Many hospitals still struggle with decontamination drills, reveals HSEM’s annual reader survey. Four years after the September 11 attacks, 90% of survey respondents said they were either “very concerned” or “concerned” about how to perform decontamination.

Decontamination is an unknown practice for many hospitals, says Greg Brison, safety and security director at Inova Alexandria (VA) Hospital. The biggest mystery is how to get started on decontamination drills. “It’s not enough to purchase personal protective equipment—you have to have an effective process [for using it],” he says.

**Get your plans, procedures, and equipment together**

Before hospital staff attempt a decontamination drill, your emergency preparedness coordinator should work with other hospital department directors (e.g., emergency department managers, head nurses, infection control personnel, hospital security officials) to create a decontamination procedure, says Joe Cocciardi, CIH, CSP, REHS, RS, PhD, a safety and emergency planning consultant for Cocciardi and Associates, Inc., in Mechanicsburg, PA.

Although it’s important to understand how to respond to all types of incidents that may require decontamination, rely on your hazard vulnerability assessment to determine which ones are most likely to occur in your area. For example, your hospital may be more likely to face a radiological spill than a chemical exposure incident.

Work with department directors to craft a written response. You may even seek input from your hospital officials determine the appropriate use of force for its security department, they will likely want a policy covering the issue. Although most security directors agree that the use-of-force policy is difficult to write—in part because of the liability involved with use of force—the following four tips should make it easier:

1. **Look at other hospitals’ use-of-force policies.** If you can track down a hospital in your state with a similar use-of-force protocol, contact its security department to see whether you can view its policy.

The other hospital may have done the homework that determines what is permissible under state law, says Anthony Potter, CHE, CHPA-F, director of public safety for Forsyth Medical Center in Winston-Salem, NC.

“It’s always a good idea to see what other hospitals in your jurisdiction have done. It saves you from reinventing the wheel,” he says.

Potter shares his facility’s use-of-force policy on p. 4, but forewarns that security directors can’t simply take this sample and plug in their own information. Because laws regarding use of force vary by state, use Potter’s...
Decontamination drills

outside experts such as local fire department officials.

However, don’t expect fire or emergency medical services to help during an emergency—that’s one mistake hospitals often make, Cocciardi warns. In many plans, hospitals rely on the fire department or state health department to provide decontamination or supplies, but in a real emergency, these people often are not available, Cocciardi says. “Hospitals need to be self-supporting,” he says.

Victims will likely arrive before the hospital receives notice of an incident, Brison points out. Minutes count in getting outside to properly and effectively clean patients before they enter the hospital and risk contaminating others, he says.

Your plan should reflect the hospital’s decontamination risks and include the following:

- Response procedures
- Decontamination team members for every shift
- Necessary equipment
- Communication techniques among hospital staff members

The plan should determine where to set up decontamination tents, what equipment to purchase, how to move victims through the system, and other necessary procedures.

Remember, if you discover later on that something in the plan doesn’t work, you can always change it. “If you do a good job planning, then the next part becomes easy,” says Cocciardi.

Purchase the equipment you need

Once you purchase the necessary equipment, staff can begin training. Purchases typically include personal protective equipment, respirators, decontamination tents, patients’ kits, and a container to keep patients’ belongings.

Don’t worry if you don’t have all the funding to immediately purchase equipment. If you don’t have the funding to buy equipment from manufacturers, check out your local stores because they may provide similar items at lower prices, Brison says. Also consider building your own patient kits. At Inova, Brison modified the patient kits by purchasing Dawn detergent and soft sponges at a nearby store.

“Packaged [kits] look good, but they don’t work well,” Brison says. Manufacturers don’t put a lot of thought into patient kits, he warns. For example, manufacturers usually include the warm (contaminated zone) and cold (clean zone) kits into one package. This is not a practical or safe way to assemble your kits, Brison says.

Another simple idea is to use plastic shopping carts, like those used in supermarkets, to clean infants and small children. These carts allow staff to clean children without the risk of dropping them, he says.

Another example of making equipment from scratch includes buying PVC piping to divert hospital water into a makeshift decontamination tent. This is ideal for tapping into the warm water supply for use during the winter months.

Have your equipment ready to go outside, unpacked from containers, and on wheels so you can roll out emergency supplies. “Everything needs to be ready to go on a moment’s notice,” Brison says.

