Communication is the key in getting what you need

The security department doesn’t always have to be last in line for hospital budget requests. With solid preparation and improved communication, security directors can make successful requests that get noticed.

Russ Colling, CHPA, CPP, a consultant for Colling and Kramer Consultants in Salida, CO, says security departments’ requests for funding get turned down for two basic reasons:

1. Hospital administration doesn’t want to increase security or lacks confidence in the program. If hospital staff avoid calling security during a problem at your facility, then that’s a red flag for administrators.

A successful security program must have support and buy-in from the stakeholders—staff members and administrators. If it doesn’t, then its requests for funding will lack support, too.

2. There isn’t enough funding to go around. Security directors commonly complain about receiving fewer hospital funds than other departments. What administrators perceive as requests related to direct patient care will always win out over a security need, says Colling. For example, administration might fund a clinician’s request for heart monitors over your request for security cameras.

“You can overcome this by being a smarter manager and communicating better,” Colling says. Instead of just saying you need something, explain the reason and base your argument in facts.

Figure out your needs

When you’re thinking about ways to improve your program, put your actual needs before cost. Once you’ve determined what you need to provide excellent security, start developing your budget pitch to administration:

• Think about the

Reduce mass casualty confusion

Easy patient tracking is just one click away

Hospitals and first responders often struggle to coordinate their emergency response during mass-casualty incidents. Now, thanks to the Emergency Patient Tracking System (EPTS)—a computerized field unit that connects to the Internet using wireless technology—managing mass-casualty incidents is as easy as the click of a scanner.

Jeff Hamilton, a registered nurse at St. John’s Mercy Medical Center in St. Louis and creator of the EPTS, regularly witnessed mass-casualty response challenges. “The biggest discrepancy is that the hospital doesn’t know how many victims are at the scene, and [workers] at the scene [usually] don’t know how many victims have gone to the hospital,” he says.

Even before the September 11 attacks demonstrated this discrepancy, Hamilton, a former firefighter, was looking to technology to overcome problems with coordinating responses, tracking patients, dealing with self-referred victims, and determining how many victims were sent to a hospital. There was no way to balance the load, he says.
Communication

audience to whom you need to sell the proposal. “You need to cater your delivery to the people in administration and finance in terms that they understand,” says Rick Nelson, CHPA, CPP, regional director of security and transportation services for Franciscan Health System in Tacoma, WA. “They rely on statistics and a solid, rational reason for why you need a particular camera or additional [security officers].”

Security departments tend to be reactive in their requests for funding—when they see a potential security breach, they want it fixed immediately. Instead, research the problem first and prepare a presentation. Typically, you’re selling the proposal to administrators, so take cues from how hospital clinical directors make requests using facts and figures.

- Look at the big picture. For example, if you want to increase security for a new parking lot—don’t just say unless you get more security someone will get hurt, Nelson warns. Use specifics whenever possible. For instance, clinical nurses, who are predominantly females aged 30–40, use the parking lot,

Regardless of where your department falls on the budget priority list, don’t get trapped by these five common mistakes that security directors make when pitching funding requests:

1. Ignoring the hospital’s mission in your requests. Security shouldn’t operate as a mini police department within the hospital. Its focus should always be about what’s best for patients, staff, and the organization. Keep an open mind and listen to the needs of the organization. Remember that requests aren’t about what’s best for you, says Russ Colling, CHPA, CPP.

2. Using scare tactics to get what you want. If you are turned down for a request, don’t say to administration, ‘Well, if someone gets killed, don’t blame me,’ Colling says, pointing out that a threat is often overused and exaggerated.

Instead, establish objectives for why you want a particular item, with reasonable examples that prove the need.

3. Acting and responding negatively. Administrators recognize a bad attitude when they see one. No matter how many times your past funding requests have been denied, and no matter how important you think your request is, never act like administration doesn’t care about security needs. “If you think you’re the last one to get anything, then you’re acting disgruntled to a certain degree,” Colling says.

4. Preparing proposals based on emotions, not facts. Your presentation should include facts about why you’re choosing a particular product over another, what affect it will have on employees, and statistics to support your argument. You need to anticipate the questions that administrators will ask, says Rick Nelson, CHPA, CPP.

