Don’t wait until another baby disappears from a hospital before you look at your abduction prevention plan.

The details of a near-miss infant abduction in March contain typical characteristics of an abduction, and also demonstrate the challenges of preventing this sentinel event from happening.

At a hospital in Florida, a woman posed as a nurse, admissions clerk, language translator, and social worker to several patients and employees, according to a story in the Orlando Sentinel. She then approached two couples separately and tried to convince them to hand over their babies.

The first couple refused, but the second couple handed over and then quickly retrieved their baby when the woman tried to walk away. Police later picked up the woman in a local bus station, the newspaper said.

“This is a typical profile and method of operation for an abduction,” the manual says.

But hospital security officers who restrain patients under clinical care face a different set of rules than when restraining visitors or intruders for security reasons, says Fred Roll, MA, CHPA-F, CPP, president of Roll Enterprises, Inc., a Denver-based health care security and training firm.

“Whatever the policy is for your hospital, it should come from patient care officials, not the security department,” the manual says.

A nurse or doctor trying to calm an agitated patient can resort to calling in a member of the security team, according to the intent statement of TX.7.1.4 and TX.7.1.4.1 of the Joint Commission on Accreditation of Healthcare Organizations’ Comprehensive Accreditation Manual for Hospitals.

While nonphysical restraint techniques are preferable, security can employ force “only when nonphysical interventions are ineffective or not viable, and when there is a risk of a patient physically harming himself or herself, staff, and others,” the manual says.

Samples hospital physical restraint policy
Experts recommend that a clinical restraint policy not be long and tedious. We’ve helped you out by providing a short policy for all employees. Find the policy on p. 5.

Restraint policies in action at your hospital
Developing a policy for clinical restraint is only half the battle. Putting the policy into action involves training of security officers and development of restraint teams. Find out how some hospitals put their restraint plans into practice on p. 6.

Questions & Answers
Two health care security experts answer questions on what crime statistics to look for and how to retain video images on p. 8.

Security spotlight

Regular reviews help prevent infant abductions, expert says
Infant abduction

infant abductor,” says Fred Roll, MA, CHPA-F, CPP, president of Roll Enterprises, Inc., a Denver-based health care security and training firm.

“Thankfully, these things have been few and far between, and hospitals have used the event’s occurrence to spark a review,” he says.

The last baby abduction from a hospital in the United States occurred in June 2002.

Despite the fact that abductions rarely happen, Roll recommends a periodic appraisal anyway of all abduction prevention policies.

Look at the following three areas:

• **Access control policy**—Review by name and position who has access to security-sensitive areas on the infant floor. Look at the procedures for issuing key cards and passes to new employees and retrieving them from employees who move on. Review closed-circuit television camera images to make sure the field of view is helpful to those monitoring the area.

  Watch doors to make sure employees don’t piggyback into the infant area using another person’s access privileges, and that employees aren’t using objects to prop a door open while they step out briefly.

• **Training policies**—Make sure employees know why such policies are in place. Confirm that they know how to recognize a suspicious employee and what steps to take if they feel an abduction or other crime is about to happen.

  Train employees to be diligent throughout their shift and report anything that might be out of the ordinary.

• **Response plans**—Look at your infant abduction reaction plans. Ask yourself the following questions:

  - Are the right people paged immediately after someone recognizes an abduction?
  - How much time passes before local police are notified?
  - Are plans in place to screen people as they leave the building?

  Test plans across all shifts with both unannounced and announced drills.

  Keen observation is key

  Members of the security team can also foil an abductor’s plans by coming into close contact with those who they view as suspicious.

  Although it’s not the security officer’s job to ask visitors their reason for being in the hospital, he or she can use customer service skills to make contact with a person believed to be intent on doing harm.

  “Abductors don’t want anybody to notice they are in the building,” Roll says. “Making eye contact with the person and asking ‘May I help you?’ in a friendly . . . way forces the person to answer. It also lets the person know that they are noticed and might push them to rethink their plans.”

