Hospital administrators often bristle at the idea of charging patients and visitors to park at their facility—it just doesn’t seem like a customer-friendly thing to do. This view is particularly prevalent in suburban and rural areas where parking lots and garages are typically free. But industry insiders explain that charging for parking not only generates revenue for the hospital, but also helps the security department do its job better.

Whether the security department operates the parking facility itself or the task is outsourced to a parking management company, paid parking provides an extra layer of security and serves as a concierge service for patients and visitors.

Industry insiders encourage security departments to champion paid parking for the following four reasons:

1. It allows the hospital to control parking space availability.

A manned parking facility enables the security department to make sure only legitimate patients and visitors use the allotted parking spaces. "When you have people..."
Evacuations

anticipated the hurricane and brought in enough staff to work, Fisher says. Prior to the hurricane, hospital officials viewed the worst case scenario as not having enough staff to work all shifts, she says. No one really thought about making a community agreement to create an alternative staging area in case the building became uninhabitable.

Before the hurricane, the hospital had contacted sister facilities to inquire about bed status, “but we didn’t expect anything like this to happen,” Fisher says. When a total evacuation became inevitable, hospital staff called those nearby hospitals again for help. Two hospitals volunteered to take patients from the 60-bed facility—but getting the patients to those hospitals wasn’t an easy task.

Since many roads were closed and EMS was grounded, the National Guard arrived with Humvees to transport patients, cutting through downed trees along the way.

For 10 hours, the hospital was in evacuation mode. “We got the last patient out of the area at 11 p.m.,” Fisher says. “We had water damage in 85% of the building.”

Working the details out

Work to repair the roof began right away, and within 24 hours, the hospital emergency department was functioning again. Fisher says the hurricane changed the hospital’s evacuation planning. Over the next few years, the hospital fine-tuned its mutual aid agreements and selected a relocation site.

A year later, the hospital found itself evacuating again for Hurricane Floyd. But luckily, this time it was prepared.

Many hospital emergency coordinators aren’t prepared to evacuate their entire facility at once because they assume they’ll never need to.

Don’t make the same assumption, even if you live in an area where hurricanes or other natural disasters aren’t prominent. “Hospitals typically spend little time on evacuation. Part of this is because they think an evacuation won’t happen to them or because they don’t have resources to make it happen,” says Zachary Goldfarb, BS, CEM, EMT-P, CHSP, president of Incident Management Solutions, Inc., in New York City.

Consider the following three evacuation scenarios:

• A **planned evacuation** occurs when hospitals have 48 hours or more to move patients and ancillary services. This type of evacuation allows ample time to make notifications and mobilize resources. Moving patients because of building renovation or construction is an example of a planned evacuation.

• An **urgent evacuation** occurs when the hospital environment becomes unsafe, leaving only a few hours to evacuate the entire facility. Examples of an urgent evacuation include physical damage to the facility, such as a power outage or severe roof leak, that isn’t correctable in a short time frame.

• An **emergent evacuation** requires immediate evacuation—any delays might be life-threatening. This type of evacuation could occur because of an uncontrollable fire or explosion.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to provide processes for evacuation, as well as a plan for alternative relocation, patient tracking, patient and staff transportation, supplies, and communication. See JCAHO standard EC.4.10 for more information.

Although most hospitals fulfill the JCAHO requirement, Goldfarb says they often skimp in the details of their planning. “To do this right, you need to have a designated relocation site, a formal agreement authorizing the alternative site use, a plan on how to conduct an evacuation, and stockpiled resources to make it happen,” Goldfarb says. “These are important elements that hospitals [often] don’t [include in their planning].”
Four tips for evacuation planning

If you think it’s impossible to plan for a hospital evacuation, think again. Don’t underestimate the value of working out the details ahead of time.