5. Forgetting to practice presentations. It’s a good idea to practice your presentation or go over information in front of a colleague. Recruit someone whose opinion you value to sit through the presentation beforehand, Nelson recommends. Have that person critique it. “You don’t want to be unprepared for a presentation—especially if you only have 10 minutes,” Nelson says. Sometimes managers feel so strongly about their proposal that they assume others will automatically agree then they find themselves ill-prepared for a presentation.
which is 100 yards from campus. They fear for their safety when using the parking lot after 5 p.m. Include in the proposal crime statistics in the area and perhaps even national statistics that relate to this particular problem.

- **Give several options of how to solve the problem.** For example, to make the parking lot more secure for staff, suggest additional lighting, cameras, and call box alarms. Another option is to hire a staff member to guide employees to and from their cars during shift changes.

Once you’ve outlined the problem and provided solutions, recommend which solution you endorse and explain why, advises Colling. Be prepared to defend your recommendation.

- **Think about alternate plans.** It isn’t uncommon for administrators to make a counteroffer. For example, if you request eight video cameras, how will you respond to an administrator asking, “Well, what would you do with three video cameras?” Think about what questions might arise during your proposal, Nelson says. “It can almost be like a job interview where you don’t get the job if you can’t come up with the answer,” he says.

**If at first you don’t succeed . . .**

If you don’t receive what you’ve requested, don’t be bitter. At least you’ve made the need known, Colling says. “Then if something happens, you’re in the position to say, ‘I told you so,’ and you don’t end up looking like the person who couldn’t foresee the possibility.”

Rather than assume that administrators won’t give you what you need, focus on whether you should make the same proposal again next year, evaluate why it was turned down this time, and adjust your proposal for the future.

“You can build credibility with proposals that are well put together,” Nelson says. “Even if they deny your request, at a certain point, they will probably figure that they owe you.”

**Mind hospital relationships**

Be aware that how you interact with hospital administrators and staff members can work against you before you put your foot in the meeting room door. For this reason alone, it’s important to go out of your way to build and maintain relationships with administrators.

“Security directors have to be consummate politicians now more than ever,” Nelson says. “You have to be sensitive to working relationships with senior directors. The days of ‘a crime occurred and now you need to give us money’ are gone.”

—Rick Nelson, CHPA, CPP
Patient tracking

St. Louis Metropolitan Medical Response System hospital committee, Hamilton developed a system that would track mass-casualty victims by using a bar code system similar to scanners at supermarkets.

The primary goal was to allow emergency medical service, fire, and hospital personnel to easily coordinate response. Using grant money, Hamilton tested different versions of a tracking system, which eventually evolved into the EPTS.

How EPTS works

When an incident occurs, a medic attaches a bar code bracelet (see the graphic below) to a victim at the scene. Nurses at the hospital also attach bracelets to self-referred victims who come to the facility. The bracelet is color-coded and contains information about the victim’s location and condition.

Using a handheld PDA field unit, the medic/nurse scans each victim’s bracelet and enters medical information, such as injuries. The information is then sent to the computer system to be accessed by incident commanders and hospital staff so they know the number of victims on scene and at the hospital, as well as their conditions and personal information.

This information not only enables hospital staff to be prepared for patients’ arrival, but it also ensures that the facility can divert an influx of patients if there’s potential that it will be overwhelmed. “The bar code really gives a bird’s eye view quickly,” Hamilton says.

Sharing resources an added benefit

Registered and approved users can access the secure Web site to keep track of the number of victims and their condition through portable computers linked to the EPTS. Hamilton says EPTS patient information is secure to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996. Another highlight of the EPTS allows welfare agencies such as the Red Cross to quickly locate victims for loved ones.

The EPTS can help you

The St. Louis metropolitan area tested the EPTS for three years. Because technology isn’t 100% foolproof, the system even includes four built-in backup systems—radio frequency, wireless, cell phone, and satellite.

The Miller Group, an innovative computer database technology company, initially developed the EPTS based on Hamilton’s design. Then the Raytheon Corporation entered into an agreement with the Miller Group to market the system internationally.

