Experience and preparation are the keys to disaster planning

Editor’s note: For the next six issues, HSDA will bring you a special feature called Ground Zero report. We’ll talk to emergency planners directly involved in the September 11 tragedy in New York City, find out how they handled different situations, and what lessons they learned in the aftermath.

When it comes to disaster planning and emergency management, two elements will help your staff through the event—experience and preparation. The events of September 11 spelled that out clearly.

Experience
“In New York City, area hospitals have had extensive experience with many lower level emergencies, as well as the 1993 World Trade Center bombing,” says Zachary Goldfarb, BS, CEM, EMT-P, a New York–based emergency management consultant and a member of the HSDA editorial advisory board.

“IT's not a matter of pulling a 'disaster book' off the shelf and following the pages,” Goldfarb says. “Facilities must have a continuing cycle of preparedness for emergencies that include everyday procedures for staff members.”

In an emergency, hospital staff members should do jobs

Joint Commission issues special report on emergency management

Wondering what the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will look at in relation to your disaster or emergency plans?

The good news is that you don’t have to start from scratch and rebuild your emergency management book.

The JCAHO will, however, make sure that your plans apply to a variety of situations on different scale levels, according to a recent JCAHO report.

“As with any organization, current events will dictate what JCAHO will look for,” says Steve Bryant, practice director for accreditation at The Greeley Company, a division of HCPro in Marblehead, MA.

“Chances are good that surveyors will not look at your facility as a victim of an attack, but as the recipient of patients from an

> p. 2

> p. 4
that are as close as possible to those they normally do, but either at a higher level or with added responsibilities within their jobs, Goldfarb says.

✔ **Tip:** When you develop your emergency plans, if you must add responsibilities to staff members’ jobs, make sure the new tasks are in the realm of their daily work tasks. During an emergency you want staff to react quickly and correctly and not have to think about unfamiliar tasks.

✔ **Tip:** Using a job aid, such as a Hospital Emergency Incident Command System (HEICS) Job Action Sheet, is of great benefit to both the familiar and unfamiliar staff member in carrying out crisis assignments. Find a sample HEICS plan and job action sheet on the Web at www.emsa.cahnnet.gov/Dms2/heics3.htm.

Communications
When the World Trade Center towers collapsed, many cell phone networks, television networks, pagers, and other communications systems didn’t work because the transmitters were located at the top of the building. The servers for a citywide health alert network were also located in the buildings and were destroyed when they collapsed. In addition, several hospitals experienced problems such as loss of dial tones when their internal networks were overloaded.

“You need to build redundancy into your communication system in case the system becomes part of the disaster,” Goldfarb says.

✔ **Tip:** Work with your local agencies to ensure that your communications links are prepared for mass-casualty incidents. Test those links within your facility and on a communitywide basis.

✔ **Tip:** Establish redundant systems to ensure that your communications stay active. For example, you can do the following:

- • Use a telephone service with two providers
- • Use two phone central offices to split your trunk lines
- • Establish cellular service as a redundancy
- • Have radio equipment to augment or backup wired telephone links
- • Use Internet access as an additional medium
- • Make arrangements with local ham radio operators as a tertiary alternative

Activating your emergency plan
A lower threshold of activation will get the plan off to a quick start, Goldfarb says. “If you have a cumbersome decision-making process to activate your emergency plan, you run the risk of having the event overtake the plan.”

✔ **Tip:** When planning your emergency plan activation process, make sure you take “time of day” issues into consideration. Make sure that decision-makers are the staff members in the building at the time of the incident. “On September 11, the attacks occurred in the morning when most hospital officials were on duty,” says Goldfarb. “Should a large scale emergency occur during the evening or weekend, you will want the same rapid kick-in of the emergency plan.”

Make sure your emergency plan contains contingencies for complex situations. “New York University Downtown Hospital was the closest to Ground Zero,” Goldfarb says. “When the first tower came down, they lost all of their utilities.”

Fortunately, the hospital had a plan in place for such an event, and it was able to restore essential functions quickly.

✔ **Tip:** In support of your all-hazards plan, include logistical annexes as well as clinical support annexes to take care of the various levels of patients in your emergency matrix. Train your staff by staging emergency drills based on different scenarios.

Initial notification
For an event of the magnitude of the September 11 attacks, most staff workers who weren’t already on duty became aware of the attacks through radio and
television broadcasts. At one point shortly after the attacks, local broadcasters urged “all medical workers” not on duty to make their way into the city to assist.

