To the skirling of bagpipes, four Forsyth Medical Center Public Safety Officers marched into a Novant Health Leadership meeting to receive the International Healthcare Security and Safety Foundation’s Medal of Valor “for a selfless or courageous act taken at the risk of his/her own life with full awareness of the danger involved.”

When their radios broadcast “10-94 George (Armed person with a gun) on the ED Ambulance Dock” on the morning of November 22, 2010, Corporal Thad Boyd, Officer Tim Henley, Lieutenant Jackie Houston and Sergeant Michael Saunders responded without hesitation. Even though FMC officers are armed only with ASP batons, they immediately deployed outside the ambulance entrance to prevent the man, armed with a 9mm pistol, from entering the ED. When the subject lay down in the grass and pointed the gun at his head, the officers’ focus changed to preventing him from taking his own life. The officers said “Put the gun down, let us help you” and “Sir, you don’t want to do this. I promise you we’ll get you some help.” The subject replied “You can’t help me, I can’t take it anymore.” He then said “I’m going to do it, boys! Tell my mom I’m sorry” and shot himself in the head. Houston immediately ran to the subject and removed the pistol from his hand to safeguard it and prevent any additional gunfire. An ED physician and staff responded, placed the subject on a gurney and rushed him into the ED. He was then transported to the Gunshot Trauma Unit at Wake Forest Baptist Medical Center, where he died.

The Medals of Valor were presented by Lisa Pryse, IAHSS Vice President, and Owen Wynne, IAHSS North Carolina Chapter Chair. The awardees received a standing ovation. On hand to congratulate them were Paul Wiles, President and CEO of Novant Health, and other senior executives.

A Medal of Valor and a plaque bearing the officers’ names will be placed on display in the hospital lobby.
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