It’s crunch time at your hospital and your emergency plan is in full gear. As the casualties roll in, you notice an unfamiliar woman wearing scrubs and a stethoscope checking a patient’s wounds. She has no identification, and you don’t recognize her as part of the staff.

When you approach her, she says she is a qualified physician and that she told the volunteer at the emergency room entrance that she was going to help out. She looks at you with a measure of disgust, and returns to treating her patient.

“This situation is fraught with peril,” says Steve MacArthur, a safety consultant for The Greeley Company in Marblehead, MA. “You have a responsibility to patients that the person treating them is appropriately trained, so you want to make sure that everyone is who they say they are.”

Although the treating physician in the above scenario may have good intentions and indeed might be qualified, the hospital incurs a heavy risk by allowing her to continue work during the disaster.

Proven advice

Achieve your goals by getting to know hospital execs and administrators

If you think your job as a security boss is to review incident reports and training schedules, think again. Getting out and meeting with other administrators, department heads, and fellow security directors at other hospitals is the first step in spreading the word about your programs and issues.

Security managers must realize they are part of the administrative team, says Joe Gulinello, MPA, vice president of health care security for Securitas, Pinkerton, and Burns International, in Melbourne Beach, FL.

“Interacting with other administrators allows them to find out who you are, and lets you find out what they do,” Gulinello says.

Getting support from the top

Part of meeting with other administrators is learning about their departmental or administrative goals. This permits you to take a strategic approach toward making people understand what you need.

The safety officer’s role in disaster emergency privileging

It’s crunch time at your hospital and your emergency plan is in full gear. As the casualties roll in, you notice an unfamiliar woman wearing scrubs and a stethoscope checking a patient’s wounds. She has no identification, and you don’t recognize her as part of the staff.

When you approach her, she says she is a qualified physician and that she told the volunteer at the emergency room entrance that she was going to help out. She looks at you with a measure of disgust, and returns to treating her patient.

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Although the treating physician in the above scenario may have good intentions and indeed might be qualified, the hospital incurs a heavy risk by allowing her to continue work during the disaster.
Hospital execs

"Ask yourself, ‘who is my audience?’ and tailor your approach that way," Gulinello says.

For example, the hospital’s chief executive officer is often most interested in the overall mission of the hospital. Think of how your idea or presentation will affect the hospital as a whole. Connecting your proposal with the hospital’s mission statement or a current hot news topic will also garner more support from top executives.

Taking it one step further, the chief financial officer is most concerned about spending the hospital’s dollars in the best way. Showing the cost of more expensive alternative options also furthers your cause. Using hard data and solid dollar figures when talking to finance officers increases your chance of success.

For example, if you’re trying to purchase a series of security training videotapes to show to the entire staff, divide the cost of the tapes by the number of employees who will see them. It’s much easier to justify the expense by saying you will accomplish yearly training objectives for 300 staff members at a cost of five dollars per employee than saying you want to spend $1,500 on a video training series.

✔ Tip: Talk in the same language of other administrators. Avoid using “security speak” in your discussions and presentations. Develop a way to express yourself in terms that other administrators will understand. “Make arguments that make sense to the other administrators,” Gulinello says.

✔ Tip: Use hard data to make your arguments—know the facts and demonstrate them through data and real-life examples. (See sidebar on p. 5 for an example of using data to clarify security perceptions.)

Talk to other health care security supervisors in the area to find topics about which they recently approached their executive staff. If they have had to deal with similar problems, find out what benchmark data they used when presenting solutions to those problems.

Make sure you are involved in plans from the beginning—especially construction or remodeling projects.

For example, security is a major factor in the redesign of the emergency department. “Make sure that security considerations are woven into plans from the beginning,” Gulinello says.

What can I do?

Don’t be afraid to enter the culture of your hospital’s administrative team.

Gulinello suggests the following if you are stepping into the foray for the first time:

1. Interact with other department heads and ask them about their security concerns. Develop a profile of security problems relating to each department.

2. Develop solutions to the issues that you learn about. Figure out a short-term fix for the immediate moment, then develop a long-term plan of action.