For Angela Fisher, director of quality and risk management at Brunswick Hospital in Supply, NC, focusing on evacuation details didn’t come until 1998, after Hurricane Bonnie tore a portion of the roof off the building and required a total evacuation (see the story on p.1). “We do things a lot differently now than we did [before that hurricane],” she says.

Proper planning ensures the smoothest evacuation process. Here are four tips to consider the next time you review your evacuation plan:

1. Determine your evacuation weak spots.
   Explore your step-by-step responses to the three different evacuation scenarios listed on p. 2. Choose a leader to facilitate this conversation.

   Don’t overlook specifics. This exercise isn’t meant to only address how you will evacuate the building. Instead, answer questions such as: How will we get patients downstairs? Who can do this? How many people and how much time will it take? What stairway will we use? Who will make these decisions?

   This planning doesn’t require resources, it’s more of a mental exercise, says Zachary Goldfarb, BS, CEM, EMT-P, CHSP, president of Incident Management Solutions, Inc., in New York City. “The point is to figure out what you don’t know.”

   Assessing processes can be intimidating and difficult to face, but it’s an important aspect to planning, Goldfarb says.

2. Organize resources ahead of time.
   The last thing any hospital wants is to be up against the wall trying to find what it needs at the last minute. Since a number of incidents could require a total evacuation, prepare ahead of time. Ask yourself what resources you will need. When will you need to get help?

   Know which hospitals in the area can take additional patients and create mutual agreements with them. Also speak with vendors and suppliers and keep supplies stockpiled for specific types of emergencies.

   Goldfarb recommends hospitals review the number of ambulatory patients they have v. patients who need a hospital or ambulance stretcher to be moved. Knowing these numbers allows you to develop a transportation plan ahead of time.

3. Consult with your community officials now to find out how they can help.
   It didn’t take Fisher long to figure out that a community relationship would have made a difference during her facility evacuation.

   “Before [the hurricane], we never talked about how the community could help [during an emergency]. Everyone was doing their own thing,” she says. “The evacuation would be well-coordinated now because we’ve talked about the different roles the community has,” she adds.

   Most hospitals created mutual plans with their communities after the September 11, 2001, attacks. Remember that these relationships are important during an evacuation. “Community relationships meant more to us long before September 11 because we recognized how critical they are [after the hurricane],” she says.

4. Do your homework when choosing a relocation site.
   When looking for a place to relocate patients, evaluate whether it fits your medical needs. If you plan to evacuate to the hospital parking lot, consider how realistic this location is. “It’s nice to say, ‘We have an evacuation plan, and we can get out of the building,’ but in any situation, how long can you keep people in a parking lot?” Goldfarb asks.

   Protect patients relocated to the parking lot with a festival tent, a drop-down tarp or perhaps a decontamination tent to create an ad hoc shelter. But remember that parking lots are typically interim staging points in emergency evacuations and not ideal relocation sites.

   Following Fisher’s hurricane evacuation experience, the hospital selected a nearby school to use as a relocation facility. “We toured area schools and measured doors to see whether a hospital bed could get through,” Fisher says, adding that the hospital equipped the school with a generator and supplies as well.

Editor’s note: Stay tuned for the next HSEM to learn about performing evacuations, choosing relocation sites, and other important roles involved in evacuation.

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Parking

who work the facility’s point of entry, they can make sure employees and other nonpatients, such as delivery people, don’t take up patient and visitor spaces . . . or that nondisabled motorists don’t take up designated handicap spaces,” explains William Platts, MS, CPP, CHPA, director of safety and security at Providence Hospital and Medical Centers in Southfield, MI.

Readily available parking enhances patient and visitor satisfaction, making it something worth overseeing and controlling.

“One once a neighborhood resident claimed to be a hospital employee and tried to get an employee parking discount rather than pay for a resident parking permit,” remembers Ronald Cundiff, MS, CPP, CHPA, director of safety, security, and telecommunications at Lake Forest (IL) Hospital. “We asked her for employee identification (ID), and of course she didn’t have any. If someone hadn’t been manning the lot, she might have gotten away with it. As it turned out, she used the ruse successfully with a new cashier for several days,” he says. This incident happened while Cundiff worked as a security and safety director at Weiss Memorial Hospital in Chicago.

