Healthcare Security Council

June 2011

Chairman's Message

From the desk of Ben Scaglione, CPP Chairperson

The Healthcare Council continues its tradition of hard work and state-of-the-art educational programming and materials which help our members to better provide services to their organizations. This past September at our annual meeting in Dallas the Council conducted an outstanding panel discussion on violence in healthcare. This was followed up in February with the publishing of our first whitepaper on violence within the healthcare industry. This year we will continue to provide information on violence by conducting a webinar on active shooter in healthcare.

The Council is excited with the anticipated publication of two more white papers on the topics of staffing levels in hospitals and Return on Investment (ROI) for healthcare security. ROI will be the topic of our sponsored presentation at our national meeting this September in Orlando.

Healthcare Security Vision / Mission Statements

Vision - The Healthcare Security Council of ASIS International will be a credible and progressive source of information and leadership on issues effecting healthcare security.

Mission – To achieve this vision, the Healthcare Security Council will establish, develop, and promote excellence in the healthcare profession by:

* Developing & delivering high quality educational programs in security and related disciplines to include but not limited to: safety, risk management, transportation, parking & communications, which will include forums that foster the exchange of information and ideas

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IAHSS Standards Council

Kyle Kayler
White Paper

* Serving as an available resource, as appropriate, regarding legislation or regulation affecting healthcare security
* Promoting & communicating high standards of professional & ethical conduct within the healthcare security profession
* Identifying & promoting the "best practices" of security professionals through cooperative efforts & the exchange of information, ideas & programs
* Collaborating within ASIS International and with other outside organizations having goals compatible to fostering mission achievement

Council Members in the News . . .

Experts Warn of Rising Violence in Healthcare, Ben Scaglione, CPP quoted

In the wake of Orlando surgeon Dr. Dmitriy Nikitin murder last week, shot by a disgruntled patient as he walked from Florida Hospital's downtown building into the parking garage, security experts say doctors are increasingly the target of patients' ire. That's why many security experts say the most important step hospitals can take is to educate employees to alert security if they think they're in danger, whether from a patient, former spouse or someone else. On a temporary basis, security may change a worker's schedule or assign a person to a new parking area closer to a security entrance. In addition, hospital workers — from clerks and housekeepers to doctors and nurses — should undergo training to recognize when a patient's behavior is escalating toward violence, said Ben Scaglione, CPP a New York-based security consultant. "That's the key going into the future," Scaglione said. "At many hospitals, this kind of training has been limited to security and the emergency-room staff. But everyone in the hospital should go through it."
(Copyright 2011, Orlando Sentinel, May 31, 2011)

Bonnie Michelman, CPP: Appointed to Homeland Security Advisory Council

Bonnie Michelman, CPP, CHPA was appointed to the Homeland Security Advisory Council (HSAC) by Secretary of Homeland Security, Janet Napolitano in December 2010. This is a 26 member council consisting of governors, CEOs, mayors, senior executives, and law enforcement officials. Bonnie was appointed to represent the private sector and the infrastructures that we protect. The Homeland Security Advisory Council (HSAC) provides strategic advice and recommendations to the Security Advisory Council on matters related to Homeland Security. "I find it a fascinating group of people and enjoy the privilege of being briefed on many programs, plans and initiatives that the Department is considering or implementing." I am honored to have this appointment and hope that this Council can help make a difference in infrastructure protection.

William H. Nesbitt, CPP: "Liability Lessons for Hospitals"

According to William Nesbitt, CPP, "hospitals are held to a higher standard of care since patients under their care are less able to fend for themselves." Given this greater level of responsibility, the damages and awards when incidents happen, such as a sexual assault, are often much higher than would the same victim receive should the incident have occurred in an office environment. Mr. Nesbitt, CPP briefly discusses the theories behind premises liability and tort law to include relevant case law. He goes on to say that "hospital security managers should continue to update physical security measures and maintain strong pre-

employment screening programs, they should also pay attention to the human elements. These include cross-departmental cooperation and buy-in as well as strong training for in-house and contract staff."