3. Cultivate a network of security professionals both in and out of the health care field. Find out the major issues affecting others in the industry and apply their solutions to your facility. ASIS International (www.asisonline.org) and the International Association for Healthcare Security and Safety (www.iahss.org) both offer networking opportunities as well as educational and training programs.
Vaccination recommendation spurs hospitals into action

President Bush recommended in December 2002 vaccinating almost one-half million hospital emergency workers against smallpox. As the frontline against a smallpox attack, these workers will be among the first to handle patients of a terrorist outbreak of that nature.

The president’s decision is rife with controversy as the smallpox vaccination carries potentially fatal side effects. Based on studies in the 1960s, experts estimate that 15 out of every one million people vaccinated for the first time will face these life-threatening complications, and one or two will die, according to the Associated Press.

However, administration officials say the payoff of vaccination is worth the risk, as officials consider one single smallpox case a public health emergency.

What does this mean for hospitals?
State health departments will determine how many hospital employees receive vaccination as part of the state smallpox preparedness plan, according to the Centers for Disease Control and Prevention (CDC) Web site. Health care institutions must now decide who on their staff will respond to an outbreak of smallpox and designate them for vaccination.

“Hospitals should remember that the smallpox teams do not include just physicians and nurses,” says Steve MacArthur, a hospital safety consultant with The Greeley Company in Marblehead, MA.

Consider other nonclinical positions, such as security officers, housekeepers, and radiology staff. “Even an employee who merely greets people at the admissions desk might be appropriate for the vaccine, since he or she could be among the first people a smallpox victim comes in contact with.”

Deciding who to vaccinate
Properly screen the medical history of employees before choosing who will be on the smallpox team. The CDC recommends that people with the following medical conditions not be selected for the smallpox vaccinations:

- Pregnant women
- Mothers who are breastfeeding
- Employees with skin conditions, such as atopic dermatitis, eczema, herpes, and chickenpox
- Employees with weakened immune systems due to cancer chemotherapy or organ transplant
- Employees suffering from AIDS or using medications to treat autoimmune disorders
- Employees allergic to the vaccine (for more information on the vaccine, see the CDC Web site)

Coordination problems abound
Designating staff members to receive the vaccine is only the first of many challenges concerning today’s announcement.

“This thing has fingers all over the place,” says the safety director of a Midwestern hospital who wished to remain anonymous.

For example, hospital staff must also coordinate when and where employees go to receive the initial vaccination.

Illinois will administer its vaccine and follow-up activities from its state offices, causing hospitals to deal with transportation and other issues.

“Problems arise when you designate second- and third-shift employees for vaccination,” says the anonymous safety director. “In addition to transportation and logistical issues, the human resources department must work out compensation matters for those employees.”

Steps to take now
All these considerations require a massive organizational effort among your administrative and...
Emergency privileging

“In a situation like this, you as the safety director or emergency planner must intervene. The risk of something going wrong exposes the hospital to high levels of liability, not to mention bad publicity,” says MacArthur.

In the case presented here, a good solution for the safety director would be to escort the woman to the emergency credentialing desk where personnel can verify her credentials and grant her temporary privileges if she meets the conditions.

Joint Commission clarifies standard

In response to this type of situation and to other emergency privileging issues related to recent disasters, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently updated MS.5.14.4.1, its emergency credentialing standard.

In addition to clarifying appropriate conditions for granting emergency privileges, the JCAHO placed two conditions on approving them: the hospital activates the emergency plan, the organization is unable to handle immediate patient needs

Once these conditions are met, the JCAHO gives five credentialing methods for granting emergency privileges:

- The person has a valid photo hospital identification (ID) card
- The person presents a current license to practice and a valid picture ID
- The person is a member of a disaster medical assistance team
- The person presents ID that indicates he or she has authority to render patient care in an emergency situation
- A hospital staff member can identify the person as a legitimate caregiver

In addition, the intent statement of the standard says that only the chief executive officer (CEO) or the medical staff president (or designee) can initiate the granting of privileges, and that the decision is made on a case-by-case basis. (Activating the emergency privileging plan is not a requirement of the hospital emergency response plan.)