  The person’s reply also gives the officer a clue as to his or her intentions. For example, if the person is looking for a particular clinic or doctor, the officer can point him or her in the right direction. Officers can continue to question people who give uncertain replies.
Medical restraint

security department," he says.

Elements of the policy
Even though you don’t write the policy, review it to make sure it provides guidance for security officers called to assist in a restraint procedure.

“The policy must break down what restraint actually involves and how to assess the situation as it progresses,” says Steve MacArthur, a safety and security consultant with The Greeley Company in Marblehead, MA. The Greeley Company is a division of HCPro, which publishes HSEM.

The restraint policy developed by patient caregivers must include the following:

• **Training standards** for officers. For example, officers must know that physical restraint is a “last resort” option and that caregivers are ultimately in charge of the ongoing assessment and management of the episode.

• **Observation techniques** for different situations. Officers are not involved in the assessment phase of the restraint other than identifying behaviors where an intervention is necessary. These behaviors include a patient muttering or walking around in an agitated state.

• **Specific competencies**, including the appropriate steps and actions to take during a restraint episode. Officers also must know how to take directions from caregivers, “safe hold” techniques used to restrain a patient, and how to safely take a patient down without hurting the patient or themselves.

Evaluating the physical environment of the restraint area is also important in preventing injury to those involved in the restraint. For example, the officer must notice whether sharp objects are within the patient’s reach or whether there are other items the patient can use as weapons, such as a chair or small table.

• **Deescalation techniques**, such as proper show-of-force, talk-down methods, and avoiding a worsened situation when the goal is deescalation.

“If you bring in a uniformed officer and the patient reacts in a negative way, the caregiver must make the call to remove the officer and try a different technique,” Roll says.

In other cases, a quick change of scenery is all that is necessary to calm a patient. “Sometimes, a patient just needs to go outside for a breath of fresh air,” says MacArthur. Other ideas include closing or opening doors or lowering or raising light levels within the room.

Other general guidelines
In addition to the specific elements mentioned above, the following common rules apply to all personnel involved in restraint incidents.

• **The number of people on the restraint team**—A general rule is one person per limb, one person for the head, and a clinician to supervise.

However, not all situations will require that many people. For example, restraining a nine-year-old male is going to be much different than restraining a 40-year-old male.

“The clinician in charge of the patient and the lead security person must know how to make the call on how many people are necessary,” MacArthur says.

• **The use and recognition of excessive force**—All restraint personnel must realize when they use too much force. Injuring a patient during a restraint episode unnecessarily harms the patient and subjects the hospital to legal liability and unwanted bad publicity.

✔ **Tip**: Train officers to recognize the signs of a restrained patient in pain. Body language as well as verbal moans and groans are good indicators.

✔ **Tip**: Exercise caution when deciding to use...
Managing aggressive behavior is the key to successful outcomes with unruly patients

A nurse or security officer dealing with a disgruntled patient sitting for hours in the emergency room can use several methods to help calm the patient.

“A good passive technique is to reflect a person’s emotion back to him or her,” says Roland Oullette, president and founder of R.E.B. Training International, Inc., a training organization specializing in MOAB© or the management of aggressive behavior.

For example, in the above situation, the officer or clinical caregiver acknowledges the patient’s frustration and assures the patient that the officer understands how he or she feels.

“Showing empathy for a patient’s situation is a good way to get the patient to talk,” Oullette says. “If the patient is talking, there is less of a chance he or she will turn to aggressive behavior.”

Solid results in the field

When security officers at Newton-Wellesley Hospital, in Newton, MA, began using this method in 1999, physical interventions dropped almost immediately, says Evelyn Meserve, CHPS, director of security, safety, and parking at the hospital.

“This training gives officers the ability to identify an escalating situation and the techniques to step in and take action before things get bad,” Meserve says.