This article can be found in its entirety in the June 2011 edition of *Security Management* magazine (p. 76-77).

ASIS 57th Annual Seminar and Exhibits in Orlando, FL

Bonnie Michelman, CPP, CHPA and Elliot Boxerbaum, CPP, CSC will be presenting "Business Case for Security: Creative Ways to Show Security's Proposition and Profitability "at the ASIS Annual Seminar and Exhibits in Orlando, Florida in September.

As hospital / healthcare security budgets continue to erode it is essential that security leaders have and apply business acumen. Understanding the "business" side of security management is becoming ever more essential.

The session is intended to provide mid and senior level security managers with insights and strategies for developing their "business case" when building security program budgets and presenting them to C-suite leadership.

BUT . . **. we need your help!** If you have developed a business case for any aspect of your security program and are willing to share this information or if you have other experiences that would be helpful, please drop either Bonnie or Elliot a call. They can also be reached at ElliotB@S-RMC.com or BMICHELMAN@PARTNERS.ORG .

We want to make this a valuable and informative session and provide real-world examples (we can redact the institution if you wish) of successes will be an important part of this program. We also hope to see you all at our session, Monday, September 19th 11:00 AM in Orlando.

Healthcare Security Training and Initiatives

How do you get the word out about fraud prevention and compliance with security policies? HealthSouth Fraud Investigations personnel play games.

During a recent all-hospital Human Resources training summit at the company's headquarters in Birmingham, Alabama, the Fraud unit set up an information booth where employees played the game "**Truth of FRAUD sequences"** for prizes. Employees got to pick their category of question ranging from the internal investigations policy, interviewing techniques, internal audit and fraud prevention.

According to Tom Slimick, CPP, CFE, Director of Investigations for HealthSouth, it was a lot of fun for the Human Resource Directors and gave our Internal Audit personnel an opportunity to meet and talk in a less stressful atmosphere. HealthSouth operates 106 Rehabilitation hospitals in 26 states and Puerto Rico.

Cincinnati Children's Hospital Emergency Department Security Enhancements Initiative

In mid-December, 2010, a patient, who was in the Emergency Department (E.D.) for approximately five hours acted out when he was told that the Cincinnati Police would arrest him for open misdemeanor warrants. He tried running from the E.D. but failed to push the automatic door push-plate opener and crashed into the door. He hit the door with such force that he collapsed to the floor where multiple staff members, to include Protective Services, gained control and restrained him to a gurney.

When E.D. and Protective Services staff finished restraining him, a small caliber handgun was found in his jacket pocket. He was brought into the E.D. by an emergency squad due to minor injuries that he incurred when he jumped out of his family's second story window. His mother called the hospital and informed Protective Services that her son was in the Emergency Department and that he had open felony warrants. She also said that he is involved with drugs. During the transport, the emergency squad did cut away his clothes to observe his injuries. The patient called his girlfriend to bring him clothes for when he was discharged. She brought the clothes to hospital and the weapon was contained in the jacket pocket. We assumed that when he was told that he would be arrested, he probably ran because he knew he had an illegal weapon in his jacket.

Immediately after the incident with this patient, the E.D. staff raised several concerns about their safety and wanted the hospital to take action. Is this a case of hypersensitivity and overreaction by some staff or reality? Prior to the incident, Protective Services had one officer stationed in the E.D. 24/7. Additionally, the hospital had an off-duty Cincinnati Police Department (C.P.D.) Officer for 12 hours a day (18:00 – 06:00) stationed at the front desk seven days a week. Protective Services collaborated with the E.D. and implemented the following security enhancements, which were supported by senior leadership:

- Increased the off-duty C.P.D. officer coverage to 24/7.
- Stationed a second Protective Services officer in the E.D. 24/7. One officer is assigned to the Security Desk in the E.D. 'Waiting Area' who grants access to visitors to the patient care area while the second officer patrols the E.D. patient care area.
- Increased utilization of the hand-held scanner (metal detector) for patients and visitors who meet certain criteria; this was the result of collaboration among Protective Services, E.D. staff, and the Legal Department.
- Additionally, Protective Services along with Facilities recommended four structural security renovation projects for the E.D. to increase security and safety for that area.