Seventeen cities in the country currently use the EPTS, according to Raytheon’s David Gellan, and 43 cities are waiting to implement it. Depending on area population, the EPTS price tag begins at $25,000.

“[EPTS is] something that you can add to your current disaster management system, Hamilton says. Even the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) is impressed with the EPTS. “JCAHO wants hospitals to have a disaster response system that’s interoperable with the community response system,” Hamilton says. “This integrates with a community system so you’re already connected to other hospitals and the fire and police departments in the system.”

Hamilton recommends that states and regions buy the system to track patients and emergencies every day, like St. Louis does. “To just take expensive technology and roll it out two or three times a year is not cost effective,” he says. “It’s an extra step for hospitals, but once you find out how simple the data are to use, it’s easy,” Hamilton says, noting that staff also need to be familiar with the equipment. “Plus, administrators love it.”

For more information about the system, visit www.raystl.com/eptsinfo/system_architecture.asp.
When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released its 2005 prepublication infection control (IC) standards for nonhospital settings in June, it emphasized standard IC.6.10, which requires facilities to prepare a response to epidemics and outbreaks.

The accreditor revised the wording of that standard to say organizations must prepare to respond to an influx, or the risk of an influx, of infectious patients.

“What the JCAHO is looking for in this standard is a more active role by emergency managers in detection or response to infectious disease outbreaks,” says Pablo Gonzalez, director of crisis management services for Telemus Solutions, Inc., based in Falls Church, VA.


What to do now
Response to an influx of infectious patients could include a variety of actions, such as temporarily halting services or admissions, delaying the transfer or discharge of patients, limiting visitors, or fully activating the emergency management plan.

In the elements of performance for IC.6.10, the JCAHO notes that organizations must have a plan for handling the ongoing influx of potentially infectious patients over an extended period of time. It must also do the following:

- Determine how to stay informed about the emergence of epidemics and infections that could result in the organization activating its response
- Determine how to disseminate vital information to staff and other key practitioners
- Identify community resources through local, state, and federal health systems for obtaining additional information

Gonzalez recommends the following five ways emergency managers can make a difference in IC plans and meet the JCAHO’s expectations:

1. Introduce yourself to the IC person at your facility. If you don’t already know who this person is, find out. Because a disease outbreak will likely require an emergency response, you will work closely with the IC staff in your facility.

2. Understand the risks involved with disease outbreaks. Do your own background research and talk to the IC department about specific diseases so you become familiar with the associated risks.

3. Make sure you are one of the first staff members contacted during a suspicious outbreak case. Early detection is vital to bioterrorism response. You can lose precious time if you lack 24-hour coverage for infection control issues.

Traditionally, Gonzalez says a registered nurse or other staff person handles IC by maintaining records and evaluating cases. “The problem is hospitals usually don’t have an IC nurse working around the clock. So unless there’s a clear indication that the outbreak is an emergency, the IC nurse arrives the next day, and you could lose valuable time.” The emergency manager can fill this gap by being informed and staying in contact with the IC department.

4. Create a plan for surge capacity. Fear alone could send hundreds of people to your facility during a potential outbreak. Hospitals must be able to respond properly to masses of people arriving with or without illnesses. “[Patient overflow] is the one thing that can render a hospital useless,” Gonzalez says.

5. Think beyond your facility. A bioterrorism response requires help from the entire region. “The trick to overcoming any emergency is to out-resource the needs,” Gonzalez says. “It’s difficult to wait for resources to arrive.”
Five ways to safeguard your patients’ valuables

Improperly safeguarding patient property may be perceived as careless and lead to the assumption that staff are equally as careless in their medical care. Security departments should make sure their hospitals have clear policies and procedures that spell out how to handle valuables during a patient’s stay.

HSEM spoke with four industry insiders about this issue. They recommend that policies and procedures regarding patients’ property include the following five measures. (see a sample policy on p. 8):

1. Encourage patients to leave valuables at home.
   When a patient first makes arrangements for his or her hospital stay, the admitting office and other involved parties should make it clear that he or she should leave all valuables at home, explains Steven Dettman, CHPA, director of security and visitor support at the Mayo Clinic and Hospital in Scottsdale, AZ. If he or she still brings items to the hospital, arrangements should be made for a relative or friend to take them home.
   “These statements should be right in the hospital’s admission paperwork so the patient understands the hospital’s policy up-front,” Dettman advises. Staff should also reiterate the policy verbally to make sure the patient didn’t overlook the language in the paperwork.