Start with small, focused drills

When you start decontamination drills, watch out for one of the biggest mistakes hospitals make—doing more than they can at one time. “If you jump out there and drill with 50 patients for your first drill, you will probably fail. This will cause you to lose control of the drill and, most importantly, to lose the confidence of your staff,” Brison says.

Consider a full-fledged drill involving the entire hospital and community as the final step in your decontamination drills—it’s the goal you want to work toward.

To get started, test specific aspects of your decontamination plan, such as wearing personal protective

“You don’t need to perform all the procedures, such as flowing water through a decontamination system, to have an effective exercise. You can do a good exercise in an hour.”

—Joe Cocciardi, CIH, CSP, REHS, RS, PhD
equipment and respirators, setting up decontamination tents, communicating with hospital staff, and disposing of waste. Create a list of short drills that take only a couple hours to try each month.

Even if you only drill an hour each month, remember that these functional exercises aren’t a waste of time. “You can do a good exercise in an hour,” Cocciardi says. “You don’t need to perform all the procedures, such as flowing water through a decontamination system, to have an effective exercise.”

Smaller drills will allow you to evaluate all parts of your decontamination plan incrementally and eliminate problems from the start. You’ll also ready hospital staff for the big picture.

**Move onto bigger decontamination drills**

Once staff know their job roles, practice decontaminating a patient. Begin with one patient, ideally a hospital staff member who’s on the organizing team.

“It may sound ludicrous, but [as in] a tabletop exercise, you want to start off simple,” Brison says.

By only processing one patient, staff can use the drill as a brainstorming session. They will retain more information this way and generate better ideas to streamline the process, he says.

Have the patient pose as an ambulatory victim, and then as a nonambulatory patient to give staff an idea of the problems that arise with different patients.

An easy way to decontaminate a nonambulatory patient is to use a stainless steel stretcher without the mattress. The stretcher allows staff to wash easily underneath and around patients because the wheels lock in place to stand at waist level, and its bedside rails prevent patients from falling, Brison says.

**Learn from constructive drill critiques**

Whether you’re conducting a one-hour drill on setting up equipment or are under the gun in a real emergency, always make sure that someone critiques the response and observes the decontamination team’s performance.

Some hospitals hire consultants to evaluate drills. Also consider asking someone from the fire department to look at how you set up your decontamination tent and process patients.

A checklist can help someone evaluate whether staff take the right steps. For instance, did they put on their respirators correctly? Did they put on their personal protective equipment correctly? Check off actions as they happen, Cocciardi says. Be open to criticism of the drill—even with seemingly small drills.

After a drill, meet with everyone involved. The person who observes the drill should take notes on what needs work and what doesn’t. Go back and look at your plan to see how to improve it. Also hold two meetings:

- **An immediate discussion following the drill that identifies specific problems**, such as respirators not working or someone slipping on ice in a location, Cocciardi says.

- **A second meeting that occurs at a later date when people have reflected on what happened** and compared their notes to the actual plan. This action report should include recommended changes for improvement.

“No drill [should] go perfectly,” Brison says. “The key is to take it slowly, learn from it, and not try to process a group of people just to say you did it. When setting up your decontamination plan and process, always put your staff’s and facility’s safety as the first priority.”
**Sample use-of-force policy**

**I. Purpose**
To establish a hospital policy regarding the use of force by a public safety officer, when necessary, to maintain a safe and secure environment for patient care.

**II. Policy**
At Forsyth Medical Center (FMC), the public safety officer will employ only the minimum level of force that he or she believes to be necessary.

A. One goal of the use of force is to assume control of a situation that threatens the security of FMC by protecting the public safety officer and others in the immediate area from danger, as well as the subject from himself or herself.

B. Another goal of the use of force is to detain a subject for arrest by the Winston-Salem Police Department or in accordance with state law. The public safety officer shall limit force to those instances when he or she reasonably believes that use of force is the appropriate method to ensure the safety of the environment and control the situation.

**III. Qualified personnel**
All public safety officers, including senior officers, lead officers, team leaders, emergency department police officers, and the director of public safety, can enact the use-of-force plan.

**IV. Equipment**

A. Public safety officers
Every public safety officer will carry handcuffs and a combination flashlight/expandable baton issued by FMC. FMC does not authorize the officer to carry any other weapons. Public safety officers will successfully complete all training prescribed by the director of public safety, including the baton certification course and training to carry and use handcuffs and combination flashlights/expandable batons. All public safety officers will successfully complete a required annual inservice training in defensive tactics, handcuffing, and baton procedures.

