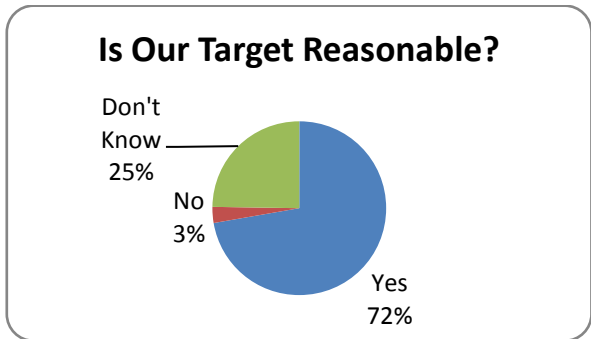
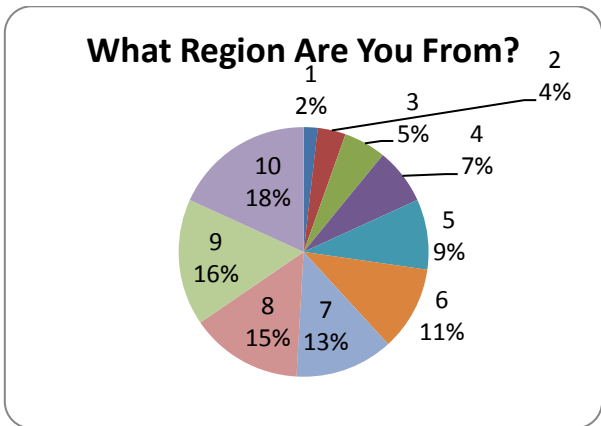


Q 1: We are unable to see the results of the polls.

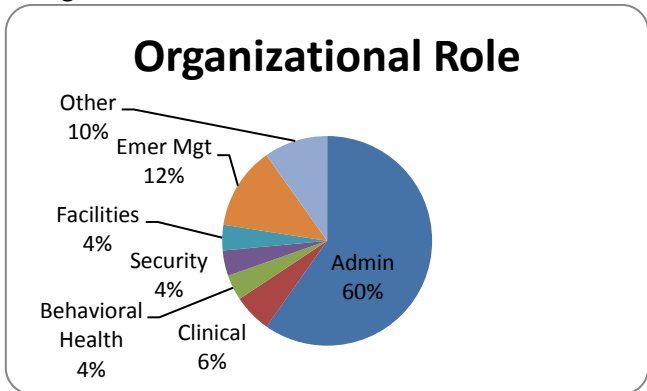
Poll 1: Target = 75% of participants will conduct a security assessment for your organization within the next 2 months



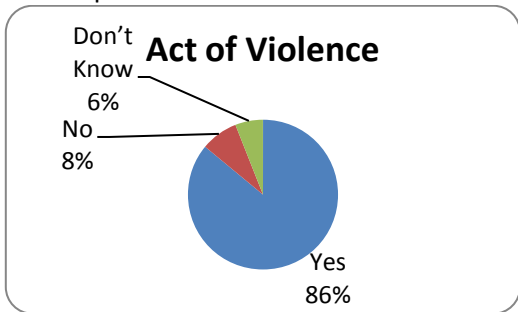
Poll 2: Which DHHS Region are you from?



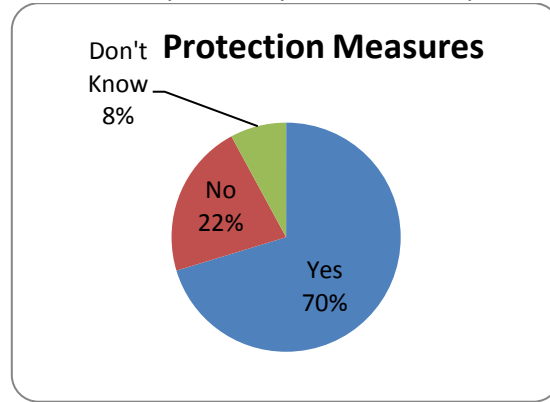
Poll 3: What role do you play in your organization?



Poll 4: In the last year, has your organization experienced an act of violence?



Poll 5: Do you have specific protection measures in place for your front desk personnel?



Q2: Can you recommend trainings for staff on aggression management?

AVAILABLE AGGRESSION MANAGEMENT TRAINING PROGRAMS	
Techniques for Effective Aggression Management (TEAM)	www.hss-us.com
Crisis Prevention Institute (CPI)	www.crisisprevention.com
Management of Aggressive Behavior (MOAB)	www.personalprotectiontraining.com
The Mandt System	www.mandtsystem.com
Verbal Judo Institute	www.verbaljudo.com
Professional Education Services, Inc. (PES)	www.pesinc.net
Handle With Care	www.handlewithcare.com

Q3: If we have a video camera doing surveillance, do we have to have a sign stating that they are being taped? We have gotten conflicting answers. We also wonder if we could record audio.