2. Require patients to sign a liability waiver.
   If patients arrive at the hospital with valuables and are unable, for whatever reason, to send them home, require them to sign a waiver of liability as part of the admissions process, recommends Don Walker, director of security at Sentara Norfolk (VA) General Hospital, to relieve the hospital from responsibility for any lost or stolen property, he explains.

3. Offer patients a place to lock away valuables.
   If possible, make a safe or lockbox available for holding patients’ belongings. “[The safe] could be located in the admitting office or the security office,” says Linda Glasson, security manager at Obici Hospital in Suffolk, VA.
   “Storage and lockup capabilities differ from institution to institution,” she says, “but whatever they may be, make sure the patient understands up front what your policy is and where [his or her] items will be kept.”

   For example, Sentara Norfolk General Hospital requires its patients to put small valuables (e.g., watches, money, glasses, etc.) in an envelope, sign a waiver, and keep the envelope on their person for the duration of their stay, Walker explains.

   Large or electronic items, such as laptop computers and personal digital assistants, are locked in a safe located in the security office.

4. Use an inventory and receipt system.
   When patients request the safekeeping of their belongings, have them place the items into a tear-resistant envelope and record the inventory on a form that clearly displays the patient’s name and

How to reach us
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- e-mail: janderson@hcpro.com
- mail: 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945

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date and time that inventory was taken. Also have space for the signatures of two witnesses, preferably hospital staff, advises Fred Roll, MA, CHPA-F, CPP, president of Roll Enterprises, Inc., in Morrison, CO.

“Describe the belongings in objective terms, being careful not to write down simply what a patient may tell you about an item,” he says. For example, a watch may be gold-colored, but not necessarily made of actual gold. “And don’t simply put down ‘watch.’ If it’s a Seiko, write down ‘Seiko.’ ”

If you put money in an envelope, note the bill and coin denominations. These measures ensure accurate inventory control.

Consider using a numbering system to avoid confusion among patients with similar names, Roll adds.

Ideally, the inventory forms should be made in triplicate. That way, the security, admitting, or business office can keep a copy for its records, the patient can take one as a receipt, and the third copy can be placed in the item envelope as backup.

“Items should be inventoried regularly,” says Dettman. “Compare the items listed on the form to what’s actually in the envelope.” Individuals who take the inventories should initial and date the form to document their efforts.

When a patient is discharged, he or she turns in the receipt in exchange for the envelope. If a patient is unable to pick up his or her items, a designated family member or friend may do so instead.

“When patients originally fill out the inventory form, have [them] write down the names of one or two individuals who have their permission to pick up items for them,” suggests Walker.

Hospitals should require all designees to show at least one form of positive identification (e.g., a valid driver’s license)—in addition to the receipt—when retrieving belongings for a patient.

Always make sure the patient or designee opens and empties the envelope before leaving the security office (or wherever items are held), Roll recommends. Have him or her double-check all of the items in the presence of a staff member and sign out. If money is in the envelope, have the person count it out for the staff member.

5. **Don’t forget the emergency department (ED) and outpatients.**

Policies and procedures should make provisions for safeguarding the property of hospital outpatients and ED visitors.

“Patients brought to the ED are often alone and are rarely admitted to the hospital, so we give them special green envelopes to put their belongings in,” says Walker.

These envelopes stay in a secured location at the ED main desk. They also include a form that serves as an inventory record for the ED staff and a receipt for the patient.

The Mayo Clinic and Hospital has a dedicated locker room where outpatients can store their belongings.

“Outpatients have total control and responsibility over their locker keys,” Dettman explains. But he acknowledges that providing lockers would be challenging for hospitals with large outpatient populations. “They would have to apply a modified version of the inventory and receipt system,” he says.

Dettman predicts that, in the future, many hospitals will follow the hospitality industry’s example and provide lockers or safes in patient rooms.

“I’ve heard of new hospitals being designed this way,” he says, “but for now, most of us need to stick to clear policies and procedures.”