B. Emergency department officers
Off-duty Winston-Salem Police Department officers employed by FMC as emergency department police officers will carry firearms and other equipment issued or authorized by the police department. Emergency department officers will not use chemical sprays inside the hospital because of the potential for contamination of medical facilities.

**V. Procedures**

A. Use-of-force continuum
When faced with an incident that may require the use of force, a public safety officer should assess the situation and determine which of the following alternatives will most effectively bring the situation under control with the least amount of injury to everyone involved. These alternatives are listed in order below, from the least severe to the most drastic. A public safety officer must never use a greater level of force than necessary without first exhausting all less severe alternatives or reasonably believing that any lesser degree of force would be ineffective.

1. **Level one—Presence:** Presence is defined as psychological force established by the public safety officers’ arrival in the area, and symbols of authority, such as the police uniform. The public safety officers’ positioning, stance, and reaction times may control confrontations and facilitate officer safety.
   
   a. **Calling for backup:** The prompt appearance of additional uniformed public safety officers frequently brings situations under control. Backup may include the emergency department police officer on duty or local police. Public safety officers should refrain from initiating contact until adequate backup has arrived, unless immediate action is required to preserve human life.

2. **Level two—Verbal direction and control:**
Use of conversation, advice, commands, or instructions by public safety officers to control or deescalate a confrontation describes the level of
use of force. Public safety officers should use the Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention techniques when appropriate. Verbal direction and control are the most desirable use-of-force options.

**a. Verbal compliance:** After obtaining verbal compliance, the public safety officer may escort nonpatient subjects either off the medical center campus or to the public safety office to be detained for police arrest.

**3. Level three—Physical control:** Use of physical contact includes touching, assisting, grabbing, and manipulating joints. Contact may include an officer using his or her hands or handcuffs. Public safety officers should use handcuffs only when a subject is detained for arrest and when the public safety officer reasonably believes it is necessary to control the subject’s movement for the safety of patients, visitors, staff, or the officers involved, and to facilitate a search for weapons.

**4. Level four—Impact weapons:** Level four use of force includes the expandable baton in accordance with recognized training methods to impede the subject’s movements and to protect the public safety officers and others from assault and serious body injury.

**a. Patients:** Public safety officers must limit the use of force against patients to the defensive techniques taught in the CPI Nonviolent Crisis Intervention Course.

**i. Handcuffs:** CMS considers handcuffs a law enforcement restraint device that is not a safe or appropriate healthcare restraint on patients. Public safety officers must not use handcuffs to restrain a patient in lieu of authorized clinical restraints applied under the supervision of a physician or nurse in accordance with hospital policies and procedures. The police department and other law enforcement agencies may use handcuffs to detain someone under arrest in accordance with state laws. The only exception to this rule is when a public safety officer reasonably believes it is necessary to prevent patients from creating risk of serious injuries or death to themselves or other people, and no other means are available to do so.

**2. Expandable baton:** CMS does not consider the use of weapons (e.g., the expandable baton) to be safe, appropriate healthcare interventions, and their use is not appropriate in the application of restraint or the initiation of seclusion. Public safety officers must not use the expandable baton to threaten, intimidate, or strike patients. The only exception is when a public safety officer reasonably believes it is necessary to stop patients from causing serious injuries or death to themselves or other people, and no other means are available to do so. If an officer uses the expandable baton on any person in the medical center (e.g., patient, staff, visitor) to protect people from harm, handle the situation as a criminal activity, and the officer will be turned over to local law enforcement.

**B. Discretion:** The use of handcuffs and the expandable baton is always discretionary, based on the public safety officer’s assessment of the situation and the perceived threat to the public safety officer and others.

**C. Use of force:** The public safety officer will immediately notify the director of public safety whenever a public safety officer or an emergency department police officer uses any level of force beyond level two. This includes any situation in which the expandable baton is extended but not used. This does not apply to assisting in the restraint of a patient under clinical supervision.

**VI. Documentation**

A use-of-force report will include every use of force beyond verbal compliance, other than the restraint of a patient under clinical supervision. When a person is removed from the medical center or escorted off the medical center campus and the officer uses no force, the public safety officer will include a statement that no force was used in the appropriate report.

*Source: Forsyth Medical Center in Winston-Salem, NC. Adapted with permission.*
Use of force

Another way to view sample use-of-force policies is to consult the National Law Enforcement Policy Center of the International Association of Chiefs of Police.