Start with a plan

As with all issues in emergency management, plan for emergency privileging long before a disaster takes place. “It’s a good idea to include the emergency privileging as part of the incident command system,” says Carol Cairns, CMSC, CPCS, president of PRO-CON, a medical staff consulting company in Morris, IL.

Vaccination

logistical team. Further guidance from state and federal agencies will clarify many of these issues. Until then, take the following steps to prepare for the upcoming vaccination:

- Work with other department heads to decide which employees will receive the vaccine. Ensure that medical screening take place.
- Contact the human resources department to bang out compensation issues. Employees will appreciate a full explanation of compensation issues when told they are designated for vaccination.
- Review consent forms with the risk manager to ensure that employees are fully aware of the risks associated with vaccination.
- Educate all employees on what the smallpox vaccination plan means.
- Stay in communication with your state and local health department. They may have some information that will help you plan your next move.
“Include triggers in the plan that activate the emergency privileging function. Likewise, the hospital has the responsibility to define when the emergency is over and the privileges end.” The plan also defines the circumstances for activating the granting of privileges and the ultimate authority to make those decisions.

But deciding who will make those choices and when to make them is often easier said than done as the emergency privileging process is the domain of the medical staff office, not the safety director or emergency planner.

Politics as usual
Some safety directors report that they have a hard time getting medical staff to address the issue, while other hospitals say the process is mired in political squabbles. A major point of contention is who to checks the credentials while the event takes place.

“Our hospital wanted to put the head emergency room physician in charge of credentialing and granting temporary privileges during an emergency,” says the safety director of a Midwestern hospital who wished to remain unidentified. He pointed out that it was not a wise decision since physicians aren’t always the best managers. “Besides, during an emergency you want the physicians out there taking care of patients, not doing administrative work.”

✔ Tip: The intent of the JCAHO standard says the CEO or the medical staff president (or designee) can grant privileges. Work with your medical staff to develop an emergency credentialing and privileging plan. Ask them to designate one administrative person to run the credentialing and temporary privileging desk during an emergency.

✔ Tip: Give employees and volunteers working in reception areas instructions on what to do if someone approaches them and says he or she is a physician or nurse and wants to help out. 

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Solving security problems—data v. perception

Use data to help you confirm or deny a security perception among the hospital work force and work with department bosses to achieve these goals. Look at the following example:

Problem: The head of the nursing department expresses concern that night shift staff do not feel safe in the parking lot and asks you to install cameras or an emergency phone system. You tell him that you can’t recollect any incidents in the last few months concerning assaults or other safety concerns in the parking lot, but you will check it out and follow up with him on the topic.

Incident reports reveal that no attacks have occurred in the parking lot over the last three years. Several long-term employees also confirm that they cannot remember the last time they heard about an incident in the parking lot at night. A visit to the parking area during the night shift reveals the reason for the concern—lighting is bad and access to the area is very open.

Solution: After gathering the data and making your observations, you report your findings to the head of the nursing department. Together, you decide that more lighting and landscaping around the perimeter of the parking area will give night employees a better sense of security.

Follow-up: In this case, the two department heads worked together to achieve the common goal of providing a more secure environment for the night shift in the parking lot. As a next step, they’ll talk to the hospital’s facilities department about extra lighting and landscaping. They’ll also write a memo to the nursing department explaining that no incidents have occurred yet they are planning to take action.

On a separate level, when the finance director questions the expense of extra lighting and landscaping, use the hard data to justify those improvements over the cost of installing an expensive closed circuit camera or telephone system.
Security spotlight

Customer service skills necessary for security officers

A visitor to a large hospital is looking for his wife who was just admitted to a patient-care ward. He quickly becomes lost, but is afraid to ask directions of staff members because they look so busy.

A uniformed security officer approaches and the visitor thinks he might have wandered into a restricted area. Instead, the officer smiles, and asks the visitor whether he is lost. The visitor explains that he is indeed lost, and the officer points him in the right direction.