Cundiff recommends using different colored stickers, decals, or hang tags to easily differentiate between patients, visitors, and employees’ vehicles. “And always ask for ID,” he adds.

Regardless of whether the security department or an outside company runs your hospital’s parking facility, put policies and procedures in place to guard against parking revenue theft and fraud.

“You don’t want the same individual or group collecting, counting, and depositing the cash made from your parking lot,” says William Platts, MS, CPP, CHPA, director of safety and security at Providence Hospital and Medical Centers in Southfield, MI. “There need to be checks and balances.”

Draw up a contract

If you hire an outside parking company to manage your parking facility, hospital administration and security should work together to draw up a contract that spells out your expectations and criteria, the company’s responsibilities, projected parking income, and so on, explains Ronald Cundiff, MS, CPP, CHPA, director of safety, security, and telecommunications at Lake Forest (IL) Hospital.

“When you set up expectations and project income, talk to other similar-sized hospitals in your area and compare notes,” he suggests. “This will give you a good idea of what to look for and what’s realistic.”

Conduct regular audits

Periodically audit the outsource company (e.g., quarterly) to make sure it’s living up to the contract and reporting the correct amount of revenue.

“At our facility, the cashier counts the money daily, as does [his or her] supervisor . . . then we periodically audit the [parking facility’s] bank records in addition to auditing the parking company itself,” Platts says.

Auditing should take place even if your hospital’s own security department mans the parking facility. “The security department, as well as an outside group, should audit the operation,” recommends James Miller, president of Miller Parking Company in Detroit. An outside group could be members of another hospital department (e.g., finance or administration) or an external auditing firm.

“Don’t be lulled into a false sense of security just because your own people are running the lot,” he adds.
2. It adds an extra layer of security at the hospital’s entry points.

Parking facility cashiers and valets play an important role in hospital security, according to James Miller, president of Miller Parking Company in Detroit.

“They see just about everyone who drives in and out of the hospital,” he says. “So they act as extra sets of eyes and ears for the security department.” If they see something suspicious or out of the ordinary, they can immediately report it to security.

Parking facilities can also incorporate hospitals’ security equipment at their points of entry. For example, the cashier booths in Providence Hospital’s parking lot are equipped with cameras that record all vehicles as they enter and exit, explains Platts.

“These cameras record important information, such as license plate numbers, that could prove crucial if we ever need to track down someone,” he says.

Capturing each vehicle on tape also comes in handy when patients or visitors claim their cars were damaged while in the lot. “We can check to see whether that dent or scrape was already there when they entered,” he says.

3. It involves security in customer service issues.

With hospitals striving to achieve high marks for patient satisfaction, it’s important for all departments to pitch in and provide good customer service wherever possible. Manned parking lots and garages give security personnel the opportunity to make a good first impression on visitors.

“Parking attendants are usually the first people at the hospital whom guests come into contact with,” says Cundiff. “Friendly and helpful staff make that first encounter a positive one.”

Platts points out that parking attendants and valets often field questions about directions, wheelchair services, and other basic information. Knowledgeable and courteous parking staff play a huge role in making sure patients and visitors are comfortable and get to the right place.

“Over time, our parking staff forms relationships with frequent visitors,” Platts says. “These relationships are important for customer satisfaction. And they add a personal touch to someone’s experience.” They also give the security department greater visibility in the public relations arena.

4. It generates revenue.

No one can ignore the fact that paid parking facilities are revenue sources. And these revenues can go toward services that directly benefit the security department.

“Rarely are parking revenues used exclusively to fund the security department, but they’re often figured into the hospital’s maintenance budget, which includes the upkeep of parking facilities,” notes Evelyn Meserve, CHPA, CECM, former director of security, safety, and parking at Newton-Wellesley (MA) Hospital.