Potter says this organization constantly updates its policies. Visit NLETC’s Web site at www.iacp.org for up-to-date info on the law and to review court decisions.

2. Be specific. If you allow security officers to carry weapons, spell out the names, makes, and models of the weapons in your policy. Doing so allows the hospital to demonstrate that employees were issued, authorized to use, and trained with specific weapons.

Also include in the policy all the required certification and training that security officers receive. For example, if there is no state law on baton training, you may seek the same training for your officers as local and state police officers receive.

This way, if a situation arises where a security officer is accused of using a baton on a patient and the hospital is taken to court, you can point to the policy and to the fact that security officers receive the same training as police, Potter says.

3. Cover the continuum. Your policy should include a continuum that outlines several levels of force, from verbal confrontations to those involving weapon use, if you permit officers to carry weapons.

For example, if your security officers carry firearms, the highest level of the continuum would be weapon use. The policy should also detail when and why officers can use a weapon and a general rule about escalating to the next level of force.

The continuum provides an outline and a basis for training officers in use of force, Potter says. “This puts use of force in a framework for officers to understand, employ, and articulate,” Potter says.

Additionally, the continuum is an important aspect of your policy because if the hospital gets sued, it illustrates the hospital’s standards for training.

4. Seek legal advice. Once you’ve written the policy, have it reviewed by legal staff, risk managers, and possibly an outside expert who deals specifically with use-of-force law.

Most hospitals use an outside counsel to review the policy because they don’t have the appropriate background, Potter says.

Remember that any use of force carries significant liability if it isn’t done properly, he cautions.

Understanding JCAHO’s periodic performance review

By 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will require hospitals to annually complete a periodic performance review (PPR), or a self-assessment of standards compliance.

Although your hospital may have completed the PPR as part of its triennial survey requirements, this portion of the JCAHO survey process gives hospitals opportunities to prepare for the survey, to work on compliance concerns daily, and to improve patient care. Through the PPR, organizations can identify areas that need improvement and can ultimately be in compliance during the survey cycles.

Since the PPR’s inception in 2004, many hospitals have struggled with how to conduct the review.

With over 1,800 standards to judge compliance on, including all of the environment of care requirements, the self-assessment can be a daunting task, says Jodi L. Eisenberg, CPHQ, CMSC, coordinator of accreditation and licensure at Northwestern Memorial Hospital in Chicago.

Originally, the JCAHO was only going to allow facilities to complete a full PPR, but risk managers raised concerns about disclosing areas of noncompliance to the JCAHO, says Bud Pate, director of clinical operations effectiveness for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

These concerns led to the development of three alternatives—option 1, option 2, and option 3—that we will discuss later in this story.
The full PPR

The full PPR review asks that a hospital conduct a compliance assessment during the midpoint of its survey cycle, identify areas that need improvement, and then develop action plans that contain measures of success.

Once the hospital has completed the process, it sends the information to the JCAHO electronically via the accreditor’s Web site. The JCAHO and the hospital schedule a conference call to discuss the PPR and action plans, Eisenberg says.

The full review forces you to take an honest look at your organization’s compliance and policies.

As a security director or an emergency manager, you won’t get to choose which PPR option is right for your facility—that’s up to hospital leaders—but you will likely be involved in the self-assessment process.

Here’s a breakdown of the different PPR options available to your facility and what they mean:

• Option 1

Under option 1, an organization completes a self-assessment, develops a plan of action and measures of success, and retains the results on site. Although this option is similar to conducting the full PPR, your organization does not have to submit the results electronically to the JCAHO Web site for review.

Instead, you can discuss standards-related issues with JCAHO officials without giving specifics. Your organization may provide measures of success to the JCAHO for assessment at the time of your on-site survey.

• Option 2

A hospital that chooses option 2 performs a self-assessment, develops plans of action and measures of success, and keeps the results on site. However, under option 2, the organization will undergo an on-site survey for approximately one-third of the length of the normal survey time.

The visit comes with a cost. The hospital will receive a report of noncompliance areas within a week of the visit, says Steven Bryant, practice director of accreditation and regulatory compliance services at The Greeley Company.

Based on the noncompliance areas, the hospital develops an action plan and measures of success with the JCAHO. At the regular on-site visit, the organization provides the measures of success to JCAHO. It is unclear whether the organization needs to show that it actually completed the measures of success because the process is new, Pate says.