All 18 officers on the hospital’s security team undergo the two-day training program and refresh their training every two years.

Nonsecurity employees also benefit

Security officers aren’t the only employees who take advantage of the instruction. Meserve offers a one-day training program to employees throughout the hospital. Staff from human resources, registration, finance, psychiatry, and the emergency room have all learned from the program, taking MOAB© techniques back to their desks.

Editor’s note: For more information on MOAB© training techniques, go to www.rebtraining.com.
Sample hospital physical restraint policy

**Statement of purpose:** The standards for restraint detailed in this policy apply to patients physically restrained in any area or department of the hospital.

**Definition:** Restraint is any physical or mechanical method of restricting freedom of movement or normal access to the patient's body. This includes the use of other clinical and nonclinical personnel to assist in the restraint.

**Clinical justification:** Restraint is limited only to clinically justified situations. The decision to use restraint is driven not by diagnosis, but by a comprehensive assessment that concludes that the use of a less-restrictive method poses a risk to the patient and caregivers.

Use restraints when
- emergent, dangerous behavior shows suspected or obvious intent for harm or personal injury to the patient or others
- behaviors result in the pulling of tubes, IVs, wires, or other invasive lines
- disorientation accompanies behavior with the potential for harm
- Verbal aggression or escalation signals obvious intent for harm
- disruptive behavior indicates obvious intent to harm
- patients display impaired abilities to follow basic instructions for their safety

**Patient rights, safety, and education:** Determine the choice of restraint method based on the patient's assessed needs, taking into account previously used restraint methods. Consider patient and staff safety when making these decisions.

Each patient has a right to respectful care that maintains his or her dignity. Thus, with each episode of restraint, make sure
- the application or initiation respects the patient as an individual
- the environment is safe and clean
- you encourage the patient to continue participating in his or her own care
- you maintain modesty, visibility to others, and comfortable body temperature

After placing the patient in restraints, staff will explain to the patient the reason for the initiation and the behaviors necessary for discontinuation. Document the medical record if the patient's mental status is such that he or she is unable to comprehend/remember this information.

**Documentation:** Record the use of restraint in the patient’s medical record. Include clinical justification for use when less-restrictive alternatives appropriate to the patient's condition fail.

Source: J. Buford Tune. Reprinted with permission.
Putting your restraint policy to work
Spell out the role of your security team before an incident happens

A hospital that doesn’t have a policy dealing with patient violence puts employees in awkward circumstances if a patient becomes physically or mentally unruly.

For example, not too long ago a patient kicked and pinched Jose Hernandez, the safety officer at Mercy Medical Center in Roseburg, OR.

Because Mercy Medical, an acute-care and behavioral health provider, didn’t have a security officer use-of-force policy for violent patients, there wasn’t much he could do during the incident.

Mercy Medical has a management policy on assault behavior that discusses how to restrain patients, but doesn’t go beyond those actions if a situation escalates.

Hernandez is trying to convince his administrators to adopt a new use-of-force policy that spells out exactly what steps security officers should take when confronted by a violent patient.

“Unfortunately, a lot of hospitals don’t have [this type of policy] and should have it for legal reasons,” says Hernandez, adding that in a courtroom, you don’t want a lawyer badgering a hospital on why its security team didn’t observe such a policy.

Former police officer J. Buford Tune agrees. It’s best to aim such policies at security officers and not clinicians, says Tune, who is owner of the Academy of Personal Protection and Security Inc. in Nashville, TN.

Otherwise, a hospital raises too many murky questions and risks someone asking why a nurse needs a use-of-force policy, he adds.

Consider using restraint teams
An option to deal with these episodes is to develop a restraint team as part of the policy, says Earl Williams, HSP, safety coordinator at BroMenn Healthcare in Bloomington, IL.

BroMenn uses local police to train its contracted security force in handling unruly patients and developed the team approach to cope with out-of-control patients.