Interestingly, since implementing these new security measures, no weapons of any kind have been found. Protective Services continues to work closely with the E.D. leadership team to manage the E.D. staff's safety and security concerns. Dan Yaross, CPP, CHPA, Director of Protective Services for Cincinnati Children's Hospital, stated that the E.D. leadership team plans on conducting a follow-up survey of the staff later this year to gauge the effectiveness the new security measures have made on staff.

Job Rotation Enhances Loss Prevention Program at University of Michigan Hospitals & Health Centers: Loss Prevention Unit "Tour of Duty"

Several years ago, Director Marilyn Hollier, CPP supported the proposal to assign a security officer to work as a temporary investigator to the Loss Prevention Unit (LPU). She believed rotating officers through LPU would give them a chance to gain valuable investigative training and experience. Officers would return to their shift with valuable experience that they would be able to apply in the field, such as enhanced investigative and report writing skills. The leadership team decided that officers would compete with their peers for a six month rotation through the LPU with interviews following a call to all interested security officer candidates. And thus, the new temporary investigator position was born. The temporary investigator is also temporarily assigned to a Lead Officer position and receives a 3% pay increase while in this assignment. The assignment gave investigators the opportunity to hone their investigative instincts and close cases that would have challenged the more experienced gumshoes. For this article, we asked each temporary investigator a few questions describing the highlights of their assignments in the LPU.

What was one of your biggest cases? For this question, Laura and Ben described their effort to nab a serial thief who trolled the halls of the North Ingalls Building. Their investigative thoroughness and persistence put an end to the perpetrator's long-time operation. He was captured and convicted and better yet; he's no longer stealing property at the North Ingalls Building.

Laura also related the time she helped U.M. Police track down a suspect in a thorny sabotage case. The effort paid off and the suspect was caught and pled guilty – another bad guy off the streets.

Robert fondly recalled investigating a case where a trouble-maker gained entry into the facility to commit a crime. Robert's flair as an investigator resulted in a conviction.

Nick talked about the time he zeroed in on two credit card thieves who had been running their criminal enterprise for a long time. First, he nabbed the ring leader, and then he nabbed his partner in crime. Both were arrested and convicted.

What cases gave them the most satisfaction? Robert gained plenty of satisfaction after he identified a thief that frequently ripped off property from our gift shop. She won't be stealing from the Gift Shop, or anywhere else for the time-being. Robert's effort took her off the street for a while.

Laura fondly recalled two employees she caught stealing from their work place. Nick mentioned several but his all-time favorite was the case of the stolen moped. In that case, Nick teamed up with several outside agencies to round up the moped and the suspect. One of Ben's favorites involved a suspect using a relative's identity to gain medical services. Ben's investigation put an end to his criminal operation.

What did you learn in LPU that you had no idea about? Nick recalled being amazed at the numerous tasks assigned to the LPU. One thing he took advantage of was the interviewing training that has improved his skills immensely. Ben did not realize how integral our work is to other departments within the health system. Laura mentioned the new and varied tools available to investigators that

she never knew about before. Plus, she learned that interviewing people in an investigation is a very precise and nuanced skill that has to be learned. Robert stated that he was surprised to learn how long the court (legal) process can actually take.

What were your biggest surprises? Robert was surprised at how closely we work with U.M.P.D., Risk Management, other police agencies and departments within the University. Laura's biggest surprise was finding out how closely the LPU works with the Child Protection Team. As for Ben, he also enjoyed how well the LPU worked as a team. Nick agreed with Ben and added that he actually enjoyed taking work home.

What advice do they have for others including co-workers? Grab a case and go for it, own it and work it through to the end. People will judge you by the quality of your work so do your best. Robert believes every officer should take this assignment for six months so they can really see what happens behind the scenes.

