With the new emphasis on security and related procedures now a major focus of Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) surveys, coordinators and security directors wonder exactly what surveyors will look for in relation to security guidelines.

“Surveyors are learning as they go along,” says Philip Nielson, CHPA, CPP, vice president of Healthcare Security Services (HSS), a provider of security systems and services for more than 100 hospitals throughout the western United States. Hospitals with HSS security systems undergo surveys every other week, according to HSS’ Web site, www.healthcaresecurity.com. Managers track questions asked during the document review and site walk.

“Its been our experience that whatever surveyors saw at the last hospital, they’re going to ask about at the next hospital,” Nielson says.

Through the first half of this year, HSS identified the following trouble spots during the security survey:

• VIP recognition
  The common perception

Portable safety kits keep staff prepared for all kinds of disasters

When making emergency management plans, don’t forget a key element—supporting your hospital for at least 72 hours without supplies.

Last year’s floods in Houston provided an example that hospitals need enough provisions to sustain themselves for at least a few days.

“Flood planning in Texas placed more emphasis on preparing to defend-in-place,” says J. Douglas Rolll, CHSP, CHFM, general manager of hospitality services at Arizona State Hospital in Phoenix.

“Even though first responders arrived early, one can expect to wait up to 72 hours for relief from the outside.”

The Federal Emergency Management Agency (FEMA) recommends on its Web site, www.fema.gov/diz00/d1354n41.shtm, that the general public prepare for at least three days of sustainment during a disaster.

The Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) surveyors look for...
Portable safety kits

Evidence of emergency supplies under standard EC.1.4, but do not require a survival time frame.

“This whole concept of having an emergency supply available goes back to the Cold War duck-and-cover days,” Roill adds.

“After September 11, we saw articles about putting together an emergency kit and expecting 72 hours before getting relief.”

To satisfy this requirement, Roill and his staff created “go bags”—portable disaster kits designed for specific situations during an emergency.

Roill uses the following four types of go bags:

• The disaster command post
• Amateur radio
• Personnel
• Vehicle

“Go bags are a mitigation strategy as well as a preparation strategy,” says Steve MacArthur, safety consultant for The Greeley Company, Marblehead, MA. He recommends using them during your recovery efforts, also.

Why transportable safety?
Even before the September 11, 2001, terrorist attacks (which prompted a closer look into emergency management standard requirements by the JCAHO), Roill and his staff envisioned the go bag for Arizona State Hospital.

Yet, adopting a terrorist response plan was on the back burner since the hospital was more focused on on-site, minimal emergencies and those revealed in its hazard vulnerability analysis, Roill says.

“After September 11, there was more interest in a comprehensive emergency plan approach, so we decided to make the go bags available.”

Therefore, consider the following go bags to ensure you have all the supplies you need if your hospital loses power, your command post gets wiped out, or if you must evacuate:

• The disaster command post box

This go bag is actually a grab-and-go box on wheels. Staff bring the disaster command post box with them to the disaster site or the command post.

A command post is a predetermined spot where decision-makers (i.e., administrators, medical leaders, incident commanders, and others) gather to enact an emergency plan—typically after the hospital sounds the emergency code.

The command post kit also comes in handy if a hospital’s command center gets knocked out or becomes unavailable to staff. For example, a designated command post, such as a conference room, could flood.

The command post bag contains a clipboard, pens, paper, flashlights, batteries, and a first aid kit, for example. See the full list of contents for all go bags on p. 5.

• The amateur radio

This mobile kit helps when staff must evacuate the hospital or if a disaster or event interrupts facility-wide communication with the outside world. The bag contains items to support ham radio operations.

Arizona State Hospital has two amateur radio stations on site for evacuation reasons since the facility relies on short-range radios.
“The amateur radio bag gives us that flexibility for a longer range,” Roill explains.

“When people must evacuate, they lose communication with what goes on in the community, as was the case in New York City. So we included an AM/FM radio for those leaving the hospital grounds.

“They can hear firsthand what’s happening around them if it is a community-based event.”

This bag also contains a local street guide, a small, hand-held radio, and 16 AA batteries in case staff must leave the amateur radio site.

• Personnel go bag
The idea behind this kit is that staff may have to wait as long as 48 to 72 hours to get assistance from the outside, whether from the FEMA or vendors who supply medications, Roill says.