At Children’s Memorial Hospital, parking revenues helped fund a shuttle service—an extension of regular parking services—that runs back and forth from the hospital to offsite parking, a Ronald McDonald House, and commuter train stations, says Cundiff who used to work at Children’s before Lake Forest Hospital.

“This service is extremely popular with employees, and it affords us an even greater measure of control over available parking spaces and who enters the hospital,” Cundiff says.

Parking revenues at Providence Hospital pay for a concierge service set up in its valet office. “The concierge directs visitors, provides wheelchairs, and so on, which is a big help to the security department,” Platts explains.

Make a case for paid parking

Use these reasons to lobby for paid parking at your hospital.

Although paid parking isn’t for every facility, its security benefits are worth considering.

Note: Even if an outside company manages and mans a hospital’s parking facility, the security department customarily oversees that company’s operations, according to Meserve. So paid parking is a security issue even if security personnel don’t staff it directly.
The Hospital Association of Southern California (HASC) recognized that standardized emergency codes could make a difference in hospitals after a September 1999 shooting at West Anaheim (CA) Medical Center left three workers dead. A man became upset over his mother's death and blamed the hospital staff for her deterioration. She received hip replacement surgery at the facility months earlier. Hours after her death, he reappeared at the hospital with a gun and shot a nurse, a pharmacist, and a maintenance director.

“Since everyone knew this person, no one thought this could happen,” says Aviva Truesdell, senior vice president of AllHealth Security, the hospital association’s security subsidiary and staff executive of the HASC safety committee.

When staff members saw the gun, they instinctively called the emergency code for a violent patient, Truesdell says. “When you call a code for a violent person, there’s a team that usually responds to subdue the person. There’s a different response code for someone with a weapon,” she says.

That response involves evacuating people from the area. At the time, the medical center didn’t have a specific emergency code for a person with a weapon. The shooter, a 47-year-old Vietnamese refugee, later admitted he shot the staff workers, although they weren’t responsible for the care of his mother. In 2003, the shooter was convicted of first-degree murder and received the death sentence.

Following the incident, Truesdell and other HASC members wondered whether standardized codes could have prevented this tragedy.

**Code invention**

After the shooting, HASC decided standardized emergency codes throughout the region could benefit employees the most. “Many people work in different hospitals, like nurses who travel from one hospital to another,” Truesdell says.

“Everyone has to go through new employee orientation, but it gets confusing if one hospital uses a specific code and another hospital uses a different code.”

While visiting a hospital, Truesdell experienced code confusion firsthand. “The hospital called a code orange, which California hospitals typically use for a hazmat spill,” she says, noting it was actually the hospital’s infant abduction code.

To prevent emergency code confusion and possibly reduce tragedies, HASC focused on standardizing emergency codes in southern California hospitals, using its safety and security committee.

**Common code**

HASC sent a survey to all 442 hospitals in California requesting a list of codes, their purpose, and code names. Three healthcare doctoral candidates from a nearby university compiled the survey responses from more than 200 hospitals.

Despite the large response, only a few common codes among hospitals existed, making it difficult to find common ground. “There really wasn’t a majority of common codes,” Truesdell says. “Hospitals were just all over the map.”

The survey revealed that over 90% of hospitals used “code red” to indicate a fire and “code blue” to indicate a medical emergency. However, there were 47 different codes to indicate an infant abduction and 61 different codes for a combative person. HASC also discovered that few hospitals had a code for someone carrying a weapon. “Not only did hospitals have to add this code, but it required training for proper response,” Truesdell says.

Ultimately, HASC decided to use the most common colors and established 11 emergency codes for the most common or significant security events.

**Disseminating the information**

Once HASC determined the 11 emergency codes, the tough job of establishing a response protocol lay ahead. The entire process took almost a year.

