

# SAFETY AND SECURITY IN THE VA

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**HEARING**  
**BEFORE THE**  
**SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS**  
**OF THE**  
**COMMITTEE ON VETERANS' AFFAIRS**  
**HOUSE OF REPRESENTATIVES**  
**ONE HUNDRED FIFTH CONGRESS**  
**FIRST SESSION**

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**MAY 22, 1997**  
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# **SAFETY AND SECURITY IN THE VA**

**THURSDAY, MAY 22, 1997**

**HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON VETERANS' AFFAIRS,  
Washington, DC.**

The subcommittee met, pursuant to call, at 9:30 a.m. in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Clyburn, Snyder, Evans.

## **OPENING STATEMENT OF CHAIRMAN EVERETT**

Mr. EVERETT. The hearing will come to order. Please cease all conversations. Good morning. Today's hearing by the Subcommittee on Oversight and Investigations will examine the safety and security of our veterans and our valued 240,000-plus VA employees. I've become increasingly concerned about personal safety issues at the VA after hearing about the tragic murder of Dr. Ralph Carter at the G.V. "Sonny" Montgomery Veterans' Affairs Medical Center in Jackson, FL, this past February. I understand that this is the second violent assault at this facility in less than 2 years. Other incidents at VA facilities have also raised complex questions about the safety of veteran and VA staff alike.

The VA's response has been to develop a pilot program to arm its hospital law-enforcement officers. The arming of VA police must be done at a very deliberate pace with stringent safeguards. Before going full-scale we must be confident that this is the right way to improve hospital security. We want to be reasonably assured that fire fights won't erupt in hospital lobbies, wards and parking lots. Standards for the VA should be no less than that for any other armed federal law-enforcement agency.

We will also examine the security of controlled drugs in VA hospitals, VA pharmacy operations which cost more than \$1 billion this year. Due to the high value of the VA drug inventories with respect to theft, we'll examine how the VA has addressed accountability and security problems which have previously been identified by VA's I.G. Additionally, the VA still maintains 30 hospital fire stations with an annual operating budget of over \$16.3 million and staffed with 357 fire fighters. Today we will review fire safety issues critical to our VA patients, employees and our fire fighters. I think we have a full plate for discussion today. I look forward to hearing testimony, and I would ask that all people testifying please condense your statements to 5 minutes. And now at this time I'd like to recognize our ranking member, Mr. Clyburn.

**OPENING STATEMENT OF HON. JAMES E. CLYBURN**

Mr. CLYBURN. Thank you, Mr. Chairman. As ranking Democratic member of this Committee, I'm pleased to join with you in holding this important hearing. I know that safety and security of our VA hospitals are of utmost importance to the VA and to members of this Committee. In my view, we would not be accomplishing our mission of providing the highest possible health-care service to our veterans if we are unable to protect the safety and integrity of our VA hospitals. I am greatly interested in hearing testimony from the VA on its pilot project to arm VA police officers at certain VA hospitals.

I'm aware that the tragic shooting of a doctor in Jackson, MS earlier this year has caused renewed concern over the adequacy of the safety and security of our VA hospitals. I must say, however, that I believe the VA ought to be taking a measured approach when it comes to making any final decision to arm its police officers. Very few private hospitals even in some of the dangerous crime-ridden areas of our country allow the officers who guard their facilities to carry guns. I believe there is a reason for this. As the written testimony of the Nurse's Association suggests, hospitals are for making sick people healthy; guns are for killing people. The VA should be extremely cautious in its approach to this issue. There should be an extensive, well-thought out hospital-by-hospital analysis of the feasibility and propriety of arming VA officers before jumping into such a course of action.

To my mind at least, it is just as easy to imagine a situation where a VA officer accidentally kills or seriously injures somebody during the course of his duties as it is to imagine a situation where the officer's gun keeps a killing or serious injury from occurring. I welcome the opportunity to hear testimony on this extremely sensitive issue, as well as the chance to get an update on the status of VA fire departments and the VA's accountability of controlled substances. Thank you again, Terry, for working with us to put together such a timely and important hearing.

[The prepared statement of Congressman Clyburn appears on p. 43.]

Mr. EVERETT. Thank you, Jim, and this Committee is honored to have the ranking member of the full Committee as a member of this Committee, and at this point I'd like to ask my ranking full Committee Chairman—full Committee member—ranking member if he has any comment.

**OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS**

Mr. EVANS. Thank you, Mr. Chairman. I think this is a very important hearing with the VA right in the middle of its pilot program to arm VA police officers at selected cities. There's no more appropriate time than now to conduct diligent oversight of this program, and I of course share the concern about the recent efforts out at the Jackson, MS facility, and I'm also deeply troubled by the deaths of four VA police officers in the last 5 years. Safety and security of patients, law-enforcement personnel and the doctors and staff at our facilities has got to be an utmost priority and we

should closely consider the means by which we can best accomplish this mission. I am pleased that John Baffa is testifying before us again. I think he has brought a new level of training and sophistication and effort on the part of the VA and I look forward to the testimony. Unfortunately, I will have to be attending the quadrennial review of the armed forces today with the Joint Chiefs of Staff, so I won't be able to stay for the hearing, Mr. Chairman, but I just wanted to thank you for your diligence and hard work.

[The prepared statement of Congressman Evans appears on p. 43.]

Mr. EVERETT. Thank you, Lane. I'd like to welcome all the witnesses testifying today. At least one of our witnesses has traveled some distance to testify and I want to thank all of you in advance for being here. I would ask again that you limit your oral testimony to 5 minutes. Your complete written testimony will be made part of the official hearing record. We will ask members to hold questions until the entire panel has testified. I now recognize Mr. John Baffa, Deputy Assistant Secretary for Security and Law Enforcement and ask him to introduce the members of his panel before we go any further. Also, at the end of Mr. Baffa's 5-minute testimony I would ask—be given an additional 5 minutes for a brief demonstration for a safety feature on this gun holster. Mr. Baffa assured me and assured the staff that the weapon is appropriately disabled and is not loaded. Mr. Baffa.

**STATEMENT OF JOHN H. BAFFA, DEPUTY ASSISTANT SECRETARY FOR SECURITY AND LAW ENFORCEMENT, DEPARTMENT OF VETERANS AFFAIRS; STATEMENT OF RICHARD P. MILLER, DIRECTOR, G.V. "SONNY" MONTGOMERY VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN E. OGDEN, DIRECTOR, PHARMACY SERVICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KENNETH FAULSTICH, ENGINEERING MANAGEMENT AND FIELD SUPPORT OFFICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS**

#### **STATEMENT OF JOHN BAFFA**

Mr. BAFFA. Thank you. Thank you, Mr. Chairman, members of the subcommittee. I am pleased to be here today to discuss issues related to safety and security of VA facilities. With me today I have Mr. Richard Miller, Director of the VA Medical Center, in Jackson, MS; Mr. John Ogden, Director of Pharmacy Service in VHA; Mr. Kenneth Faulstich, fire protection engineer in VHA; and Mr. Walt Hall, Assistant General Counsel. VA's official statement provides details about security in law enforcement, the strides we have made in the area of securing in our pharmacies against theft, VA's fire protection program and the recent desecration of the National Memorial Cemetery of the Pacific.

Thank you for the opportunity to speak to you today. I think it is fitting that this hearing is being held just a few days after the National Police Week activities in which the President, Congress and the nation paid tribute to the police officers killed in the line

of duty during 1996. This year as in years past my department has lost one of its own. Officer Hoerst Woods of Albuquerque was wantonly and without provocation gunned down in the VA parking lot in Albuquerque, NM. Officer Woods was unarmed. Seven years ago when I took this position I received beneficial insight, comments and advice from some members of this Committee and/or its staff. I feel I've answered every question, addressed every issue, calmed many fears and made many improvements. Recently, VA's magazine, "The Vanguard," did its feature article on the VA police. It was entitled, "VA Police: the Force is With Us." I think that one title emphasizes what we are all about and how we feel about our veterans and want our veterans to feel about us. In addition, the first sentence stated, and I quote, "For the VA, the nineties have been a decade of reinvention. For the VA police, make that a transformation." We have increased the VA basic police training course to 160 hours. We have developed specialized training for chiefs and detectives. We have implemented a regimented monthly in-service training program for all officers at their stations. We have a police chief's intern. We have use of a K-9 program for missing patient searches, security and the illegal drug interdiction. We have moved the physical location of the police officer at most hospitals to make them more visible to our customers. We have increased foot patrols and at some facilities instituted bicycle patrols to be more visible, closer and accessible to our customers.

Recently we have implemented a pilot program to arm our VA police at selected locations. In short, we have made significant strides, but we must go forward if we are to continue to provide a safe environment for our veterans and our employees. I spent 26 years, my entire adult working life, in federal law enforcement in protection of citizens of this country. The last 7 here in the VA have been challenging, sometimes frustrating but overall very rewarding. With the guidance and help of the Secretary we have accomplished much, but as I stated and you have articulated, we have much to do. I can assure you that my office is driven by the goal of providing a safe and secure environment for our veterans, their guests and the employees of the Department of Veterans Affairs.