Although this go bag does not contain medications, it has personal items, including disposable gloves, a first-aid kit, eye wash, and a pocket knife—the things people need over a 72-hour period.

People should always keep these go bags in their cars, says Roill who keeps four personnel bags in his office for backup.

“I don’t want to overreact, so I told staff that these personnel go bags are available if they are interested,” he adds.

Hospitality services briefed hospital staff on how to put these bags together for their personal and family use.

With a major international airport within one mile, a military installation within four miles, and a nuclear power plant within 40 miles, the organization’s hazard vulnerability analysis showed that additional preparations are necessary.

Extra caution includes considering a supply of hazardous material protective clothing, full-face respirators, self-contained breathing apparatuses, and hooded and full face, rapid response-powered air systems to supplement the personnel bag.

• Vehicle kits
The go bags for storing in cars resemble emergency road kits. They contain a flare, jumper cables, a gas can and siphon, as well as items such as a sewing kit and deck of cards.

People can use these emergency kits as they do the personnel go bag, which they can store in their car, Roill says.

Go bag training
Since the go bags are pretty self-explanatory in nature (i.e., you wear a mask if there’s dust in the air), there’s not too much involved in training staff on how to use them, Roill says.

For example, each personnel go bag comes with a three-page handout explaining how to use it, how to care for the batteries, replace items, and rotate stock, if necessary.

Only the amateur radio operators use the amateur radio go bags, so they already know what to do, Roill says.

The disaster command post bag doesn’t contain any unusual instruments, as most people know how to use a radio and the other items, he adds.

Cost considerations
Go bags will cost you from $75 up to $350 for a personnel bag. If you need to scale back, ensure that each one includes the basic items, such as a flashlight, batteries, first aid kit, 72-hour supply of food and water, and an AM/FM radio, which can run as low as $5, Roill says.

The most expensive item of all is a shortwave radio receiver ($100–$150), which does not transmit but receives shortwaves from all over the world—which would come in handy in an extreme disaster with no communication.

“It all depends on how much you want to...”
put into this,” Roill says. “But with disasters, you don’t know the extent or when they will happen.”

Thus far—and it’s a good thing—the hospital has not used the go bags for disasters but included them in overall emergency management drills, such as the community drill. The personnel handbag came in handy for Roill when helping a fellow motorist with a flat tire and when he needed the first-aid kit for a minor injury.

“I use them more on a personal basis, and I encourage the same for others because the more you use the go bags, the more you’re aware of what’s in them,” he says.

“That’s why hospitals must practice their emergency management plans. A lot of people do it because of regulatory compliance requirements, but we hold even more drills than required to ensure general safety.”

Hospital emergency planning chief speaks at congressional briefing

A group of congressional leaders, aides, and news reporters all listened intently to the words of Barb Bisset, RN, MPH, MS, as she explained how government financial support of health care facilities is imperative to guaranteeing well-planned emergency response.

Bisset is director of emergency response, safety management, and special police at New Hanover Regional Medical Center in Wilmington, NC, and a member of the HSEM editorial advisory board.

“In a large disaster, 80% of the population will bypass response units and head to the hospital under their own means,” Bisset told the crowd. “So in this case, hospital workers must be considered as first responders.”

Bisset addressed a congressional briefing in July sponsored by the American Hospital Association designed to “keep Congress mindful of the challenges” facing hospitals in dealing with emergency planning.

Flanked by the mayor of San Antonio on one side, the chief of emergency medicine at New York City’s Bellevue Hospital on the other, and a portrait of George Washington peering from above, Bisset spelled out the challenges of handling a surge of patients during an emergency or disaster situation, focusing on the following three points:

• **Unique qualities of patients arriving at the hospital**—Prior to September 11, the traditional hospital disaster plan covered a short-term event such as a plane crash or weather event, Bisset said. Patients from those events need acute care for a short time. “In a biological event, you may not have as much acute care to give, but the care you do give will have to last longer,” Bisset said.

• **Key strategies of how to plan**—“While planning, we assume that patients coming to the hospitals have their full facilities,” Bisset told the group. “We need to take into account ‘special needs’ patients, such as the aged, those on medication, and those in need of mental health resources.”