“Once the clinician exhausts verbal options, he or she calls a code for the restraint team.”

Every shift has designated workers on the restraint team who have undergone further training in take-down and deescalation techniques.

“Usually, just calling in the team is good enough to calm the patient, but if not, all verbal techniques cease and the clinician directs the team to subdue the patient,” Williams says.

✔ Tip: After calling the code for the restraint team, keep a safe distance from potentially violent patients and always keep an escape route open, Hernandez says.

That distance should be far enough that the patient can’t kick you. Never lock the door to the room, and always let another staff member know your location.

Draft policy addresses security team
Back at Mercy Medical Center, Hernandez’s draft any use of physical force or handcuffs should also trigger an incident report.
use-of-force policy would apply to his security team and includes the following sequential steps to take if faced with a combative patient:

1. Contact backup security officers for help
2. Follow the previously mentioned assault behavior policy
3. Use defensive tactics to block kicks and blows
4. Use physical holds and takedown techniques to control the patient
5. Handcuff the patient to control him or her

Editor’s note: For more information on what to put into a restraint policy, see story on p. 1. For a sample basic policy, see p. 5.

Be careful with handcuffs
Step no. 5 is “about as high as I’d want my guys to go,” Hernandez says.

If things become worse even with handcuffs in use, it’s probably time to call the police for assistance if staff members haven’t already done so.

Also, once a patient is under control with handcuffs, staff members should replace the cuffs with soft restraints, he says.

Remember, employees must receive proper training on restraint use to keep up with accreditation and Medicare requirements.

Any use of physical force or handcuffs should also trigger an incident report. “I want it documented,” Hernandez says.

The policy—keep it simple
That said, don’t weigh down your use-of-force policies, says Tune, who wrote several of these documents for hospitals in Tennessee.

“The biggest problem I see [with use-of-force policies] is they want to make it too complicat-
ed,” he says.

For example, if the policy states that a security officer must fill out a form every time he or she touches a patient, then paperwork becomes necessary even if an officer merely helps a patient out of a car.

Local laws provide groundwork
One good idea is to use local or state regulations to serve as your policy’s backbone.

“What I try to do . . . is refer to state law as much as possible, so people can’t say I made it up,” Lane says.

He often mentions Tennessee’s self-defense statute in policies he authors.

Local law enforcement authorities can assist in developing your policy since many police stations already use them, Hernandez says.

However, police officers have the ability to use a greater degree of force with weapons. Discuss weapon use with your local police in case it conflicts with hospital policy.

For example, Mercy Medical doesn’t allow any weapons in the behavioral health unit, even those carried by cops. Police must place their weapons into a secured locker.
The following questions came from the February 27, 2003, HCPro audioconference, “How to detect and correct security risks in your hospital.” HCPro is the publisher of HSEM.

Walt Sarratt, CPP, regional director for Healthcare Security Services in San Diego, and Russ Colling, CPP, CPHA, of Colling, Kraemer, and Associates, Salida, CO, provided the answers.

Editor’s note: Remarks have been paraphrased.

**Q:** What are the alternatives to collecting crime data if local police don’t want to release such information?

**A:** Another option is to access the CAP index for your neighborhood.

The CAP index is a commercial service that breaks down statistics by neighborhood zones within a city and projects crime statistics into the future, taking into consideration data such as the neighborhood’s transient population and the education level of residents.

A quick Internet search will provide companies that can retrieve those statistics.

**Tip:** Be careful when analyzing police statistics. They can mislead you because the address on the police report is where the police officer was dispatched to investigate, as opposed to where the actual crime took place.

**Q:** What statistics should I look at when performing a security assessment?

**A:** Look at your internal incident profiles, which include data such as root causes, types of incidents, when they occurred, and whom they involved. Local crime statistics are important, however, because they can help you decide what kind of perimeter security system you need.