Any words of wisdom? Investigate as many different cases as you can. Good investigation requires creativity so remember to think outside the box!

Department of Homeland Security and FEMA Online Training

Numerous training opportunities are available online thru the FEMA website. These independent study programs may be an effective tool to assist you with educating your staff or to help them with their professional growth. Courses include but are not limited to: active shooter, communications, emergency planning, exercise planning, leadership and managing, NIMS and many more. Consider adding this to your training repertoire. You can go to http://training.fema.gov for more details.

Healthcare Security Statistics:

- **4% OF PERSONS ARRIVING** at the emergency department carry weapons.
- **37% OF AMERICAN WORKERS** have been bullied at work, and 72% of the bullies are bosses.
- **MORE THAN 40% OF NURSES** say their organizations don't provide formal zero-tolerance policies and procedures to thwart workplace violence.
- **THE AVERAGE LOCKDOWN TIME** for U.S. hospitals is 11 minutes (median is eight minutes).
- **FROM 2004 TO 2008** the number of ER visits from medication abuse doubled.
- **92% of hospitals** strongly agreed or somewhat agreed with the statement "My campus is adequately prepared for a weather emergency or natural disaster."

Source:

Campus Safety: (2011) Hospital Public Safety Statistics: Yearbook 2011, downloaded from website www.campussafetymagazine.com, April 9, 2011.

What's keeping you up at night?

Recent topics presented to council members for discussion have included infant/pediatric security, ballistic vests in healthcare security, and security staffing metrics.

INFANT & PEDIATRIC SECURITY

Photo Badging System for Parents, Legal Guardians, and Visitors at Children's

The University of Minnesota Medical Center recently completed construction of a new, free standing Children's Hospital which was occupied on April 30, 2011. One of the many security components discussed was how to best badge everyone entering the facility including parents/legal guardians, visitors, volunteers, and contractors. According to Linda Fite, CPP the decision was made to badge everyone entering the building and not allow entry to any unit without a proper badge. Once the philosophy was agreed upon, the following guidelines were created.

- A committee was charged with selecting a visitor badging system. Easy Lobby was selected for ease of use, interface capability with the security platform, and badge quality. Locations were selected for three stations, the entry lobby to the building, the ED and the Birthplace.
- Since all units are locked, it was important for parents/legal guardians to have access to the units and not have to be badged every time they entered the hospital. Upon admission, parents are given a temporary access badge only for the unit on which their child is a patient.. As soon as possible, they are asked to obtain a more permanent photo/access badge. The badges are color coded for the unit their child is on. The temporary access badges are collected when the new badge is issued and access is immediately de-activated. When the patient is discharged, the photo/access badges are deleted from the system.
- As people enter the facility, information desk staff prepare the sticker photo badge. A color coded badge is issued for the destination unit. A driver's license is used to populate the fields. If the person does not have a DL, the picture is taken manually and the fields populated. Children over the age of six are required to have a photo badge. Children under six are issued a sticker. The photo stickers are valid for the day issued only. Further visits require visitors to get a new badge.

  A security officer is posted in the lobby 24/7 and checks to make sure everyone is badged before they are allowed onto the elevators. When a person arrives on a unit who has a sticker badge but does not have an access badge, they are buzzed in by a welcome desk staffer.
- Volunteers receive badges upon being accepted into the programs. Vendors and contractors are badged at a different location after undergoing safety training.

Staff are trained to watch for piggybacking onto units and asked to question anyone doing so. If anyone gets on a unit without a photo badge, they are asked to return to the appropriate area to get a badge made. Security is called to speak with anyone who is unwilling to comply with the program.

For more information on how you can better protect your healthcare facility's infant and pediatric patients please see the publication *"For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions, Ninth Edition"* or contact the National Center for Missing and Exploited Children at www.missingkids.com or 1-800-THE-LOST (1-800-843-5678).