• **Budget challenges**—Emergency planning comes at a crucial time, when hospitals are cutting back large parts of their budgets, she said. “We need very sustained and long-term support form the government.”
Disaster command post go bag:
- One metal form holder/clipboard
- Two pairs of safety glasses—shaded
- Two pens
- Two safety vests
- One letter-size pad of paper
- Two corded earplugs
- One 6-in x 9-in spiral pad
- Ten assorted glow sticks
- A copy of the disaster manual
- Two road reflectors
- Emergency valve shut off diagrams/maps
- One multipurpose fire extinguisher
- Telephone directory
- A tape recorder with tapes
- Two fluorescent lanterns
- Disaster response recording forms
- Two small flashlights
- Power bars (rotated monthly)
- Two 6-volt batteries
- First aid kit
- Assorted batteries
- Three whistles
- Two pairs of safety glasses—clear
- Work gloves
- AM/FM radio

Optional items for the disaster command post go bag:
- Heavy-duty rain suits
- Particulate filters
- Spotlights
- Road cones
- 12-volt battery packs with adapters for vehicle cigarette lighter plugs
- Full face respirators (restricted to individuals who have been fit tested)
- HEPA filters
- Hard hats
- Umbrellas
- Jumper cables
- Gas cans
- Sleeping bags
- Battery
- Hooded respirators
- Self-contained breathing apparatus (restricted to individuals who have been fit tested)
- Cell phones with radio capabilities
- 2-meter band amateur mobile radios with portable power packs and antennas

Amateur radio go bag:
- AM/FM radio with head phones
- One safety vest
- Two pens
- One forms holder
- One permanent marker
- 50-foot nylon rope
- One note pad
- Six bungee cords assortment
- One atlas and Gazetteer with GPS Grids
- AC adapter
- Multipurpose tools
- Two-meter/70-cm amateur hand-held radio
- One local street guide
- One road and recreation atlas
- One flashlight
- Sixteen AA batteries
- Tape, cable ties
- Whistle
- Adapters, converters, fuses

Personnel go bag:
- Lantern style flashlight (6-volt)
- Paper towels
- Standard flashlight (3-volt) “D”
- Ten disposable gloves
- Shortwave radio receiver with AM/FM
- Antibacterial wipes
- Assorted batteries
- Scissors
- Two rain ponchos
- Four large black trash bags
- Emergency (space) blanket
- P100 (HEPA) particulate respirator
- Large first aid kit
- Two N95 particulate respirators
- Eye wash
- Work gloves
- Utility tool
- Bandana
- Miniature pocket knife
- Wraparound sunglasses
- Hand sanitizer
- Safety vest
- Ten plastic storage bags
- Safety glasses
- Five large disposable cups
- Disposable camera
- Five small disposable cups
- List of suggested foods and beverages
- Small note pad/mechanical pencil
- Clothing supplies
is that a VIP is someone such as a prominent local person or an entertainment figure. There are other types of VIPs who security bosses need to worry about, Nielsen says.

“A high-profile gang member needs the same protection as other VIPs for his or her safety as well as the safety of the hospital staff,” Nielsen says. Taking the same VIP measures for a high-profile gang member will help prevent gang incidents from happening at your hospital.

Rural hospitals in which gang activity is less prevalent must still guard against violence stemming from family disputes, for example. Regardless of the situation, give VIP status and protection to a volatile patient attracting unwanted attention, whether it is more visible security around the patient’s room or placement in a remote area of the hospital.

**Tip:** Show surveyors that your procedures cover all patients who may enter the hospital under VIP status. Ask yourself the following:

- Where is the best place to house the VIP patient to protect staff and visitors?

- Is there a roadblock to limit access to this patient?

- Where should we place the media in relation to this patient? What level of access should we allow?

- Do we limit name recognition by using code names on charts and grease boards?

- Do we train staff sufficiently in VIP procedures?

**Police and community statistics**

Of course, you won’t be able to provide VIP protection to a local person if you don’t recognize him or her. Monitoring local crime and demographic statistics and issues makes you more aware of who is in your facility.

The purpose of studying local community statistics is to show that you are “plugged into the world beyond your hospital walls,” Nielsen says. “Surveyors want to know if you are looking beyond your borders.”

**Tip:** In addition to crime statistics, annually compare income levels, rent changes, and education levels of the neighborhoods surrounding your facility.

“Use these figures to help make decisions about shifting or adding resources and for planning current or future projects,” Nielsen says.

For example, if burglary rates rise and rents drop in the neighborhood abutting your parking lot, use that information to justify putting more lighting in the lot.