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Sample patient valuable policy

Procedure
I. General information

A. All patients will be instructed to send valuables home with family/other.

B. If a patient refuses to send valuables home or deposit them in the hospital safe, he or she will be asked to sign a release form.

C. Valuables envelopes: Envelopes are dispensed from central registration. Envelope numbers will be logged into the book in admitting.

D. Acceptable/unacceptable valuables: Acceptable valuables are considered to be articles such as jewelry, money, credit cards, wallets, and keys. Valuables not accepted are articles such as knives, guns, drugs, dentures, eye glasses, smoking materials, medications, and combs. If any weapons or drugs are brought in, contact security at ________.

E. Unusual/large items: Contact security at ________ for any unusual, large, or electronic item, such as a briefcase, pager, cell phone, laptop, etc.

F. Itemize all receipts as follows: 1 Set of keys, 1 Exxon credit card, 1 driver's license. All cash must be totaled and amount written in designated area. All items of jewelry must be described (i.e., 1 gold-colored watch, 1 ring with clear stone, etc.)

G. Envelope receipts: One receipt is given to the patient and placed in the chart at admitting.

H. Transporting valuables to admitting*
1. Emergency department (ED)—At the end of each shift, the valuables envelopes of admitted patients are to be taken to admitting.

2. Nursing units—From 7:00 a.m. to 9:00 p.m., call ________. Someone from admitting will respond within one hour to collect the envelope(s). From 9:00 p.m. to 7:00 a.m., call security at ________**. A security officer will respond within one hour.

* Valuables will not be accepted if an envelope is not completed.
** Document the time the call was made on the envelope. The responding individual (i.e., security officer) will document the time of the pick up.

Release

Valuables are released to patients upon discharge or as requested. Valuables may be released to a designated representative upon receipt of the signed waiver from the patient and a copy of the individual's identification card.

Follow these steps to release valuables:
1. Withdrawal of part of the listed contents is prohibited. If a patient wishes to retrieve specific items, the remaining items are to be placed in a new envelope.
2. Valuables log book is checked to verify that valuables have been received.
3. The patient or designated representative must present a receipt before valuables are released. If the patient does not have a receipt, obtain a copy from the medical record. If no copy is available, valuables may be released after positive identification is made using the patient identification bracelet or picture ID card.
4. The designated staff member and the security officer will open the safe in the presence of the patient or designated representative.
5. The envelope will be opened by the patient or his or her representative in the presence of the security officer and admitting representative. The contents will be verified, and the individual will sign the envelope.
6. All appropriate information is recorded in the valuables log.
7. The valuables log is signed by the individual accepting the valuables and the admitting representative.
8. The signed receipt is placed in the designated file in Admitting and retained for one year.
9. Any time valuables cannot be located or the patient states that valuables are missing, security is to be notified immediately.

II. Specific information

A. ED
1. All valuables are placed in the valuables envelope only.
2. Receipt is itemized.
3. Envelope is sealed in the presence of the patient.
4. If the patient is unconscious or otherwise unable to sign the receipt, it must be signed by two staff members who witnessed the placement of valuables in the envelope (name—printed and written).
5. The envelope is placed in the designated area of ED registration. At the end of each shift, envelopes of admitted patients are taken to the Admitting office by a registration staff member.
6. Envelopes of patients treated and released are returned to patients at discharge (see “releasing valuables”).

B. Nursing/clinical areas
1. All valuables are placed in the valuables envelope only.
2. Receipt is itemized
3. The envelope is sealed in the presence of the patient.
4. If the patient is unable to sign the receipt for any reason, it must be signed by two staff members who witnessed the placement of valuables in the envelope (name—printed and written).

5. A receipt is given to the patient and the second receipt is placed in the chart.
6. A call is placed to either admitting or security for valuables pick up (see transporting valuables).
7. Valuables may be kept on the nursing unit or in a clinical area for a short time. This would be done if
   • valuables are going to be returned within a few hours
   • a locked drawer or area is available
8. When returning valuables, follow release guidelines found in this procedure.