Ballistic Vests in Health Care Security

There has been some interest regarding whether or not hospital security personnel have adopted ballistic vests as part of their standard uniform requirement. In addition, is there a correlation between the wearing of ballistic vests and whether or not those personnel are armed?

One respondent stated that an executive team's decision to implement the use of ballistic vests was closely aligned with the organization's philosophy. To that point, "hospitals and healthcare institutions are places of healing; what message are we sending to our customers when they see armed security personnel?" A comment by another council member was that based upon his 24 years in the healthcare industry, proposals and or the incorporation of ballistic vests within the healthcare industry is much more closely associated with the senior security leader's affiliations with law enforcement than the equipment's implementation as a standard or even an occasional occurrence within the Healthcare Security Industry.

Based upon total responses, it appears the majority of healthcare institutions do not issue ballistic vests to their security personnel. There was not enough information compiled to draw a conclusion as to whether or not there is a correlation between ballistic vest adoption and arming of security staff.

Anecdotally, a survey released May 26, 2011, by the ASIS – CSO Roundtable, may offer further insight regarding the use of ballistic vests, weapons and commissioned law enforcement officers in healthcare security. What follows is a partial sampling of the complete survey, "*CSO Roundtable Survey on Healthcare Security Practices*."

- Organization's employing commissioned law enforcement officers to some extent: 20.6% [28 of 136 respondents].
- Organization's supplementing their in-house security team with off-duty police officers: 19.7% [27 of 137 respondents]
- Organization's arming security personnel with handguns or tasers:
    - Handguns: 14.1% [19 of 135 responses]
    - Tasers: 10.5% [14 of 133 respondents]

*Note: States and jurisdictions differ in their definition of weapons. It is recommended that anyone considering the use of any protective equipment check the laws of their state and consult with their legal department.

**The CSO Roundtable is available for membership to those organizations with annual revenues of $1 Billion or greater and, therefore, may not be indicative of your facility and or the general state of healthcare security industry.

Featured Article

Universal Metrics for Security Staffing in Healthcare Organizations

This subject was posed to the council for their perspectives. Here are the results of the conversations:

One council member conducted some research and provided these findings:

Healthcare security professionals are faced with the challenge of justifying security coverage based on staffing models. Whereby clinical departments can adjust staffing levels and FTE's based on patient length of stay, patient census, or scheduled patient procedures, ancillary support departments such as security are having a tougher time coming up with a universally accepted standard staffing model.

Clinical areas may follow the law of supply and demand where the number of nurses, technicians, or therapists can be adjusted based on benchmarking models such as patients to nurse ratios. Such a concept appears to be more complicated when it comes to security coverage. Security departments have a unique approach to staffing levels since regardless of patient beds or patient censuses, security services still need to be rendered based on factors that are indirectly related to hospital operations.

A combined mix of direct and indirect factors must be utilized to rationalize security coverage. In that regard, any formula or metric developed to address this issue must encompass at least two variables: size and crime index:

Size: Square footage is the most common variable advanced when it comes to metrics for security staffing level in healthcare or in any industry for that matter. It is an important factor when determining security coverage but not the single most relevant vehicle that drives it. Two identical hospitals of the same size in both square footage and beds may have a totally different security staffing structure if other elements differ. Square footage only determines what is to be covered but does not address the level to which it needs to be covered.

Crime index: The location of the hospital has a dominant role among all determining factors. Security or police presence is only needed because crime is present or probable. It would therefore make sense to add that the probability of criminal activity occurrence would be a leading factor in determining what kind of security coverage is needed and to what extent. It is assumed the higher the crime rate in a particular location there is an equally higher threat to the population and thus a higher level of risk. Based upon that method of reasoning, one would then assume a hospital located in an area with a high violent crime rate will need more security officers in the parking lots and at entrances than a hospital with little or no violent crimes. This crime index should result from information gathered from both Unified Crime Reports (UCR) crimes and internal security incident reports.

On top of the above mentioned variables, other factors need to be considered as part of such metric. Those said factors could be anywhere from traffic flow, type of security service provided, technology used, type of hospital (trauma level and specialization), just to name a few.