“You will show surveyors that you are using as much forethought as possible in your security planning,” Nielsen says.

**Closed-circuit television cameras (CCTVs)**

The most common misconception about CCTVs is that someone watches them at all times, Nielsen says.

“Closed-circuit cameras are a passive system. No one watches the specific cameras. They are used primarily as after-the-fact investigative tools.”

However, Nielsen cautions that some surveyors want to know who in particular watches a specific camera.
“Educate surveyors on the whole system,” recommends Nielson, “including how you test and monitor the cameras, and what you do with videotape libraries.”

**Lighting and landscaping**

Nielson recommends that you not use a light meter when evaluating your lighting, as there is no standard requiring a certain reading on the meter in an area.

Instead, show surveyors that there is enough lighting that is appropriate for the area and how you came up with that determination.

Landscaping also plays a big part in the evaluation of lighting systems. Summer foliage can often block light that gets through during the winter months.

“Evaluate the lighting twice a year. Once during high foliage and once during low foliage,” says Nielson.

**Tip:** When appropriate, show surveyors the redundancy of overlighting an area. If an individual light goes out that you can’t replace immediately, point out that adequate illumination still exists in the meantime.

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**In brief**

**Security**

**MA—Phony stabbing incident causes lockdown**

A disgruntled lab technician stabbed himself three times in the blood lab of Beverly (MA) Hospital and then told police two men attacked him, according to a story in the Salem Evening News.

Michael Potenza, 34, of Danvers, MA, claimed that two men entered the lab at 7 p.m., demanded drugs, and then stabbed him and wrapped a telephone cord around his neck after he said no drugs were available. He said that one attacker had a knife while the other had a gun, according to the report.

State police reacted to Potenza’s story by sealing off the hospital and calling in two local SWAT teams to search for the two suspects.

They also called in a hostage negotiator and began checking the trunks of cars to see whether the intruders were hiding inside.

As the evening wore on, officials began to doubt Potenza’s story, the newspaper said. The doctor who tended to his wounds became suspicious when Potenza didn’t seem to be upset about being attacked. Police further suspected his story when he told them the intruders were interested in the hospital’s blood banks.

Finally, at 1 a.m., Potenza admitted that he made the whole thing up, pulling a neck chain around his neck, cutting up his scrubs, and scraping himself with a knife to fake the attack.

Potenza now faces charges of disturbing the peace and filing a false police report. Authorities issued a summons for him to appear in court, according to the report.

**TX—Bomb threat at hospital a hoax**

Police in Tyler, TX, are holding a 29-year-old male after he allegedly made a terrorist threat and concocted a bomb hoax at East Texas Medical Center in Tyler in July, according to the Associated Press.

After receiving the bomb threat, hospital authorities notified police, who found the man still at the hospital. The suspect led police to the bomb in a nearby lot.

The bomb, however, did not contain the correct materials to cause damage, officials said. > p. 9
Does your hospital have a policy for granting privileges to physicians who aren’t members of your medical staff, but volunteer their services during an emergency? If not, guidance is on the way from the Joint Commission on Accreditation of Healthcare Organizations.

The accrediting body recently approved a new medical staff standard (MS.5.14.4.1) that addresses credentialing and privileging volunteer licensed independent practitioners (LIPs) during a disaster. JCAHO officials approved the new standard late last month.

The meat of the standard

The standard allows a hospital’s chief executive officer (CEO), or medical staff president, or their designees to grant emergency privileges when they activate the emergency management plan and the organization is unable to handle immediate patient needs. The emergency management plan must identify the individual(s) responsible for granting emergency privileges, along with any alternates, according to the June 2002 JCAHO update on the “Members Only” section of the American Hospital Association’s (AHA) Web site.

The new standard doesn’t require the responsible individual to grant emergency privileges to anyone—he or she must make each decision on a case-by-case basis after receipt of a “key identification document,” says the JCAHO says.

A “key identification document” includes any of the following:

• A current hospital photo identification (ID) card
• A current medical license with a valid photo ID issued by a state, federal, or regulatory agency
• Identification indicating that the LIP is a member of a state or federal disaster medical assistance team
• Identification indicating the granting of authority to the LIP by a federal, state, or municipal entity to care for patients in emergencies
• Presentation by a current hospital or medical staff member with personal knowledge of the LIP’s identity

Include emergency privileging in disaster plan

Many hospitals already address emergency credentialing and privileging in their bylaws, explains Richard Thompson, MD, president of Thompson, Mohr & Associates, in Springfield, MO.