“That request by the media was completely unsolicited from any agency,” Goldfarb says. “The media took it upon themselves to make those requests, which only added to the chaos and put more unprepared, unequipped people in harm’s way.”

✔ Tip: Medical staff and support members should wait until they receive notification from the proper authorities at their facilities before coming in to help. Hospital and ancillary medical personnel should never report to an incident scene unless they

• are part of a community’s planned and organized response
• have appropriate personal protective equipment and incident operational training
• are specifically requested to do so by local plan activation

Communities should plan to use this enhanced staffing capability during a mass-casualty event by assigning them to duty at casualty collection points (off-site treatment facilities set up to handle less-severely injured).

Organize staff
Keeping staff members in the same jobs will help make the transition into emergency mode easier. “All staff members, clinical or otherwise, need to continue normal activities as much as possible, until there is a need for them to switch into emergency mode,” Goldfarb says.

This is important to maximize the facility’s business continuity and minimize the impact of frequent emergency plan activation.

Initial response: “Doc-in-the-box” shops
As the events of September 11 unfolded, hospitals in the city reacted by sending out medical teams to set up in areas closer to Ground Zero. These “doc-in-the-box” shops—as Goldfarb calls them—set up in storefronts, on street corners, and at other locations and were augmented by well-intentioned but unprepared medical staff who came of their own accord.

Although hospital officials may have had good intentions, the establishment of these medical teams could have resulted in more harm then good to both patients and the staff outfitting them.

✔ Tip: Do not arbitrarily send out medical teams to a disaster site unless it is part of the overall community plan or requested by an official agency.

If you receive such a request, take the following steps to ensure both the safety of your team members and that the environmental condition of the site will allow the team to operate:

• Ensure that there is a process for coordinating team operations with the incident commander and EMS/medical operations officer. Establish direct lines of communication within the incident command system at the scene to ensure that this coordination is maintained.
• Include protective gear as part of the team’s field equipment. Make sure that the gear is serviceable and fits personnel properly. Plan training exercises so that staff members can wear their protective equipment.
attack. In the case of a biological or chemical attack, you will need to have provisions to prevent the spread of the agent.”

Environment of care (EC) interview is the key
The Environment of Care interview will afford surveyors the most opportune time to evaluate your readiness, according to the JCAHO.

Surveyors will make sure that your plan addresses the four phases of emergency management planning (mitigation, preparedness, response, and recovery), and they will also want to see how you used your hazard vulnerability analysis (HVA) to develop your emergency plan.

“If you have not yet completed an HVA for your facility, you are absolutely behind the curve as far as emergency planning is concerned,” Bryant says.

✔ Tip: The American Society for Healthcare Engineering has a sample HVA available on its Web site, www.ashe.org. Use it to develop your own HVA, taking into consideration the threats that are relevant to your community.

Involvement on the clinical side
Clinical involvement in the development and implementation of emergency management is absolutely crucial.

Among other things, surveyors will look to see how the clinical staff contributed to the development of the emergency plan as well as how you trained them in emergency management.

✔ Tip: If your clinicians are not in on your planning yet, show them a copy of your HVA and emergency plan, and then explain to them its vulnerabilities.

Ask them to pinpoint problems with the plan and suggest or provide solutions.

Explain to them that the JCAHO expects their involvement to directly affect the safety and care of patients.

Leadership in a changing environment
One thing that disaster emergency planners can count on during any emergency is that change will occur as the emergency plays out.

Hospital leadership will play a big part in how this change is managed. The JCAHO will look at how you structure command, and how well that structure integrates into the community command operation.

Leadership will also need to demonstrate how it plans to rapidly expand clinical and nonclinical staff in the event of an escalating crisis.

✔ Tip: Make sure you go over your most recent disaster drill with leadership prior to the survey. If you haven’t had a recent drill on the community level, get with local agencies and organize an exercise that involves your leadership.

Patient care units
A major element of emergency management is that every member of the hospital staff from the top executives to patient unit workers, has a role.

Surveyors will want to know whether unit staff understand the emergency management plan as it applies to their unit, and how they were involved in formulating the plan.