- Traffic flow will include everything from number of staff and visitors who navigate throughout the facility to the structural design directing this flow.
- Some hospitals may use security officers as information desk representatives or even parking attendants. Others may simply use security officers as guards. To what extend security officers are used will have an impact in determining the number of security personnel needed.
- CCTV, access controls, and related technologies can significantly reduce the number of security personnel needed but yet augment the effectiveness of a hospital security program.
- Level I trauma hospitals are more likely to receive the type of injuries involved in criminal activities such as gunshot wounds. Hospitals that have behavioral health centers will likely see more mental and behavioral health patients and drug users. In short, the specialization and characteristics of a hospital determines what type of crowd flows through the facility, thus affecting security staffing needs.

Background: Hospital administrators usually allocate FTE's based on standardized formulas.

Executives and managers use graphs, formulas, and statistics to understand and analyze the performance of the different operational elements of an organization. In that regard, hospitals use accounting algorithms that allows the C-Suite and healthcare managers to make daily sound financial decisions. This is why hospital accounting or finance departments have specialized positions such as productivity managers who disseminate information every day about patient census, productivity hours, OT hours, managed care patients, Medicare patients, Medicaid patients, self-pay patients… These same individuals, sometimes called financial specialists, act as consultants to the C-Suite when determining benchmarking notions related to staffing plans. In doing so, they rely on formulas in order to output data to the decision makers; formulae which are currently non-existent for security.

Literature Review:
Multiple articles and even studies have been done regarding security metrics but no formulas have been found to date to be an acceptable security staffing tool. According to 30 hospital security directors around the nation who were consulted, none have any such formula. It is not a stretch at this point to say there is no hospital security department that currently has such staffing reference. The uniform consensus amongst healthcare security professionals seems to echo the same conclusion: it is a combination of different variables both directly and indirectly related to a hospital that would ultimately lead to an accurate and efficient conclusion for security staffing needs. This same conclusion has been advanced by the International Association of Healthcare Safety and Security (IAHSS) who suggested 17 factors to be considered on their January 11th edition of the handbook. Research conducted by the International Association of Professional

Security Consultants last year echoed the results of IAHSS; no such formula exists.

Summary of Findings:
A comprehensible formula based on research and studies, that addresses these factors will certainly be a welcome initiative if at all possible. Metrics are excellent and efficient tools for benchmarking staffing levels. Not only they would allow security professionals to justify security coverage, they would also provide executives with tools to measure productivity and set expectations. That being said, determining the number of officers for a specific organization is not as simple as just an equation of x + y = z. Several factors that come into play differ by organization. Each security professional should determine what those factors are, how they are weighted and to what degree each will play in the determination of coverage for security. The combination of these factors prior to determining a security staffing level leads to a very familiar concept: Security Vulnerably and Risk Assessment.

The following information was included along with further analysis:

- According to a recent study conducted by IOMA:
  - The recommended ratio is 1:163 general staff

  Source:
  IOMA, Hospital Security Best Practices, Benchmarks & Compliance (2008).

- According to the November 2009 (p.38) issue of "SECURITY" magazine:

  - Square feet/Security officer: 43,167 sq. ft. / security officer
  - Employee/Security officer: 119 / 1 ratio
  - Security spending per employee: $962.00
  - Security spending per patient: $63.00

The following comment from one respondent emphasizes the difficulty in utilizing a set staffing formula: "Sadly, we currently use square footage but the equation changes based on the difference between grading organizations such as Premier and Solucient. As I have read through the responses I applied the different standards and now know I am either 40 FTE short or as much as 130 FTE over. If this isn't an indication of the issue with metrics I don't know what is."

Practical Analysis:
One council member responded to this inquiry by stating that in over 32 years with ASIS, he has seen many proclaim their ability to use square footage to assess security staffing levels. In his opinion, all have been proven inaccurate and without merit. While the concept works well with departments such as Environmental Services and Facilities, only a Security Vulnerability Analysis will effectively identify the security staffing requirements at your location.