Although the traditional role of the security officer is to protect and safeguard hospitals, many of the daily duties of security staff include customer service, making the above scenario a common part of the security officer’s workday.

Determining roles for your security officers

There is a major correlation between a secure environment and good customer service, says Fred Roll, MA, CHPA-F, CPP, president and principal consultant of Roll Enterprises, Inc., a Denver-based health care security and training firm.

He estimates that officers spend 90%–95% of their time assisting staff, providing directions, and giving general information.

“If patients encounter an environment that is clean and well lit, they get an initial sense of good security,” Roll says. “A well-dressed security officer [who] is low-key, friendly, and helpful adds to that security atmosphere.”

Good customer service skills may not be part of the traditional image of a security professional, but those skills are absolutely essential for officers working in a health care environment.

“You want patients and visitors to think that the officer is there to help them, not there because the hospital has a severe security problem,” Roll says.

Walking the tight rope of customer service

Achieving the appropriate balance of customer service skills with other security proficiencies is one of many challenges you face—and there is no hard and fast rule determining how to strike that balance.

“The customer service image of your security force is extremely important, but it has to work in your facility,” Roll says.

“The ultimate goal is to make the patients and visitors feel comfortable enough to approach security if they have a question or problem.”

Looking at the customer service role

The first step in looking at the customer service aspect of the security officer is to evaluate the facility’s security uniform, Roll says.

“Soft” uniforms, such as a gray or blue blazer with a shirt and tie, present a more approachable image to patients and visitors, but, may not work if your facility is located in a high crime area.

The “hard” uniform (i.e., one similar to what a city police officer wears) complete with headgear and a leather utility belt, presents a more intimidating image, so customer service training and skills become even more important.

✔ Tip: Evaluate your uniforms from the perspective of a patient or visitor, looking particularly at the “hard” elements of the uniform (i.e., weapons, handcuffs, and other items on the belt). Consult your hazard vulnerability analysis to determine whether these
Breaking the mold

Of course, customer service skills are not part of the stereotypical image of the hardened police officer, but Roll says it is essential to have these skills in the health care setting.

He recommends the following to enhance the customer service quotient of officers:

- **Look for customer service skills** on the résumés of potential officers—an applicant possessing experience in retail or fast food management will have more customer service training than someone with private security experience, the military, or a former patrol officer.

  “You can always teach someone the technical security side of the job,” Roll says. “It’s not so easy teaching customer service skills.” The officer also might be reluctant to learn this important part of the job. “Some people just aren’t going to want to adapt.”

- **Tap into training resources** to teach customer service skills—use the customer service training program offered by your hospital’s human resources department, Roll says. The International Association of Healthcare Security and Safety (www.iahss.org) also offers training courses on customer service.

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**Security tip**

**Plan security in rings, expert says**

Looking at your total security plan—from controlling parking lots to limiting access to sensitive areas in the building—can seem like a mammoth task.

To avoid feeling overwhelmed, approach your security plan in terms of concentric circles, says **Fred Roll, MA, CHPA-F, CPP**, president and principal consultant of Roll Enterprises, Inc., a Denver-based health care security and training firm.

The first ring in the circle is the outer perimeter, starting at the edge of the parking area.

“Do something that lets the visitor know that they are now in a more secure environment and on hospital grounds,” Roll says.

Use signs, fences, or other landscaping ideas (such as a tree line or moat), he suggests. Security items such as increased lighting or a manned security guard shack also achieve the same effect.

The next ring in the circle includes the outer exterior of the hospital building as well as general areas inside the hospital.

Place “authorized personnel only” on doors that have heavy staff traffic, but that you don’t want to control access to. Train your security guards to monitor these doors and redirect patients and visitors who try to go through them.

Highly sensitive areas in the hospital require the third ring of the concentric circle, access control.

This includes the pharmacy, nursery, medical records rooms, and behavioral health areas, among others, Roll says. These areas require access control for not only patients and visitors, but staff members who are not authorized entry.
North Carolina health care system reacts to ice storm

When weather forecasters predicted a major ice storm for the Raleigh-Durham, NC, area, hospital emergency planners at a local medical system went into action.