C. Admitting/central registration
1. Patient present
   A. All valuables are placed in the valuables envelope only.
   B. Receipt is itemized.
   C. Envelope is sealed in front of the patient.
   D. Appropriate information is written in the valuables log.
   E. Valuables are placed in the safe.
   F. One receipt given to patient and the second is attached to the patient’s paperwork.
2. Patient not present
   A. Envelope is stamped and signed.
   B. Log book is completed and signed.
   C. Valuables are placed in the safe.
3. Additional admitting responsibilities
   • Central registration/admitting team coordinator will do a monthly audit of contents of the valuables safe.
   • If it is found that valuables have been left after discharge, every effort will be made to contact the patient by phone/mail. If after three attempts the individual cannot be contacted, the valuables will be taken to the cashier office and placed in the large safe. This is to be documented in the log book.
   • Annually unclaimed valuables are sent to the [State capital building—include address].

Source: Don Walker, Sentara Norfolk (VA) General Hospital. Adapted with permission.
Understanding the new JCAHO survey

This month, HSEM spoke to Susan B. McLaughlin, president of SBM Consulting in Barrington, IL, about preparing for your Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey.

The JCAHO changed its survey scoring in several ways in 2004. The elements of performance (EP) standard requirements outline what the JCAHO expects you to do to comply with a standard, and you will be scored on the EPs, rather than the standard itself. Each EP is scored as being met, partially met, or not met. The EPs are placed into either an A, B, or C category based on their requirements, and each category has its own scoring algorithm, as follows:

1. **Category A** is scored as yes or no
2. **Category B** is scoring that addresses meeting the literal intent of the EPs, but doesn’t evaluate the quality or comprehensiveness of the effort
3. **Category C** scoring addresses frequency

McLaughlin is a former associate director of standards interpretation for the JCAHO and former director of safety and compliance for the American Society of Healthcare Engineers. For questions or comments, contact McLaughlin by phone at 847/420-3229 or by e-mail at sbmconsult@ameritech.net.

**Q: Why did the JCAHO change the survey formula?**
A: The Joint Commission announced about 18 months ago that it was planning a change in the survey process. The reason is to encourage continuous compliance, as opposed to going through a ramp-up process for a triennial survey. The goal is to keep organizations continually compliant and working toward continuous improvement.

**Q: How did the scoring aspect change?**
A: Surveyors evaluate each organization as being compliant or noncompliant based on the scoring of the standards associated with EPs. Noncompliant standards will require follow-up with the JCAHO to demonstrate compliance. In some cases, the accredditor will require data collection for EPs indicating the need for a measure of success in noncompliant standards.

The JCAHO bases its accreditation decision on organizations’ number of noncompliant standards as compared with the average number of noncompliant standards for other organizations in the accreditation program.

**Q: What do security directors and emergency preparedness coordinators need to know about the survey process?**
A: These individuals need to understand that surveyors will use the tracer methodology to evaluate standards compliance. Surveyors will look at the environment of care (EC) and evaluate it differently than in the past. There may be some instances where aspects are evaluated during patient tracer activity. Alternatively, the EC may be assessed separately while surveyors wait for interviews or other information. The surveyors will also conduct an EC interview and will likely do a specific EC tracer based on that interview information.

**Q: What do you think is the most difficult aspect of the tracer methodology?**
A: A lot of people enjoy the tracer methodology because it’s more of a hands-on, practical approach to assessing compliance. Now surveyors look at the process rather than just going through paper. But it’s more unpredictable—you don’t know now where the surveyors will visit and what they will specifically evaluate.

**Q: Is it true that the JCAHO may change certain aspects of the survey process?**
A: The Joint Commission recognizes that the scoring initially published for the 2004 standards, has proven problematic in the field. Therefore, it is changing the categorization of some of the EPs effective July 1, 2004 and also eliminating some of the requirements for measures of success. This is an attempt to clarify the scoring and data collection issues.

Under the security management plan, the JCAHO recategorized five elements (#5, 7, 8, 9, and 10) as category B. It also eliminated the measure of success for the EP relating to identification.

In the emergency management plan, there were no changes in the EP categorization. However, the...
Joint Commission changed the emergency management drills EP relating to their timing to category A. Overall, the changes seem to be an improvement. They will make it easier for the field to understand how to score the EPs and limit the measures of success to those elements that lend themselves to data collection.