When discussing this matter with senior management officials, this security professional used the following analogy:

If I am protecting 100,000 square feet of space and the area has a single access point, how many security personnel are required? What about the same 100,000

square feet with four access points, how many security personnel are required? What about the same 100,000 with 20 access points, how many security personnel are required?

If this same 100,000 square feet is used for the storage of janitorial supplies, how many security personnel would be required? What if the 100,000 square feet is a maternity or new born center, how many security personnel would be required? What if the 100,000 square feet is an Emergency Department, how many security personnel would be required? Or, what would the security staffing level requirements be if this same 100,000 square feet was used to store morphine based pharmaceuticals?

“I have found that by posing similar questions to senior management officials, they rapidly appreciate both the complexity associated with security staffing deployments as well as the reality that a simple security staffing formula does not, and for obvious reasons, will never exist in the security profession.”

Using this same analogy, if I were identifying the staffing requirements for a 100,000 square foot health care clinic that I was about to construct next to a Club House in a gated community that was located in an exclusive area of the city, what would be the security staffing level requirements?

Now that you have calculated and implemented those security staffing requirements, the health care system makes the decision to construct a second and identical health care clinic. However, this one will be constructed next door to the worse low-income projects in your city. Will your security staffing requirements be the same as those of the first clinic?

Obviously, we both know the answer. The purpose of such questions is to underscore the necessity to identify one's security staffing deployment based upon the vulnerability, probability, and criticality formulas associated with the location of the area being protected. “The question is as relevant and challenging to me today as it was in 1979 when I left law enforcement to begin my security management career.”

There appears to be general agreement among the council members. Council members agreed that it is also important to benchmark against what is being done within those square feet than just how many square feet there are. We see great disparity in the duties, skill sets, responsibilities, and authority of individual departments. If you are going to use square footage as a benchmark it needs to be within the context of the operation. Security staffing levels will and should vary greatly when comparing a like-sized Level I urban trauma center with a suburban Level II facility.

The security staff work load is also very important. We see more and more departments moving to the use of computer aided dispatch systems to accurately gage response times by type of incident/request, patrol availability, time commitment to specific types of incidents (2 officers for 1 hour on a “patient assist” is a huge staffing drain), etc. Establishing metrics and achievable goals using CAD data can be very powerful.

In sum, using square feet is '*important*' primarily because that is the measure our administrators have learned to use. As with any other metric, trying to apply this out of context does not have a lot of meaning. The consensus of the council is that nothing can replace the value of a formal due diligence vulnerability assessment.

Legal Corner

Prisoner and/or Patient: Who is Responsible for their Security?

It really depends on what part of the country you are located, and sometimes even what county you are located, to know the answer to who is responsible for prisoner patients. In some locations the law enforcement personnel will stay with their prisoners the entire time while at a medical center, but in other areas they may just "un-arrest" and walk away.

Generally speaking, law enforcement officers do not want to 'babysit' prisoners or protective custody holds. In addition, law enforcement is also concerned about the city, county or state getting stuck with the medical bills for prisoner patients. So it is becoming more common for law enforcement to un-arrest the person they have in custody for the purposes of seeking medical attention and then re-arresting them once they are medically cleared.

In a recent situation in Northern California, a deputy brought a prisoner in to the medical center who was wearing an orange jump-suit along with shackles and hand-cuffs. Once in the E.D. the deputy un-cuffed the prisoner and exchanged the jump suit for a hospital gown. Then to everyone's astonishment the deputy stated that he was leaving and would return in 30 minutes to get the prisoner. Medical staff would not approach the patient; the deputy returned 45 minutes later.

This incident and many more like it across the country all point to a disturbing and growing trend. With police services being cut due to budget shortfalls around the country, law enforcement certainly does not want to be responsible for paying the medical bills of people that they arrest. Un-arresting a DUI suspect who was injured in a car crash to receive medical care is very common in some states.