HASC created general policies and procedures that hospitals could adapt for each code and compiled the information in a book, which included references to Joint Commission on Accreditation of...
Healthcare Organizations’ (JCAHO) standards, as well as relevant state or national policies. HASC published and sent a hard copy of the book and a customizable CD-ROM to every hospital in California.

**Hospitals embrace codes**

HASC waited to see whether area hospitals would respond to the recommended changes. Since HASC is the hospital industry’s association, and not a rule-making body, nothing required hospitals to change their codes.

Initially, not all hospitals jumped on the standardized emergency code recommendation. Many hospitals waited until the JCAHO surveyed their facilities before adopting code changes, Truesdell says.

For two years following the code release, HASC followed up with hospitals that still didn’t convert. “We continuously did surveys to find out whether the change had an impact,” Truesdell says. HASC’s final survey on code adoption in 2002 showed that 89% of 86 responding hospitals had adopted the majority of the changes. “We had a phenomenal response,” Truesdell says, noting this was the highest rate of voluntary adoption of any of HASC’s security projects.

As a result of Southern California’s success, hospitals and their associations across the United States have followed HASC’s model for standardized emergency codes. Truesdell still receives phone calls from other hospitals and associations in the country about the standardized system. HASC even posted its book and CD online at [www.hasc.org/PDFs/Code_Book/CodeBook.pdf](http://www.hasc.org/PDFs/Code_Book/CodeBook.pdf) for other facilities to use.

Hospitals typically call a “code pink” to indicate an infant abduction on the premises. However, the popularity of law enforcement’s AMBER Alert has some hospitals switching to “code amber.” An AMBER Alert is a law enforcement warning that notifies the public a child has been abducted or is in serious danger, and that descriptive information about the child and abductor is available.

As tempting as the name change may be, Cathy Nahirny warns security directors and hospitals to give this some careful consideration.

“My issue and concern is that every citizen understands what the AMBER Alert means, and you don’t want to raise the stress level in a healthcare setting,” says Nahirny, supervisor of the case analysis and support division for the National Center for Missing and Exploited Children in Alexandria, VA.

Although law enforcement and state officials may persuade hospitals to adopt similar codes, Nahirny urges hospitals to keep separate codes. Having the same or similar code as law enforcement defeats the purpose of an emergency code, she says.

“The last time I checked the dictionary, a code was like a secret password and not everyone should know what it means. If you use code amber instead of code pink, there’s the potential to raise the alarm level in all the new moms and visitors who have children at the hospital. We don’t need that. We want to keep these separate. Amber is for law enforcement.”

In the past six months, New Jersey hospitals have foregone the traditional code pink for the state’s standardized infant abduction code amber. State officials encouraged hospitals to make the switch earlier this year, says Ron Czajkowski, spokesperson for the New Jersey Hospital Association (NJHA).

NJHA drafted its original standardized codes to include code pink for an infant abduction, but state officials preferred a code in tandem with local law enforcement, Czajkowski says. “We changed this to amber with no concerns about fear or panic,” Czajkowski says. “We’ve had 90% compliance so far, so it hasn’t been a problem.”

The National Center for Missing and Exploited Children encourages a national standard of “code pink” to represent an infant abduction in healthcare facilities. But Nahirny admits that hospitals ultimately make the final decision in naming their emergency codes.
What the JCAHO's latest scoring revisions mean to you

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has changed how it scores elements of performance under various standards in the Comprehensive Accreditation Manual for Hospitals. These revisions apply to category A, B, and C elements, which are categories the JCAHO uses to break down scoring methods.

Here’s what the changes mean to you, as explained by Steve Bryant, practice director of accreditation services at The Greeley Company, and Steven MacArthur, safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. HCPro publishes this newsletter.

**Category A elements of performance**

The scoring changes only relate to category A elements that have multiple bulleted items. Category A elements are usually yes or no questions—you either have a policy or plan, or you don’t. If you have it, you receive a score of 2. If you don’t, you get a 0.