✔ Tip: Make sure that patient care staff members understand the overall community emergency plan. Surveyors will quiz staffers about their role in managing a community level event. 🏥
Workplace violence remains a top issue of concern for health care safety and security professionals. Don’t wait for an ugly incident. If you haven’t looked at your policy in more than a year, pull it out and review it now.

A quick look reveals shortcomings
Take a look at what one Arizona hospital did with its program. The Mayo Clinic Hospital in Scottsdale formed an advisory committee to find and correct weaknesses in its security program.

“We just felt it was time to take an assessment of our program,” says Steven Dettman, CHPA, director of security and visitor support services. The committee consisted of Dettman, the safety director, and the human resources (HR) director. As the process went forward, development directors and chaplains were added to provide more focused expertise.

The committee found that it needed to strengthen its policy in the area of management responsibility. “We needed to define what managers and supervisors were supposed to do when they received information related to workplace violence.”

They started by adding new language to the existing policy that puts the responsibility of providing a safe environment directly on the manager’s shoulders.

“First and foremost, it starts with managers realizing there is a problem, and employees knowing that there is a place they know they can get help,” Dettman says.

The committee added a statement protecting workers from retaliatory acts. (See sidebar on p. 8 for examples of these types of statements.)

The next step was to educate managers and supervisors as to where to go with the information they received. A unique element about workplace violence is that different actions require different responses. “There isn’t one matrix or flowchart that you can set out and say, ‘This is what you should do if you hear of a workplace or domestic violence incident,’ ” Dettman says.

For example, use resources from your security department in cases where a disgruntled spouse or partner shows up at the workplace to contact or potentially harass a hospital employee.

✔ Tip: Train managers and supervisors about the different resources available through your security department. Your security department should offer the following:
  • Personal escorts on the facility grounds
  • Information on home and personal security
  • Information on proceedings such as obtaining restraining orders, if warranted

✔ Tip: Make sure you are up on all of your local and state codes and laws. There may a little-known law that could help you curb violence in your workplace.

“In Arizona, we have a law that allows a company or place of business to obtain a restraining order against an individual,” Dettman says.

Violence among coworkers
Another type of workplace violence concerns incidents among coworkers or when others fear that the tension between workers will reach a breaking point.

“The HR department will have the tools in place to deal with an issue between coworkers,” Dettman says. “Therefore, managers and supervisors must know who to contact or where to go in the HR department.”

✔ Tip: If possible, create a hotline for workplace violence reporting. If a hotline option is not available at your facility, develop a list of phone numbers that managers can use to report an incident. Make sure that all phone numbers used to report domestic and workplace violence are staffed 24 hours a day.

Training and development
As part of the program’s reassessment, Dettman brought in experts from local agencies to train selected staff members in crisis intervention. A few of these staff members became in-house trainers for other departments of the hospital.

“By having in-house trainers, more of your

> p. 8
This month HSDA begins a new feature that looks closely at a security or disaster planning success story. We’ll look at how emergency planners and security directors approached a specific problem and find out what steps they took to solve those problems.

When officials at Massachusetts General Hospital (MGH) compared their emergency room (ER) restraint statistics to other facilities, they saw a problem they needed to address.

“Our restraint statistics were considerably higher than other hospitals similar to ours,” says John Driscoll, CHPA, operations manager for police and security at MGH. The 900-bed Boston facility is part of the Partners Health Care System, employs 15,000 workers, and sits in the middle of a busy metropolitan area. Its emergency room handles over 6,000 visits a month and is classified as a Level I (most extreme) trauma center.

“There wasn’t a way to differentiate treatment between regular patients and patients in need of psychiatric or drug and alcohol help,” Driscoll says. As a result, emergency department staff used restraints if they felt a psychiatric patient was going to endanger other patients or staff. The Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) standard TX.7.1 states that a health care organization’s philosophy address “its commitment to eliminating the use of restraints and seclusion” and “preventing emergencies that have the potential to lead to the use of restraint and seclusion.” The JCAHO crafted the restraint standards with the ultimate goal of reducing the use of restraints, however, many gray areas still exist. At MGH, both the mixture of psychiatric patients with the general population and the high percentage of restraint use caused a great deal of concern and prompted hospital administrators into action.

Data confirms the problem
The acute psychiatry department analyzed the data concerning ER patients and the number of interactions with security officers and came to the conclusion that MGH needed a separate, fully staffed emergency psychiatric department. In September 1999, a task force was formed consisting of Driscoll, MGH director of police, security and outside services Bonnie Michelman, CPP, CHPA, a staff member from the acute psychiatry department, and representatives from the emergency department. They were charged with finding a way to physically configure a secure area for psychiatric patients.