Hospitals have been looking at ways to minimize their risk exposure in cases like this because, for the most part, they are not increasing their security staff to take the place of the police. In-fact, several California hospitals have cut their security staff due to budget issues. Hospitals should plan for this, because if it is not happening in your location yet, and there is no law to require police to maintain custody, this problem may be coming to your emergency room soon. According to John White, CPP be ready; assemble a collaborative team of security, risk management, emergency department, and legal personnel to plan your response. Reach out to law enforcement and come up with a joint cooperation plan so that everyone knows what the others will, won't, or cannot do. And most importantly, stay safe!

California Proposes to Amend the Healthcare Security Law

Assembly Bill 30 (AB 30) is making its way through the California state legislature. This bill is amending the Health & Safety Code sections 1257.7 and 1257.8 that were revised in July 2010.

The new changes will include required training for all employees that provide patient care, as well as stricter reporting measures, monetary fines for failure to report, and require follow-up investigations. All of these, and additional new measures within the legislation are to tighten up the laws to protect healthcare workers from the increasing levels of violence that we have all noticed in our organizations. As with a lot of other changes, even though this is currently only a law in California, watch for it to become an issue in other areas in the future. Labor groups are taking up this cause in an effort to make their workplace a safer place.

Click on this link or type this link into your web browser to see the legislation in its current form. For more information, go to http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0001-0050/ab_30_cfa_20110318_131302_asm_comm.html

Napa State Hospital fined in slaying of worker

State safety officials contend facility neglected to restrict the movements of violent patients.

California workplace safety officials have issued $100,000 in fines against Napa State Hospital in connection with the October slaying of a psychiatric technician, contending that the facility neglected to restrict the movements of violent patients -- including the man charged in the strangling. Cal/OSHA issued the citations Tuesday against the beleaguered psychiatric hospital, which has experienced steep increases in the number of patient assaults on peers and staff despite a U.S. Department of Justice lawsuit in 2006 to impose reforms there and at three other state hospitals.

The gravest citation says the hospital violated its own policies by not restricting patients' grounds passes based on their previous behavior. The hospital knew that the patient charged in Donna Gross' killing had a "recent history of aggressive behavior, illegal drug usage, and stalking," the citation states, but allowed him to wander "with no supervision, in a totally unstructured environment." Jess Willard Massey has pleaded not guilty to charges of murdering and robbing Gross, 54, on the grounds of the fenced area where patients accused or convicted of crimes related to their mental illness are held.

In its citations, first reported by KTVU in Oakland, the California Division of Occupational Safety and Health also noted faulty alarm systems, inadequate employee training to deal with the increasingly violent patient population and assault investigations that "lacked analysis of the cause and thus were ineffective in preventing future occurrences."

The state Department of Mental Health will appeal the citations, Acting Director Cliff Allenby said in a statement Wednesday. He said the department would continue working on safety improvements, but cited "significant steps" already taken at the facility, including giving employees personal alarms that work on the grounds, increasing the police presence, limiting grounds access for patients and improving staff training.

Since the death, employees have been pushing for improvements that include more officers, not just reassigned ones, and segregation of the most predatory patients in a special unit. Employee unions contend that the changes to date have been inadequate. State Sen. Noreen Evans (D-Santa Rosa) and Assemblyman Michael Allen (D-Santa Rosa) have taken up the cause and this week jointly asked Gov. Jerry Brown to act quickly to implement more measures. On Wednesday, Dr. Stuart Bussey, president of the Union of American Physicians and Dentists, called the fines "peanuts compared to a life" but "a good first step" to improving safety.

Source:
Los Angeles Times, by Lee Romney, April 15, 2011.

*Although the three previous articles cite issues that have taken place or are being reviewed in California, it is safe to say these situations could have occurred anywhere in America.

Future Articles

Any healthcare security professional seeking guidance and or wishing to write an article for a future edition of the newsletter should contact a council member. We value your input and feedback.

"*Thank you*" to all Council Members for providing their input and expertise for this edition of the Healthcare Security Council Newsletter.

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