• Option 3

Option 3 is similar to option 2 in that organizations must perform a self-assessment, develop plans of action and measures of success, and can keep the results on site. However, option 3 also includes an on-site survey, but the JCAHO sends nothing in writing to the organization after the visit.

The surveyor gives any noncompliance findings verbally, which somewhat eliminates a hospital’s fear of disclosure and allows it to write up the survey findings on its own. “This leaves the organization to choose whether it will act on a surveyor’s comments,” Eisenberg says.

In addition, at the regular survey, the JCAHO doesn’t receive any information about the PPR survey findings. However, the lingering question is whether the JCAHO will ask for the organization’s measures of success during a regular visit.

According to the JCAHO, as of September only 1% of accredited organizations had chosen option 3.

The PPR options hospitals choose

As of September 2004, the Joint Commission on Accreditation of Healthcare Organizations reported hospitals choosing the following periodic performance review (PPR) options:

- 61% selected the complete PPR
- 32% selected option 1
- 6% chose option 2
- 1% chose option 3

Editor’s note: Information in this article is from the November 16 audioconference, “Choosing Your PPR Option: Learning from 2004 and Preparing for Future Changes” by HCPro. For more information or to purchase a copy of this audioconference, visit www.hcmarketplace.com/Prod.cfm?id=2933.
Q&A: Snow, ice, and cold lower security response time and raise the number of crimes and incidents

Editor's note: HSEM spoke to Donald White, CHSP, CHCM, regarding winter security problems that can arise at healthcare facilities. White is the director of safety and security at the 129-bed Northern Virginia Mental Health Institute in Falls Church.

Q: Do healthcare security concerns change in the wintertime?

A: During the winter, the volume of incidents increases and security’s response time decreases. For example, more people slip and fall on the facility’s grounds because of icy conditions and then require security’s assistance. We’ve also found that staff members take shortcuts to get to their cars or into the building and don’t pay attention to traffic cones, so they end up hitting icy patches and falling.

More grounds-related incidents involving security occur because the number of maintenance and grounds staff is typically lower in the winter than during the rest of the year. The security department tends to fill these roles when the parking lights go out or when salt needs to be spread on a walkway. For instance, parking lot lights don’t last as long in the winter as they do during summertime, and security usually gets called to change them when necessary. Boilers also tend to die more frequently in the winter than the summer, which means security may have to respond and find out what’s wrong.

The challenge for security is to maintain a quick response. For example, when there are icy conditions, sometimes you struggle to see the closed-circuit television monitors, unless you keep the outdoor lights and camera lens clear.

Q: How do you overcome common winter security concerns?

A: Take the issue of property theft, which increases in the wintertime. People may try to sneak items out of the building under their coats, such as hospital supplies or even laptop computers.

People also try to conceal weapons and other dangerous items under their coats and bring them into the hospital. Although visitor control is a touchy issue for many hospitals, security departments should implement screening systems. Hospitals should consider setting up a security checkpoint with a hand-held scanner to ensure that people don’t bring in guns or knives or attempt to steal items from the facility. However, security must tread lightly with this issue because if it implements too much screening, the practice may convince visitors and patients to use other hospitals.

Another major issue is outdoor surveillance, which decreases in inclement weather. Snow, ice, and rain can impair lights, cameras, and even alarms. One way to overcome these problems is to install more lights, send a security officer out to keep alarm sensors clear of snow and ice, and diversify the types of outdoor surveillance cameras used at the facility.

Security should also watch out for unwanted guests who seek refuge in hospital vehicles, outbuildings, and stairwells. For instance, a lot of hospitals have large grounds with gazebos. Watch out for unwanted visitors or hospital patients who may fall asleep in the gazebo—they may freeze to death. Despite frigid temperatures, assign security officers to check all hospital vehicles, outbuildings, and stairwells during at least every evening shift.
Q: What should the security department do to prepare for winter weather?
A: First, make sure that security staff have an updated list of hospital staff members. During an emergency, security may need to call off-duty staff to come into work. You’d be surprised by how often wrong phone numbers are on the list. What we’ve discovered is that hospital personnel often disregard personnel office requests to update their contact information. So every six months we practice calling the recall staff list. We test the phone numbers by calling the last home telephone numbers listed for staff to see whether they are current and update information as necessary.