The August 2004 Joint Commission Perspectives discusses the changes. They will be published in October in the third quarter update of the Comprehensive Accreditation Manual for Hospitals.

Q: What areas are surveyors focusing on?
A: The emergency management plan is a hot topic. Some things that went into the standard in 2001 were requirements for a hazard vulnerability analysis and community integration. I think surveyors look more closely at this area now, as well as cooperative planning, which was added as a requirement after the September 11 attacks. Hospitals have had a few more years to deal with this and get the planning done. Most organizations are at some point along the learning curve and are making progress.

There were a few minor changes made to the security requirements. A new EP requires hospitals to have an infant and pediatric abduction policy, but most have already had one some time. There is also a footnoted requirement to address workplace violence as part of the security risk assessment process.

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**Understanding JCAHO lingo**

Following are some basic definitions of Joint Commission on Accreditation of Healthcare Organization (JCAHO) terms for you to clip and save:

**Evidence of standards compliance**—A report your facility must send to the JCAHO 90 days after the triennial survey (note that the JCAHO will reduce that window to 45 days after survey in 2005) for any standard scored as “not compliant.” The report must detail the actions taken to comply with the standard since the survey. Organizations can also explain why they believe they complied with a standard scored as not compliant. The report must explain how the organization met the elements of performance (EP) and must include a measure of success for each element involved.

**Measures of success**—A component of both the evidence of standards compliance and the periodic performance review processes. The JCAHO defines a measure of success specifically as “a numerical or quantifiable measure, usually related to an audit, that determines if an action was effective and sustained.” You can use a percentage to express your measure of success and level of compliance. When a surveyor determines that your facility doesn’t meet a standard, you must develop a measure of success for each EP scored as partial or insufficient compliance. You must provide the measure of success four months after the accreditor approves your evidence of standards compliance.

**Periodic performance review**—Formerly called the self-assessment, organizations assess their own compliance with JCAHO standards via an electronic tool on the JCAHO’s secure extranet site. The facilities use these reviews to determine in which compliance areas they fall short to develop corrective action plans.

**Tracer methodology**—The evaluation method in which surveyors select several patients—typically those who received multiple or complex services—and use their records as a road map to gauge an organization’s compliance with care and service standards. Surveyors retrace the specific care processes the patient experienced by observation and talking to staff to examine the care each department provides and how departments work together. The JCAHO says on average surveyors will trace 11 patients per survey.

*Editor’s note: This glossary was adapted from Briefings on JCAHO, published by HCPro, Inc.*

Stay tuned for future issues of HSEM that will discuss JCAHO scoring changes.
**Hospital security officer kills attacker**

A security officer at a North Carolina hospital shot and killed the father of a teenage girl in labor on July 8, the Associated Press reported.

The father, Billy Ray Oxendine, 37, allegedly threatened to kill the officer with a knife in the labor and delivery unit at Southeastern Regional Medical Center in Lumberton, NC.

Lumberton Police Chief Robert Grice said the shooting occurred late in the evening after security guard Johnny Thompson broke up a fight between the girl's father and boyfriend. Thompson then shot Oxendine with his .357 magnum, Grice said. At press time, Thompson had not been charged with a crime. The incident is under investigation.

**Cocaine stolen from Florida hospital**

Lakeland (FL) Regional Medical Center officials are investigating the theft of cocaine from a pharmaceutical supply in July, the Ledger reports.

Hospital spokesperson Cindy Sternlicht could not disclose the amount of stolen cocaine or any details about the investigation.

The discovery coincides closely with an audit at the facility by the Joint Commission on Accreditation of Healthcare Organizations, the Ledger reports.

Hospital employees with access to the drug supply underwent a drug test, but no one tested positive for cocaine, Sternlicht said.

**Woman murdered at TN hospital**

A female patient at St. Francis Hospital in Memphis died after being stabbed in the head in July, the Associated Press reported.

Police are investigating the death of Shunta Howard, 24. Howard's boyfriend was in her room when she died, according to police reports. No charges have been filed pending an autopsy report.

Hospital security officers are stationed both inside and outside the hospital, but anyone can visit a patient unless there's been a specific request otherwise, says St. Francis spokesperson Marilyn Robinson.