“For example, what if there’s a terrible train wreck in your town and a badly injured passenger needs a neurological procedure right away, but your hospital doesn’t have a neurosurgeon?” he asks.

The hospital would have to either send the patient to another facility with a neurosurgeon or bring in a neurosurgeon to perform the emergency procedure.

“Bylaws often account for this type of situation with a short paragraph on patient-specific privileges that states physicians may be granted temporary privileges to treat a particular patient,” Thompson says.

But according to the pending standard, a paragraph in the hospital bylaws won’t be enough. Your hospital must incorporate emergency privileging into its emergency management plan.

In addition to identifying which individual may authorize emergency privileges, the intent statement says hospitals’ emergency management plans also must

• spell out the responsibilities of the individuals with emergency privileging authority
• develop a plan for overseeing volunteer LIPs with emergency privileges (this plan should include a method to quickly identify these LIPs)
• recognize the credentials verification process as a high priority (i.e., once the immediate situation is under control, the hospital must verify a volunteer’s credentials using a process identical to that of granting temporary privileges)

“Medical staff services professionals [MSSPs] should bring this new standard to the attention of whoever handles the disaster plan at their hospital,” advises medical staff consultant Kathy Matzka, CMCS, CPSC, of Lebanon, IL. “MSSPs should also take an active
role in developing the credentialing and privileging aspects of this plan.”

The JCAHO responds to post-9/11 climate
In the wake of September 11, many organizations turned their attention to emergency preparedness issues. The JCAHO is no exception, as evidenced by this pending standard.

“This new standard is indeed in response to 9/11,” says Susan Rowland, medical staff services manager of Community Hospital of the Monterey Peninsula, Monterey, CA. It formalizes what many hospitals already have in place, and at the same time gives guidance to those who have never considered this issue before.

“With the U.S. government’s warnings that another terrorist attack could happen at any time, hospitals need to make sure their disaster plans address privileges for volunteer LIPs in an emergency,” concurs Matzka. “It’s good to see that the JCAHO has responded so positively to this need.”

Editor’s note: According to the JCAHO, more information about this new standard will appear in the September 2002 edition of Joint Commission Perspectives.

In brief < p. 7

The suspect has a history of mental problems and is being held in jail in lieu of bond payment.

• Emergency planning
CA—Los Angeles begins plans to spend federal dollars
Officials in Los Angeles County have begun consulting with the 81 hospitals in their area to spend $28.3 million in emergency management funds awarded by the federal government, according to a story in the Daily News of Los Angeles. The money will help hospitals buy personal protective gear and decontamination showers, expand laboratory facilities, and start a surveillance system to detect the outbreak of a biological agent, the report said. The county is also surveying the hospitals to determine how many isolation rooms are available and how the air handling systems work within those rooms.

TN—Chattanooga hospital forms DMAT team
The Federal Emergency Management Agency named Erlanger Hospital of Chattanooga, TN, as the official sponsor of Tennessee’s first Disaster Medical Assistance Team.

The hospital will spend $99,000 per year over the next three years developing the team, which will respond to emergencies and disasters throughout the nation. Officials at the hospital expect the team to be ready within a year.

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 Emergency Management’s future Question & Answer columns. Send questions to Associate Editor Ed Justen via

✔ mail to Healthcare Security and Emergency Management, 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 (send your fax to the attention of Healthcare Security and Emergency Management)
Response team members and planning

Editor’s note: The following is an excerpt from Opus Communications’ new book Preparing for Mass-Casualty Incidents: Hospital Readiness for Biological, Chemical, and Radiological Disaster. For more information or to order a copy of this book, go to www.hcmarketplace.com.

Hospitals must use an Incident Command System (ICS) when dealing with a decontamination emergency/hazardous materials response, according to the Occupational Safety and Health Administration (OSHA). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also recommends that facilities use a system consistent with the ICS used in the community. An ICS establishes a chain of command and standardized procedures for managing personnel, communications, facilities, and resources.

One commonly used form of ICS is the Hospital Emergency Incident Command System (HEICS). Originally designed by the San Mateo County Health Services Agency in California, a HEICS establishes a chain of command, assigns positions to a command post, and gives necessary staff checklists to follow during a disaster.