But you also need a track record, Bryant says. You may have a policy, but if it has been in place for only six to 11 months, you’ll receive a score of 1. You will receive a score of 0 if your policy has been in place less than six months.

With the recent changes, the JCAHO now says that if there are multiple bullets under a category A element, an organization must have all components to comply. Here’s how the JCAHO will now score elements with multiple bulleted items:

- **2 =** if you comply with all the bulleted items
- **0 =** if you don’t comply with all of the bulleted items

This type of scoring applies to a few EC standards, such as EC.4.10 (emergency management plans). EC.4.10’s element of performance #2 has three bulleted items, which include requirements about establishing priorities with the community about potential emergencies, what the facility’s role is in a communitywide emergency plan, and how the hospital and community interact in an incident command system.

So you will receive a score of 2 if your emergency management plan covers all three aspects, or a score of 0 if your plan only addresses one or none of them, Bryant says.

**Category B elements of performance**

The changes to category B elements are similar to category A’s, except surveyors will evaluate compliance in two ways. The scoring for multiple bulleted items is the same as category A. However, surveyors will also consider whether you demonstrate principles of good process design if your method of compliance isn’t obvious.

For example, under EC.2.10, element of performance #8 requires hospitals to identify and implement security procedures for handling an infant or pediatric abduction as applicable.

Although this may be an either/or situation, there are two security risks you need to handle: one for infant abductions and one for pediatric abductions. If a surveyor determines that your organization hasn’t planned for both risks (if both risks are present in your organization), you would probably receive a score of “1” for the element of performance, MacArthur says. Although, some surveyors could flunk you for the total, he adds.

Conduct a comprehensive risk assessment that considers each event to develop risk strategies, he says.

Remember, with category B elements, there is flexibility in how you accomplish the standards’ goals. But if surveyors are unfamiliar with your process or perceive it to be atypical, they may want to ensure that when you designed the training, you considered the hospital’s mission, patients’ needs, currently accepted practices, current safety
information, and relevant performance improvement results.

Surveyors will also use the second part of this evaluation if they have concerns about the quality of your training development.

**Category C elements of performance**

The revisions to category C’s scoring are more complicated. The first change is that when surveyors notice instances of noncompliance with a category C element, they must find those instances from different sources.

This type of scoring applies to EC.2.10 (managing security risks). For example, element of performance #6 requires hospitals to control access to and egress from security-sensitive areas, as determined by the hospital.

If your pharmacy has two unsecured entries, it represents a single instance of noncompliance, says MacArthur. The other instances must come from a different security-sensitive area, he adds. The surveyor shouldn’t solely count one bad finding against you.

This same rationale applies to element of performance #5 (the hospital identifies, as appropriate, patients, staff, and other people entering the hospital’s facilities).

If one individual lacks his or her identification badge, this doesn’t denote a 0 score. The surveyor needs to find a few staff without their badges, MacArthur says.

The scoring changes are slightly different than the ones for category A and B. When surveyors evaluate category C, they generally assume a sample size of 10. Chances are, however, they will look at more than 10 records.

But using the sample size of 10, they will issue the following scores when dealing with Category C elements that have multiple bullets:

- **2** = if you meet all bulleted items or if you are missing one item
- **1** = if you miss two of the bulleted items
- **0** = if you miss three or more of the bulleted items

**The overall significance**

These changes are specific only for the scoring of elements of performance with multiple components. Be aware of them so surveyors don’t inadvertently overscore you during a survey, Bryant says.

Bryant recommends not getting hung up on the loopholes or the greater flexibility in scoring when you do your own evaluations.

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Q&A: Focus on hospital emergency management

This month, HSEM spoke with Peter Ginaitt, director of emergency preparedness at Rhode Island Hospital in Providence, about the importance of hiring an emergency preparedness coordinator and how to seek emergency management funding.