The task force took a good look at the ER layout and found an administrative area that the hospital could reconfigure into a secure area. Once reconstruction and engineering finished, the new secure emergency department had a lounge, four holding/patient care rooms, and four interview rooms.

Should you decide to permanently assign any personnel to work in a secure psychiatric emergency department, train them in the management of aggressive behavior.

Staff assigned to the psychiatric emergency ward at Massachusetts General Hospital receive certification training in the following areas, according to John Driscoll, CHPA, operations manager for police and security at the Boston facility:

- Identifying situations where aggressive behavior can occur
- De-escalating a potentially violent situation
- Physically interacting in a way that minimizes patient violence
Security and staffing
The new emergency department was secured by front and back doors accessible only with passcards. MGH secured medication in a staff area out of sight from the patient care emergency department and installed closed circuit television cameras. Driscoll configured the security schedule so that at least one officer was posted within the unit at all times. Along with the security presence in the new emergency department, a psychiatrist and a psychiatric nurse are on duty 24 hours a day.

Various administrative personnel work at the emergency department during the business hours, and all permanently assigned staffers receive special training in aggressive management behavior before beginning their duties. (See sidebar on p. 6 for information on aggressive management behavior.) The new emergency department underwent a trial run in October 1999 and went full time in September 2000.

Success for the new emergency department
Since it opened in September 2000, there have been over 10,000 interactions between patients and security officers. In that time, only three injuries occurred.

Because of its separation from the general emergency room population, restraint use—the issue that brought about the project in the first place—fell by 20%. Use of the new emergency department led to the availability of more beds to the general patient population.

The new emergency department comes with other benefits. “During our last Joint Commission on Accreditation of Health Care Association survey, the physician surveyor was a psychiatrist,” Driscoll says. “She just loved the facility.”

The new emergency department also received commendations from the president of the hospital, and the annual “Partners in Excellence” award from its health care system.

The development of the new secure psychiatric emergency department also produced a positive working relationship between security employees and acute psychiatric staff.

Security staff within the secure area assist with many nonclinical functions, such as completing paperwork, assisting with families, answering phones, and collecting patient valuables, thereby freeing psychiatric staff to perform other duties. The two departments also meet on a monthly basis to discuss administrative and operational problems.

“We find ways to help each other,” Driscoll says. “This has been a complete team effort.”

Editor’s note: If you have a security or disaster planning success story that you would like to share with our readers, contact HSDA Assistant Editor Ed Justen at 781/639-1872, Ext. 3432, or send an e-mail to ejusten@hcpro.com.

What can I do? Applying ‘proven advice’ to your facility

Good data analysis will help you to focus in on the actual threats to your hospital.

Look at patient demographics, local crime statistics, and analyze the types of interactions between patients and staff members, says John Driscoll, CHPA, operations manager for police and security at Massachusetts General Hospital in Boston.

“After analyzing the data, you may find that you can deploy staff differently or change the protocols that you use,” Driscoll says. Through data analysis, Driscoll and others at MGH discovered the trends that led to the construction of a secure psychiatric ward for their emergency room.

Tip: Use your data as a source to find your most urgent needs. You might not have the resources of a large metropolitan hospital, but your data can give you clues to effective changes and improvements that you can make.
Workplace violence

line staff will be able to get the necessary training.

Getting the word out
Changes to your domestic violence program won’t mean a thing if no one knows they exist. There are several tools available to help you get the word out to employees. “We used our various communication programs to get the word out about the changes in our program,” says Dettman. The following elements of the new plan were emphasized:

• Overall changes in the program
• Various reporting avenues available to workers
• Prompt reporting of events
• Potential triggers that exist

Dettman used the following communications tools to help spread the message:

• **E-mail.** “We sent out a company wide e-mail that included the changes listed as bullet points and information on how to access the policy,” he says. “We will use that tool periodically throughout the year, as a reminder to everyone.” The policy was also posted on the company intranet.

• **New employee orientation.** “This was the most important element of the communication plan,” Dettman says. Enhance the training module within the orientation program to ensure that all new employees are well aware of workplace violence reporting procedures.