A: No, there is no legal or mandatory requirement to notify people that they are being taped in public settings, like the waiting room of a community health center. It is also permissible to record the audio in addition to video and can be very helpful. If resources are limited, video without audio is still a good investment.

Q4: Is there any system that provides a silent alarm through the computer system with a icon on the desktop?

A: [http://www.lynxguide.com/](http://www lynxguide.com/)

Q5: Could you share one solution on how to achieve ADA compliance in the reception desk while ensuring staff safety?

A: Organizations can design front desk areas with multiple layers of glass inserts to accommodate conversations at varying heights.

Q6: Did you suggest having a live monitor in a waiting room so that patients can see that they are actively being videoed?

A: Yes, this is a relatively simple and low cost measure that sends a clear message to everyone walking into your facility that security is taken very seriously by your organization. Monitors can be placed at the entrance, in the waiting room, or at other points, such as a pharmacy counter.

Q7: Do you have a recommended way to physically set up a mental health counseling room so that the staff person can exit safely if a patient becomes violent?

A: It is important to have two points of entry/exit to each counseling room. If that is not possible, arrange the furniture so that the counseling staff is nearest the exit. It is also important to consider having the space visible to other staff outside the room, such as a partial glass door or window. In addition, be mindful of any medical instrumentation that could be used as a weapon and remove it or place it in a lockable cabinet and position all wall decoration out of reach or securely fasten it to the wall so that it cannot be easily removed and used to harm another person.

Q8: What recommendations do you have regarding any media type information for community awareness or even employee information?

A: National Crime Prevention Council (www.ncpc.org) is a great resource

Q9: How do you define "first responder"? The police?

A: First responder for the purposes of my presentation was law enforcement personnel; i.e., police, sheriff, Highway patrol, etc.

Q10: We have staff (usually leadership) who responds to our codes for potential violent situations. What kind of extra training do they need and how do we find training resources for responders?

A: I suggest you review the aggression management training programs offered above and mandate that all responders attend the training program elected. Additionally, you should periodically exercise your violent episode response and use this as an educational opportunity. If a violent episode does occur, use a 'hot wash' approach to learn from the actual situation and improvements that can be gleaned.

The mistake many organizations make is to have 'all staff or all male staff respond' which can be very dangerous as well as difficult to manage. More is not always better.

Q11: Can you elaborate on wireless panic buttons. How do the responders know where the event is occurring?

A: The wireless duress alarm allows the user to move about a given 'protected area' so that the activation device can be carried or worn on the person. The wireless system generally operates using radio frequency (RF). The alarm enunciator can have a visual and/or audio indicator. Most organizations monitor centrally at a staff location that provides more specific details on where the alarm signal is generated. Contact your local security system integrator to learn more.

Q12: If you use video surveillance, would the health center be required to turn over tapes to immigration officials if asked? We've shied away from video surveillance and heavy police presence because we don't want to scare away patients who are immigrants.

A: If an appropriate court order has been issued, the health center would be required to turn over any recorded images. Otherwise, it is an individual decision of the health center to cooperate with the requesting law enforcement official/agency.

Q13: The Health Center takes a photo of the patient for EHR use. What should the Health Center be aware of in regards to the taking of the patient's picture, i.e. person was accused of some wrong doing at the health center and the picture was given to police.

A: A photo of the patient that is taken purely as a clinical endeavor should be treated as PHI. No other collected/stored images need to be treated with such privacy concerns.

Q14: You mentioned M.O.A.B. and some other organizations for aggression management trainings. Could you recommend a self study program or CD-ROM or DVD that could be incorporated into standard new staff member orientation from any of those organizations?

A: I am not familiar with any organization currently offering a self-study program for initial aggression management training. I suggest you speak with the individual providers to clarify if such training exists.

Q15: Most of our facilities are leased, so we have less control over external security. Do you have any tips for working with landlords to improve external security? If they are not responsive, should we go as far as considering a different building?

A: I suggest you obtain a Cap Index report (www.capindex.com) to obtain quantifiable information as it relates to the security risks associated with the external environment. If high, it is difficult for a landlord to refute when security recommendations are made. If not successful, you may want to hire your own security consultant to assist and provide a third party objective review of the risks faced. If they are still unresponsive, identifying an alternative space would be a consideration, but hopefully one of last resort.

Q16: Would you suggest having a door that can be electronically locked to protect employees from abusive patients

A: Protection measures for high risk patients should be designated based on the assessed vulnerability of the patient population served. However, be mindful of the seclusion & restraint requirements stated in the CMS conditions of participation before installation. Placing a patient behind a locked door does constitute seclusion and there are specific requirements for all healthcare facilities when this occurs.