Although Ginaitt has worked as a hospital emergency preparedness director for only a year and a half, he helped secure $2 million in related grants from the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). He also helped obtain $1 million in homeland security grants from state first responders.

Rhode Island—to Ginaitt's knowledge—is the only state to treat hospitals as first responders. Ginaitt also works as a firefighter, emergency medical technician, registered nurse, and a Rhode Island state legislator.

Q: How can hospitals do a better job of emergency management?

A: Hospitals need to develop an emergency preparedness staff position. Many times, hospitals put this position on the safety coordinator's back. It doesn't have to be the safety officer, who has ongoing requirements to maintain the facility.

Create a separate position for someone to work with the different players in your community, such as your state emergency management agency, bioterrorism representatives in your state department of health, and emergency management services. This person can become involved and make a mark in the community.

You need someone who has the freedom to go out and develop relationships with the state government and other hospitals. Don't assume everyone knows what hospitals' needs are because only the hospitals can relay that message. Your argument needs to be as strong as possible to be effective. Also use your local hospital association, but don't rely solely on it. Hospital associations are an excellent resource, but they represent their members as a whole and not necessarily issues that only pertain to your hospital.

Q: Do you think state government overlooks hospital emergency preparedness?

A: Hospitals in all states are vulnerable institutions to potential terrorist attacks. Since we deal with patient care, hospitals are an alluring target. We're the largest and only level 1 trauma hospital in Rhode Island. If you take out our hospital, you've eliminated an important health resource to the region. Hospitals need to prepare for attacks on their facilities and communities. In most terrorist attacks, the goal is to erode the economy or take as many lives as possible to instill fright in the nation. So hospitals must work closely with their states to prepare a response.

Even if a hospital has a lot of resources, it needs someone to communicate its needs to the people who control the funding in the state. Hospitals must [now] think of emergency preparedness as a state of healthcare.

Q: What is your experience with emergency preparedness funding in Rhode Island?

A: After the September 11, 2001, attacks, more hospitals bolstered preparedness through their own capital funds and purchased personal protective equipment and decontamination tents.

A year later, federal money became available, such as the CDC and HRSA grants for disaster and bioterrorism planning. Those organizations were the only funding source for Rhode Island. The state, which hasn't been a major partner in funding, has allocated little to no money for hospital emergency preparedness.

Q: How did you secure $1 million in first responder funds?

A: Rhode Island hospitals fought hard to be...
considered first responders. We explained to other first responders that the crisis continues when hundreds of victims are delivered to the emergency room.

We experienced this firsthand during The Station nightclub fire in West Warwick, RI, in 2003. (Note: On February 20, 2003, the rock band Great White performed at The Station nightclub and lit pyrotechnics during its performance, which ignited soundproofing foam behind the stage. The fire quickly engulfed the nightclub and mass confusion erupted as hundreds of people tried to escape. About 100 people died in the fire and nearly 200 more were injured. The fire is reportedly the fourth deadliest in U.S. history.)

Within an hour and a half, 180 people were triaged at the scene and the majority transported to two area hospitals, including ours. After that fire and a vulnerability assessment, first responders agreed that hospitals needed a portion of the Department of Homeland Security’s $21 million grant.

Rhode Island’s fire chief also acknowledged that hospitals needed help, which is primarily how hospitals received a piece of first responder funding. The state emergency management agency split $1 million of that grant among 14 hospitals, including ours. Since first responder funding was limited, we appreciated the agency’s commitment. We are using the funds for physical security enhancements and improving bioterrorism response. One million dollars doesn’t sound like a lot for Los Angeles or New York City, but in Rhode Island, it can boost our ability to respond to an event that requires decontamination.

Q: Is it more challenging for Rhode Island to obtain emergency preparedness funding since it’s a small state?

A: We complete the same grant process like all states. The federal government likes Rhode Island because it’s easy to examine. We have a single health system and a population of only 1 million, so you can easily see the effectiveness of a program.