The type of system you use can mitigate that threat to your facility. Internally though, the problems you deal with every day are the most important statistics in your assessment.

**Q:** How can a hospital find out whether an employee is in a domestic violence situation that can spill into the workplace?

**A:** These things just don’t happen spontaneously. People who perpetrate this type of violence develop a history of domestic violence that is repeated throughout their lives. Drinking problems or drug abuse can almost always be tied to this problem. Most states provide at least a criminal history of convictions. Some states have a clearinghouse of this type of information while commercial services can also do this type of research.

If the potential victim doesn’t let you know about the problem, there really is not a lot you can do. Often, a supervisor or fellow staff member realizes the problems, but won’t take those concerns to an authority or the security department. Train and motivate supervisors to report those fears.

Security can take action behind the scene to intervene in a problem, but only if it is aware of the problem in the first place.

**Q:** How long should we retain recorded images from the security closed-circuit television system?

**A:**
A: The National Center for Missing and Exploited Children requires seven days’ retention for infant areas, so as a general rule keep recorded images for at least that long. Most hospitals keep recordings on hand for 30 days.

✔ Tip: If you have had an incident that leads to further inquiry and litigation, pull that tape out of the rotation and keep it as a part of your documentation.

Q: How many security officers should actually watch live monitors?

A: In the old days, a security officer would watch a central bank of monitors, however, studies show that a person can’t watch a live monitor effectively for a long period of time.

Today, we are getting away from live monitoring and decentralizing viewing of video images.

For example, if materials management wants a camera on the dock to handle inventory control, someone from that department would monitor the activity.

New technology also helps, as new cameras don’t activate unless there is something to view.

For example, an alarm triggers a camera to start rolling or a camera remains in standby mode until motion in the field of view triggers the recording.

A new process out there entails a director of security or his or her designate to review the tapes in fastforward modes at least once a week.

The benefits of this system are that the viewer will catch important information before it is taped over, and the tape doesn’t lie on the shelf unwatched.

Q: Do all images from security cameras need to be recorded?

A: The rule of thumb is that all camera images need to go on tape, especially as we move further away from live monitoring situations.

On the other hand, there are situations where you don’t need to tape the live camera images.

For example, a camera viewing a patient corridor for patient care reasons doesn’t need to record its images. Patients under observation for mental health treatment also do not need recording. However, setting up a “dummy” camera is absolutely forbidden.

No camera should ever be mounted that does not have a real picture either recorded or observed through live monitoring.

Editor’s note: To purchase a copy of this audio-conference, go to www.hcmarketplace.com/Prod.cfm?id=1480.

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)
Accreditor’s white paper offers community emergency preparedness accountability advice

The Joint Commission on Accreditation of Health-care Organizations (JCAHO) recently provided hospital emergency planners with guidance on how to move forward with community emergency planning.

Citing a growing complacency among communities despite the horrors of 2001’s terrorist attacks, the accreditor last month released Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems, a 48-page white paper that outlines ways for hospitals to prepare for emergencies in concert with local community responder agencies such as police, fire, emergency medical technician groups, and other hospitals.

The white paper contains 41 recommendations that propose how hospitals should make contact and network with other agencies in their areas, and also suggests who in the community is to be held accountable for those actions.

For example, the white paper suggests that health care and community organizations be responsible for establishing mutual aid agreements among community hospitals and other health care organizations.

“Not one of these entities can respond to an emergency alone,” said Dennis O’Leary, chief executive officer of the accreditor during a press conference to announce the release of the publication.

He suggest that hospitals think in terms of “partnerships” with other community response agencies while going forward with a program or system that deals with large-scale emergencies. “In most of America’s communities there has been no mobilization . . . at the local level to make this possible,” he said. “This action, we suggest, is at the community level.”

What will surveyors look for?

We know what you’re thinking: Is this yet another document to refer to when survey time rolls around? Not so, says a JCAHO spokesperson.