Another practice the security department should adopt is stocking supplies and hardware. For example, stock extra lubricants, replacement padlocks, and chains to lock fences and storage sheds. Also keep stepladders and extension cleaning rods stored securely near outdoor surveillance equipment to help keep lights, cameras, and alarms clear of snow and ice.

Since power outages and nonworking emergency generators can strand security staff in parking lot booths and entry gatehouses, stock portable heaters, generators, and emergency fuel at these locations. Also keep battery-operated radios, lights, and non-perishable yet healthy foods for security officers stocked in these outdoor structures.

Q: What practices do hospital security departments overlook in the winter?
A: During the winter, more security officers may take sick time, leaving the department in a bind for coverage. I’m a proponent of assigning other hospital staff, such as housekeepers and nurses, to fill in for security officers as needed. This type of collateral duty in our job descriptions means that sometimes nonsecurity staff take on security duties, primarily after hours or during emergencies. This way, if security staff are sick and need to go home, we still have staff outside the department to fill their positions. Of course, we also need to train these staff members in their security roles. Some of those roles might include issuing keys to hospital vehicles, providing directions, or using the metal detector scanners. They need to practice at least one month before the winter weather hits. Make sure you document this inservice training for your liability protection.

Q: What kind of suspicious behavior should security look out for during the winter?
A: Security officers should watch for unwanted people in the building and on hospital property. If you discover unwanted people in your facility, find out why they are there. Be polite and ask whether you can help them. Ask whether they are visiting someone and get a valid name of a patient, nurse, or doctor—or even a room number. If there’s no one in the facility by the name given to you, then tell them so. Ask whether they are sure they’re in the right facility and suggest they try another hospital. If they continue to resist, tell them that you don’t think they’re in the right place. Nine times out of 10, the people will realize they’ve been detected and leave.
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Former employee used hospital laboratory to grow psychedelic mushrooms

Police arrested a man in November for allegedly growing thousands of hallucinogenic mushrooms while working at the University of Rochester (NY) Medical Center lab, WROC-TV reported. Gregory Liptak, 26, made over $2,000 per week selling the mushrooms to people living in the area, police said.

Authorities noticed a problem when residents began acting strange. “Road deputies were having problems on the road, handling complaints, and rolling up on people who had ingested mushrooms and had violent, out-of-control behavior,” Lieutenant Robert Hetzke with Wayne County Sheriff’s Department told WROC-TV. Five people went to the hospital suffering from overdoses.

After an investigation, police discovered that Liptak had allegedly set up a lab in his home and had grown mushrooms for more than two years.

Liptak worked as a lab technician at the University of Rochester Medical Center. Hospital security reported to WROC-TV that Liptak allegedly taped open a fire exit door and reentered the lab during the night to use an autoclave to sterilize the rice the mushrooms grew in. As a result, the hospital added a new security system to alert staff when doors are left open, locked, or disabled.

Patient arrested for threatening hospital staff

Lufkin police officers arrested a patient in November at Memorial Health Systems of East Texas who threatened hospital staff with a knife, the Lufkin Daily News reported.

William Horace Glover, 59, used a steak knife saved from a dinner tray to threaten nurses and hospital security, Lufkin Police Lieutenant Greg Denman told the Daily News.

Glover allegedly thought someone was trying to kill him. He was taken to jail and faces charges of aggravated assault.
Quiz questions

1. (T) (F) Security directors decide the level of force for their facility.

2. (T) (F) The use-of-force policy should include a continuum.

3. (T) (F) Insurance agencies should review the use-of-force policy.

4. (T) (F) Decontamination drills should start out as large as possible.

5. (T) (F) Following decontamination drills, hospitals should hold two meetings to review the process.

6. (T) (F) Hospital officials can make some of the necessary decontamination equipment on their own.

7. (T) (F) Hospitals should conduct an annual periodic performance review.

8. (T) (F) Winter time brings different challenges for hospital security.

9. (T) (F) More grounds-related incidents involve security during the winter time.

10. (T) (F) Security should watch for people who try to conceal weapons under their winter jackets.
1. **False.** Although security directors will likely recommend the level of force, hospital administrators will ultimately decide.

2. **True.**

3. **True.**

4. **False.** Don’t conduct a decontamination drill with multiple patients until you’ve tested all parts of your plan.

5. **True.**

6. **True.**

7. **False.** The Joint Commission on Accreditation of Healthcare Organizations will require an annual periodic performance review in 2006. Currently, hospitals conduct the review on a triennial basis.

8. **True.**

9. **True.**

10. **True.**

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