After the nightclub fire, we proved that first responders work well with the hospital system and could facilitate healthcare to injured people. I’d hate to say The Station nightclub fire changed the way the state gives grants, but we experienced a catastrophic event. A lot of hospitals don’t experience the “what if.” We felt the pain and know the impact that an emergency has on communication and hospitals. We learned the hard way.

The legislature toughened fire safety laws, but other states haven’t followed suit. Massachusetts changed its laws in August 2004, but no other state has. If this tragedy can happen in Warwick, RI, in the middle of night, it can happen in any small community.

Q: What actions do you recommend hospitals take to be prepared during an emergency?

A: Get to know your hospital associations and hire your own emergency preparedness coordinators. Deal directly with state emergency management agencies and get involved in state meetings on a regular basis. I spend as much time in the hospital as I do out of the hospital dealing with mass casualty protocols and other disaster-related issues. You don’t want to leave the planning to others. You want to be involved, and hospitals can’t assume someone else will do it. Once hospitals have a voice in government, the state will begin to listen.

How to reach us

We want to know what you think of our newsletter. If you have any feedback or suggestions for what you’d like to see in future issues of HSEM, please contact Associate Editor Jill Anderson by

• phone: 781/639-1872, Ext. 3807
• e-mail: janderson@hcpro.com
• mail: 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945
**News briefs**

**Gun-holding doctor suspended**

Salem (MA) Hospital and the state medical board are investigating a doctor who allegedly left a loaded handgun in an employee bathroom, The *Boston Globe* reported. The doctor agreed to not practice medicine for the next two weeks during the investigation.

Richard L. Pegar, MD, worked the overnight shift at the hospital. In a rush to answer a page, Pegar reportedly left the gun in an employee bathroom on August 30.

Another staffer discovered the gun and contacted hospital security, which called the police.

Pegar carries a valid license for the firearm, so police allowed him to keep the weapon, but the hospital suspended him for two weeks.

Pegar’s attorney said he carried the gun for security because he worked late hours at the hospital emergency room and left his car in the parking lot. Pegar said he was not aware of the hospital’s policy to leave guns at home, the attorney said.

**Man kills wife and self at AL hospital**

Security concerns at Thomas Hospital in Fairhope, AL, arose August 18 after an 80-year-old man shot his wife and took his own life, the *Mobile Register* reported.

Police said Robert S. Duck Jr., killed his wife, Maurine because he couldn’t stand to see her in pain.

She underwent two hip surgeries and suffered complications.

No one in the hospital heard the shots. A nurse discovered both victims during a routine bed check.

The hospital has several security officers on duty during the day and night, as well as 10 security cameras.

However, there are no metal detectors. A hospital spokesperson said additional security measures wouldn’t have stopped the killing.
1. (T) (F) Total hospital evacuations can happen at any facility.

2. (T) (F) It's impossible to practice hospital evacuations.

3. (T) (F) A hospital's relocation site should be as close as possible to the building.

4. (T) (F) Hospital parking can increase security's presence.

5. (T) (F) Hospital parking facilities can bring more funding to the department.

6. (T) (F) Outside parking companies should be under contract to prevent theft and fraud.

7. (T) (F) Hospitals must change their infant abduction emergency code to code amber.

8. (T) (F) Standardized emergency codes make it easier for hospital staff to work in multiple facilities.

9. (T) (F) The Joint Commission on Accreditation of Healthcare Organization's (JCAHO) scoring under category A requires hospitals to comply to all multiple, bulleted items in order to receive a score of “2.”

10. (T) (F) An emergency preparedness coordinator should focus on building relationships with state officials.
1. True.

2. False. Hospital staff can practice evacuations by holding facilitated discussions that evaluate step-by-step responses.

3. False. Relocation sites need to be selected based on hospital risk assessment and medical needs.

4. True.

5. True.

6. True.

7. False. Hospitals are not required to create a code amber and can individually decide their emergency code names.

8. True.


10. True.