“This paper does not promulgate any new standards, requirements, or recommendations for the field. The specific recommendations it makes will not be surveyed,” Mark Forstneger, media relations specialist for the JCAHO, told HSEM. “The Joint Commission will continue to survey organizations for compliance with E.C.1.4 and E.C.2.9.1.”

Editor’s note: Download a free copy of the Joint Commission’s emergency planning document at www.jcaho.org.
CDC tracks first cases of smallpox vaccine reactions

Three people vaccinated against smallpox developed symptoms that could constitute an adverse reaction to the inoculations, according to a Reuters report.

None of the cases is life-threatening and two could be associated with other conditions, but officials from the Centers for Disease Control and Prevention (CDC) are keeping close watch on the reactions.

All three people live in Florida, officials said. They are among the 7,354 civilian health care and public health workers vaccinated against smallpox.

The Department of Health and Human Services hopes to eventually vaccinate 450,000 health care workers, but some are resisting because of the possible health risks.

Denver hazmat team decries lack of proper equipment

Members of Denver’s hazardous materials (hazmat) team say the city is woefully unprepared for a chemical or biological attack by terrorists because it lacks basic equipment to identify substances such as anthrax, the Denver Post reports.

The 90-member hazmat team says it is good at decontamination when the substance is known, but unknown agents cause serious problems.

Captain Dave Frank says it would cost $200,000 for equipment and training for the hazmat team to identify chemicals. But city officials cite a lack of available funds.

CDC Internet program helps hospitals monitor smallpox vaccinations

The CDC on February 18 began a voluntary, Internet-based program to help hospitals monitor and track health care workers who receive smallpox vaccinations.

The Hospital Smallpox Vaccination Monitoring System records daily assessments of recently vaccinated health care workers, who should be seen daily for 21 to 28 days following vaccination.

Hospitals should keep track of the daily assessment of the vaccination site, symptoms reported by the worker, vaccine take, determination of fitness for duty, and work days lost.

The program is open to hospitals or other vaccine monitoring sites that have designated health care response teams and that provide a secure mechanism for data transfer between facilities and the CDC.

For more information on how to enroll, visit www.bt.cdc.gov/agent/smallpox/vaccination/hsvms.

Oregon psychiatric patient shoots himself in hospital ward

A patient at Salem (OR) Hospital snuck a gun into the psychiatric ward and committed suicide, according to the Associated Press.

Michael Shay, 37, of Salem, voluntarily checked himself into the inpatient unit of the hospital on March 3, and shot himself the next day.

Officials at the hospital searched Shay during the admitting process and said he did not have any visitors during his stay. He did leave the building to move his car, but was escorted by staff members at the time, the report said.

No other patients or employees were hurt in the incident. At presstime, hospital and state officials were still investigating the event.
Training solidifies roles during nightclub fire

Emergency planning experts say training and coordination are key to organized disaster response. Nowhere was this more evident than February’s nightclub fire disaster in West Warwick, RI.

Rhode Island officials had developed a statewide disaster plan in response to the September 11 terrorist attacks that included establishing clear routes to hospitals, organizing a communications system across all response agencies, and establishing procedures to quickly assess large numbers of mass casualties, said a story in the New York Times.

A Justice Department grant funded a statewide terrorism drill at nearby T. F. Green Airport involving hundreds of actors portraying victims and terrorists.

Responders also trained with computer simulations at Newport Naval War Colleges’ war games theater. That training paid off, as burn experts told the newspaper that the speed and precision with which responders transported patients to appropriate hospitals saved many lives, including more than 50 patients with inhalation burns.

“We never expected this kind of test,” Lieutenant Governor Charles J. Fogarty told the newspaper. “But there is no question that all the training and focus on terrorism helped our readiness and capacity to respond.”

Editor’s note: Check out next month’s HSEM for further coverage of Kent Hospital’s and Rhode Island Hospital’s response to the nightclub disaster.