In general, I like having a compartmentalized medical treatment area that is separated from the waiting area and controlled by staff. If your question is focused on a hardening the exam room, the following design considerations should be considered:

- 1) Isolating the patient, distancing the patient from department exits, locating the patient in close proximity to dedicated restrooms, providing for direct observation of the room by clinical staff
- 2) Incorporating video surveillance with audio capability to remotely monitor patient activity; cameras should be enclosed in tamper proof housing. Monitoring locations should meet patient privacy and clinical requirements.
- 3) Controlling access in and out of room if occupied
- 4) Equipping doors with tamper proof hardware and observation window with window coverings managed from outside of the room
- 5) Hardening walls, ceiling, and doors to prevent penetration
- 6) Equipping the room with removable objects and protecting medical equipment behind locked cabinetry, gates, impact resistant laminate or other hardened material
- 7) Incorporating safety measures to address the potential for a patient to cause harm to themselves or others
- 8) Using protective hardware for wall hangings

Q17: We have on one occasion had a patient walk all around the building to our entrance door for employees. Can you suggest ways to prevent this from happening again?

A: Without taking overly obtrusive security precautions, it would be difficult to prevent a person from walking around the facility to a door. Strongly suggest however, that all employee entrances restrict entry to authorized staff only. Preferably, this is some type of electronically controlled access; i.e., card or code, but in some situations, this may be basic key control.

Q18: Do you recommend reception areas remain locked between patient waiting area and rest of clinic, which requires employee to physically open door to allow entrance? Are elec. lock releases expensive to implement so receptionists could "buzz" patients in?

A: My basic recommendation is that the reception desks have additional protection measures. To what extent has to be based on the assessed vulnerability. In general, this should include:

- 1) Clear distinction from the waiting area.
- 2) Protection to prevent unwanted access and be of sufficient height and strength to make it difficult for someone to jump over or physically assault an employee. Again, the degree of enclosure and protective material used should depend on the assessed vulnerability.
- 3) Positioned to provide staff direct access to an exit portal (safe drop-back zone) and equipped with strategically located duress alarms.

Q19: Is there a list of common items that are in waiting rooms that can be used as weapons?

1. Wall hangings if not properly fastened
2. Furniture pieces that not affixed to each other; i.e., tables and chairs
3. Plants, fire extinguishers or other hard objects that are not properly fastened
4. Book holders

Q20: Do you have any recommendations on how to assess the need for an onsite security guard?

A: There are a number of issues that an organization should consider when determining if onsite security staff is needed. For instance, do staff and patients feel safe while onsite? Has an act of violence or a crime occurred at your health center? Has the organization exhausted all of the other security measures discussed today, such as video surveillance, environmental controls, and staff training? Is there a high crime rate in your community? Do you have a lot of patients with violent tendencies? What is the law enforcement response time? What role would an onsite security staff person play – provide a security presence or get actively involved if an event occurs?

Q21: Can you give specific examples of special procedures for high risk patients?

A: First, high risk patients should be identified in their chart along with how they are a risk, i.e. threat to themselves, threat to others, or have an altered mental health status. Second, expedite placement in an exam room. Other things to think about - consider including an additional staff member into the process to reduce staff vulnerability. In addition, determine a discrete way to flag the exam room when a high risk patient is inside, i.e. place red paper or flag on door that alerts staff who may be in and out of the exam room that this patient has exhibited worrisome behavior in the past.

Q22: Is a silent alarm or one that sounds loudly better during an active pharmacy robbery in your opinion?

A: If weapons are involved, it is best to meet their material demands (money, drugs, etc) and get them out of the health center while mentally noting their description and anything else that will help police identify them.

Q23: Do you think that "we ban weapons" signage is effective and/or useful?

A: This is a very important part of keeping your health center safe. Signage should go by all public entrances. In some jurisdictions where concealed weapon permits are more readily obtained and accepted, organizations are largely obligated to post such signage. Lack of such signage may be construed as permission to carry weapons into the organization. It is also important have staff policies related to this and that the term weapon is clearly defined.

Q24: How do you recommend that we notate or flag the patient's chart to indicate that the patient might be a security risk?

A: This will vary by organization.

Q25: what are the legal requirements about notice if we are going to have video surveillance inside/outside the clinic?

A: There are no mandatory or legal requirements to tell people that they are being watched in a public area, like the waiting area of a community health center.

Q26: What are the HIPPA implications of using video surveillance in a waiting area?

A: There are no specific provisions or regulations that prohibit an organization from monitoring patients in the public areas of their facilities. There is an obligation to control who can view the images being collected by video surveillance equipment.

Q27: What mileage is represented by the outer ring on the CAP report?

A: Three miles for most areas, but if located in a highly concentrated population, it would be limited to 100,000 people

Q28: Can you speak to policies around leaving children alone in waiting rooms and other measures designed to preventing child abductions?

A: It is a great policy to prohibit parents and guardians from leaving children left alone in waiting rooms. It is important to provide staff training to on techniques and methods to enforce the policy. In addition, it is important to clearly identify age limits in this policy, i.e. children under the age of 16 are required to be accompanied by a parent or guardian at all times while on health center property, etc.