“As we monitored the weather through our emergency management office, the executive staff decided that the medical system would house staff in nearby hotels if they chose,” says Carla Stevens, director of occupational health and safety for WakeMed, a 746-bed health system located throughout Raleigh-Durham.

“The next step was to review the emergency management plans for each of our facilities and send copies to them,” Stevens says. “We then polled employees to find who wanted to stay in hotels near their facilities.” WakeMed has a standing agreement with hotels to house employees during weather emergencies.

Activating the plan
The morning before the storm, the system activated five emergency contact phone numbers for employees to call and get information. The chief operating officer also sent a system-wide memorandum reinforcing emergency plans and procedures.

When the full force of the ice storm hit, the main building in Raleigh went on emergency power. Electrical systems inpatient care and other areas worked well but two transformers failed eliminating power to the kitchen.

“The only thing working in the kitchen was the steam table, so the entire kitchen went into disaster mode,” Stevens says.

**Pre-planning saves the day**
As part of its disaster plan, dining and nutrition managers developed a complete menu to serve should the kitchen lose the ability to serve hot food. Because the steam table still worked under emergency power, the hospital served some hot foods along with other items, such as sandwiches and salads from the disaster mode menu.  

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In brief

Local officials still await homeland security funds
State and local officials last month voiced concerns that the federal government will not allocate funds in 2003 to train first responders for potential terrorist attacks, Global Security Newswire reports.

The troubled economy has hit states and communities hard, leaving little money left to fund anything beyond traditional projects. Officials at the recent Republican Governors Association meeting criticized the Bush administration and Congress for failing to keep promises to help local governments in the fight against terrorism.

President Bush signed into law the bill creating the Homeland Security Department just before Congress adjourned last year. City and state officials say no strategy exists to provide them with the resources to fund homeland security efforts.

In addition, states need smallpox vaccines should the government require inoculations after a biological attack. Local officials also say they want to see improved communication and information sharing from federal agencies.

Hospital security guard and two other officers sued for wrongful death
A bizarre series of events led to a wrongful death suit filed against a hospital security guard in Cobb County, GA, according to a story by American Lawyer Media’s Fulton County Daily Report.

In September 2002, the Kennestone Hospital emergency department paged neurosurgeon Daniel Moore for emergency brain surgery on a 16-year-old patient. Moore then allegedly hit an SUV while leaving the parking lot of a store he was at when he received the page. A hospital security guard and two other officers confronted him about hitting the SUV after he arrived at the hospital.

Moore told the officers he had to attend to his patient, but they allegedly blocked him from leaving the security office. The officers took him out to the parking lot where the SUV driver was talking to another police officer.

After a few minutes of questioning, the officers handcuffed Moore and took him to the local jail. Police arrested and charged him with battery and misdemeanor hit-and-run.

Even though Moore called a colleague to treat the patient, the teenager later died. Medical records stated the boy would have survived with faster treatment.

Police eventually dropped the charges against Moore. The parents of the teenager are now suing the two officers, the hospital security guard, and the hospital for wrongful death, stating they were negligent in restraining Moore and preventing him from providing emergency care, the report said.

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)
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Pennsylvania distributes $3.3 million in federal emergency funds

The state of Pennsylvania plans to give out $3.3 million in federal funding to hospitals for emergency preparedness planning and response. About 200 hospitals will receive a base amount of $5,000. In addition, they will take in 50 cents for every emergency room visit reported to the Department of Health in each hospital’s most recent annual survey. To qualify for funding through the grant, hospitals agree to:

- participate in a regional counterterrorism task force and disaster-planning activities
- work on developing of mutual aid agreements with local health care facilities in the event of a disaster or infectious disease outbreak
- contribute their data to the state’s electronic disease reporting project
- enroll appropriate administration, laboratory, pharmacy, medical command, medical staff, nursing, and infection control staff in an online learning program for disaster preparedness training.

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