• **Staff meeting presentations.** “We encourage department heads to include us as an agenda point during one of their staff meetings,” he says. Security staff will come to a meeting, do a short presentation and then answer questions about the policy.

**Tip:** Safety awareness programs are good vehicles to let your employees know about changes in your workplace violence procedures.

Develop a “Workplace violence prevention day” program that includes

• domestic and workplace violence awareness posters
• a tabletop display in well traveled area
• a videotape presentation on domestic and workplace violence programs offered by your facility

**Sample policy statements for domestic violence**

<table>
<thead>
<tr>
<th>Here is an example of a statement that encourages employees to report workplace violence concerns without reprisal. Place this statement in employee manuals or documents related to workplace violence issues.</th>
<th>Here is an example of a retaliation statement. Use these types of statements in employee manuals and other publications regarding workplace violence.</th>
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<tr>
<td>Supervisory/management personnel have the responsibility of promoting and providing a safe work environment for employees.</td>
<td>Employees will not face retaliation for reporting incidents of workplace violence. Employees who feel they have been retaliated against should immediately notify their supervisor/manager and the human resources/security department.</td>
</tr>
<tr>
<td>Supervisors and managers should not place employees in assignments that compromise safety and should encourage employees to report incidents.</td>
<td>Source: Steven Dettman, CHPA, director of security and visitor support services at Mayo Clinic Hospital in Scottsdale, AZ.</td>
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OSHA releases anthrax guide
Workers throughout the nation have a new resource to help determine whether their workplace is susceptible to anthrax exposure.

The Occupational Safety and Health Administration has posted “The Workplace Risk Pyramid” on its Web site. The pyramid is broken down into three sections classified by level of risk exposure.

The matrix guides employers in assessing risk to employees, providing protective equipment, and safe work practices for the different risk levels. To view the matrix, go to www.osha.gov/bioterrorism/anthrax/matrix/pyramid.html.

Patient violence still a top fear
Despite an increase in concerns about bioterror threats, the American Hospital Association (AHA) reports that emergency department staff still consider patient violence as the top threat to emergency room workers. The AHA cites a poll that it conducted during a recent meeting of emergency department managers. Eighty percent of those polled believe their facilities are inadequately prepared for a bioterrorist-related medical disaster. Clinical concerns continue to be a hindrance to disaster planning, say 51% of survey respondents.

National health database in the works
A new health data network will bridge the gap between federal, state, and local officials, according to a report in last month’s Wall Street Journal.

Homeland Security Director Tom Ridge is planning the new network, which would “alert doctors and other public health officials to biological threats and help coordinate responses to a bioterrorist attack,” the newspaper reported.

Health officials have complained for years about their inability to quickly disseminate information about infectious diseases, the report acknowledged. Ridge would eventually like to link the data network with other countries involved in the war on terrorism, the report said.

Hospitals will spend millions on mass casualty prep
Disaster preparedness funding is a hot topic. The Healthcare Association of New York State (HANYS) recently announced that New York hospitals need to spend between $750 million and $850 million to prepare for potential biological, chemical, nuclear, and mass casualty disasters. The funds would not address the need to increase staffing, the cost of calling in all staff during disasters, and the patient care revenue that is lost when a hospital focuses on a particular incident, according to HANYS.

For more information, see the HANYS Web site at www.hanys.org

Senate approves $20B anti-terrorism bill
After three days of debate, the U.S. Senate on December 8, 2001, approved a compromise $20 billion package that includes $9.5 billion for anti-terrorism efforts and bioterrorism preparedness.

Senate Democrats had proposed a $35 billion bill, but President Bush and Republican senators opposed the measure until both sides reached a compromise; the previous week, the Republican-led House of Representatives approved a $20 billion package.

FEMA plans garner a second look
The Federal Emergency Management Agency (FEMA) is taking a second look at plans for its new facility, according to a report in the Washington Post.

The agency was to move into a new $220 million building at the end of next year, but director Joe Allbaugh reassessed the site because of concerns following the September 11 attacks. “My overwhelming concern is for the safety and security of our employees and the ability of the agency to carry out its mission,” Allbaugh told the Post.

The top security concern is the building’s location near Reagan International Airport, the paper reported. Allbaugh said the site is better suited for a lower risk, lower profile government agency, according to the report.
Questions & Answers

Each month, we’ll ask an expert questions related to security and disaster planning in the health care environment. Earl Williams, HSP, safety coordinator for BroMenn Healthcare in Bloomington, IL, provides this month’s answers.