When setting up an incident command system, work with local authorities to ensure that all responding emergency personnel are on the same page. In communities where emergency personnel are unfamiliar with a HEICS, hospitals that decide to implement the system need to explain it clearly to authorities to ensure a timely and efficient response.

The system is devised with 49 positions on an organizational chart, each with a specific mission to address in an emergency situation. Duties assigned to each position are ranked “immediate,” “intermediate,” and “extended.” The hierarchy is usually the emergency incident commander, followed by a section chief, director, supervisor, unit leader or officer. The system is flexible to allow more or fewer positions, depending on the emergency or size of the facility.

In Wilmington, NC, New Hanover Regional Medical Center’s incident command system designates 15 individual response plans with teams for various events that disrupt hospital operations. Infant abductions, hostages, and bomb threats require teams with an emphasis on law enforcement, while a mass casualty incident (MCI) calls for a team weighted with patient care providers.

The incident command system does not name individuals to various teams, instead designating different positions to the teams, says Barb Bisset, director of emergency response, safety management and special police at New Hanover Regional Medical Center.

For each event, the ICS includes a checklist with all the tasks that must be completed by the hospital.

Your facility’s emergency plan should include the following items:

- Pre-disaster departmental readiness checklists
- A policy for termination of the hospital’s disaster plan
- Personnel recall procedures
- A security/lock-down policy
- An evacuation procedure
- A volunteer credentialing policy
- A policy regarding standing orders for patient care during a disaster
- A policy allowing for rapid patient discharge during a disaster
Crowd control: Planning is key
Crowd control will be essential in an MCI to deal with sick and injured victims, relatives searching for each other, the “worried well,” and curious onlookers. Preparedness plans should include photo identification cards issued or authorized by the hospital to facilitate access by physicians, hospital workers, and any reserve staffers. Facilities can expect to deal with large numbers of psychosomatic casualties during an MCI.

All organizations involved in the community preparedness plan should agree on a communications plan to ensure delivery of a consistent, coordinated message.

Personnel roles and responsibilities, including who will direct the response, training, and communications, must be included in the hospital’s overall emergency response plan. The plan should also cover evacuation procedures and identify alternative facilities that could provide treatment in the event that patients would need to be rerouted because of contamination of the emergency department.

In addition, the plan should identify personal protective equipment including type, quantity, location, and use; it is also important to detail specific contamination procedures, materials, and equipment. A facility’s plan should also cover critiques, and follow-up of drills and actual emergencies.

What to do with staff?
In most disaster responses, you will not have the luxury of picking and choosing who comes into work when they are called. This means that you are going to need to maximize the productivity of those who do show up. Make sure that, as you plan for staffing considerations, you pay attention to developing “alternative duties” for folks, especially in the support services.

Often these “alternative duties” are not direct reflections of support staff daily activities. Patient escort, security, and serving as greeters are all duties that could become critical during your disaster response continuum. Work with support services department leaders to identify alternative tasks that will allow you the greatest efficiencies and the least amount of standing around and watching.

But don’t forget the clinical staff when it comes to alternative duties—make sure you maximize those resources as well. You may find that managing the patients themselves is the least of your worries.

Clinical staff often have experience in managing distressed families, discharge plans, or social work activities. Work with clinical leadership to identify those clinical support tasks that could be encountered during an MCI and how best to use staff in an “alternative” universe of patient care.
Pennsylvania hospital boosts its decontamination capacity

Officials at Community Hospital of Lancaster, PA, planned to purchase a portable decontamination unit long before last September’s attacks in New York City. Since that day though, officials looked at decontamination with a wider eye.

“After thinking about it, we realized a single decontamination unit just wouldn’t be enough,” Dan McGraw, safety officer for the hospital, told the Lancaster Intelligencer Journal in July.

Instead of buying a single unit, Community Hospital spent $6,000 to purchase a four-stall decontamination shower. The new unit will “facilitate treatment for large groups of incoming patients,” McGraw told the newspaper.

Although the shower is portable, it is unlikely to leave hospital grounds as other emergency management groups in the region have similar units. Instead, officials integrated the hospital’s decontamination resources into the regional plan.

The new decontamination facility replaces a make-shift shower set up outside the emergency room consisting of a hose and plastic sheets.