Q: What is a good method to make staff aware of their role in security on a daily basis?

A: In a small hospital that doesn’t have a security force, members of the safety committee should periodically talk to employees about their security concerns. They should ask employees to show them specific situations where they might feel unsafe.

You can also review security videotapes for bad security situations. Print out a picture of a security breech, and mask the identity of the employee. Post the picture in a common area with a handwritten sign that says, “Is this you?” Your purpose is not to embarrass the employee, but to point out the unsafe security practice so that other employees will not make the same mistake.

Security drills are also good. Conduct a security drill in a small area such as the admitting office or a patient care unit. After conducting the drill, ask employees whether they understood their roles.

Q: How can my facility get up-to-date information on disaster preparedness and emergency management, and how do I educate employees on this information?

A: Review the JCAHO environment of care standards. Then read books on security, and subscribe to magazines and newsletters on the subject, such as Healthcare Security and Disaster Alert. Consider joining a hospital security association.

One way to educate staff is to assign a line employee to educate others on an identified security issue. By allowing a staff member to research an issue, he or she will take ownership of it. Other employees will know they can come to that person if they have questions.

Q: How can you motivate staff to work with you in security management?

A: Get one or two employees together, have them walk through an area of your facility, and ask them to note any security problems that they observe. Then bring in a police officer from a local agency and have him or her go through the same area. After the walk through, have the officer and the employee compare notes.

You can also have staff members solve their own security problems. Give them a choice of options, but let them decide what works best for their situation. This method lets workers get involved in their own security.

If staff members have a specific problem with a drill over and over again, tell them to discuss their failures at the next staff meeting. This will often motivate employees to find a way to accomplish their mission so they don’t have to.
explain themselves in front of peers.

Q: What are some tips on better protecting the facility during the night shift?

A: There are several common sense things that you can do. Make sure that you lock all doors and never go anywhere alone.

Pay close attention to personal identification during the night shift. You should coordinate your routine activities with the local police, and ask them to make your facility a part of their patrols.

Look into issuing personal alarms for your night shift personnel. These small, pager-like devices can be clipped to a belt buckle and will sound an alarm if a person stays in a horizontal position for a period of time.

There are different types that you can use. Some will emit a loud buzzer or a siren sound, while others will actually transmit a signal to your dispatch room or command center.

Q: What methods can you use to identify sensitive areas where breaches can occur?

A: Start with the common area that you see if you are walking around. Once again, common sense will tell you where there could be a problem.

Any place where cash transactions are made, such as a cafeteria or vending machine area, could be a problem. Other places to look include your pharmacy and other chemical supply areas.

You can also internally publish the parts of your hazard vulnerability analysis that apply to all employees. Include local crime statistics so that employees will understand where the threats may originate.

Send us your questions!

If you have a question about health care security and disaster planning, pass it along to us and we'll include it in one of Healthcare Security and Disaster Alert’s future Question & Answer columns. Send questions in writing to Ed Justen, assistant editor, by

✔ mail to Healthcare Security and Disaster Alert, 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945

✔ e-mail to ejusten@hcpro.com (put “Q&A” in the subject line)

✔ fax to 781/639-2982 (put your fax to the attention of Healthcare Security and Disaster Alert)
City preparation digest
A brief overview of a city’s emergency plans

Dallas suburb prepared for emergencies
The chief emergency coordinator for Richardson, TX, said his city is ready for any emergency, according to report in the Dallas Morning News.

“New York is no greater or different city than us,” said George Grant, emergency management coordinator for the city.

“If something equally tragic happened here, we’d have the resources to call upon,” he said.

Richardson (2001 est. pop. 42,647) outfitted its fire department with several pieces of new equipment, including biohazard suits, an outdoor decontamination shower, a radiation detector, and handheld radios, the newspaper reported.

In addition, firefighters completed a 16-hour refresher training program on emergency response to terrorism.

Editor’s note: Each month we will feature a different city to gauge how communities across the United States are coordinating their emergency preparation plans.

Opus Communications, publisher of Healthcare Security and Disaster Alert, also publishes numerous documents, books, and other products on emergency management and disaster planning. Our latest special report, Be prepared for bioterrorism, is available from our Web site, www.hcmarketplace.com.