With regard to pharmacy issues, since 1992 the House of Veterans' Affairs Committee hearing on controls of addictive drugs and drug diversion, the VA has made significant progress. Working with the Office of the Inspector General, the General Accounting Office, and the Office of Security and Law Enforcement, the Veterans Health Administration has instituted regulations over the accountability of controlled substances that are more strict than any State or any other health-care system's requirements. My colleague, Mr. Ogden, is prepared to address these issues.

VA's fire safety program is another program that ensures the safety of our VA employees and the veterans. At the vast majority of the Department's medical centers the fighting services are provided by local community fire departments. In the event that local fire fighting services do not meet VA's minimum level of requirements, VA operates in-house fire departments. There are currently 30 in-house fire departments, each which is staffed by approximately 15 employees who are fire fighters. Mr. Ken Faulstich is

here to provide details about the fire protection program. Additionally, there are two separate recent issues or events that have caused concern for VA employees, patients and visitors to the VA. One was the shooting at Jackson, Mississippi VMAC that resulted in the death of a patient and an employee and the desecration by vandals of the National Memorial Cemetery of the Pacific.

Mr. Chairman, my colleagues and I will be happy to answer any questions, but first it is my understanding you'd like to see a demonstration of the firearm and the safety factors, and I would like to have Mr. Bill Harper come up and show that to you.

[The prepared statement of Mr. Baffa appears on p. 46.]

Mr. EVERETT. We'd be happy to honor your request to show that to us.

Mr. BAFFA. Bill? Sir, I'm going to show you that this gun is unloaded. You can see that it is unloaded. It's also been checked by the U.S. Capitol Police. There is no bullet in the chamber, and there's no bullet in the magazine. The question deals with the safety of this weapon. This weapon is double-action only. Actually, it works like a magazine-fed revolver. The—hammer never stays cocked, always traveling forward with the slide coming to rest in the double-action position. Each pull of the trigger draws the hammer back and releases to fire the pistol. This feature reduces the chance that the pistol will be accidentally fired. Number two, the magazine will not fire—excuse me, the weapon will not fire if the magazine is released. The pistol will not fire unless the magazine is fully seated even if there is a round in the chamber. This feature allows the officer to make the pistol nonoperational at any time by releasing the magazine with the touch of a button. The officer then may place the magazine in the holster pocket, making the weapon fully safe. It will only fire with a VA-issued magazine. The pistol and magazine have been specially designed by Beretta at no extra cost so they will only fire with the magazine issued to the officer. The pistol will not fire using the standard Beretta magazine. The weapon will not accidentally fire. The pistol has a firing pin block on the top of the slide which actually blocks the firing pin until the trigger is pulled. Even if the pistol is dropped, it will not fire. It also has a loaded chamber indicator. When there is a round in the chamber, the extractor claw protrudes, exposing a red slide. An officer can thereby easily determine visually without aiming the weapon—a weapon or a round in the chamber.

Last but not least, we have a security holster, and it is considered a level three security holster. This holster is equipped with internal safety locking devices that drastically reduce, if not eliminate, the possibility of anyone other than the officer from drawing the weapon from the holster. Your staff member couldn't do it a couple days ago. We'd like to have this man who's never seen it try to pull that weapon out of the holster if you could. And I also would like to try it, and you can see how quickly the officer was able to get the weapon out. That right there plus the intense training both on the range and lectures make me believe this a totally safe weapon to be used in the hospital facility above and beyond what most police departments use nationwide. But anything else you'd like see with the weapon, sir? Are there any other aspects of the weapon you'd like to—

Mr. EVERETT. I assume you were holding on down the holster just to keep it from coming up—you were holding the belt. I see.

Mr. BAFFA. Sir, he's the thinnest man I've got.

Mr. EVERETT. Well, we do congratulate you on this safety feature. I assumed it was something that VA came up with, or it may have existed already.

Mr. BAFFA. The holster existed already, sir. We have spent countless days and weeks studying and coming up with the best weapon as far as safety aspects go and the accompanying holster, to make sure that—nothing is totally fail safe, I wish I could give you that assurance, but we believe we have done the best possible to assure that nothing that concerns you would happen with this particular weapon.

Mr. EVERETT. Thank you very much.

Mr. BAFFA. Yes, sir. Sir, we will answer any questions you might have.

Mr. EVERETT. Do any other members of your staff wish to make any statements?

Mr. BAFFA. I don't believe so, sir. We're ready to answer any questions that you the Chair or your colleagues have.

Mr. EVERETT. Well, first of all, I want to thank you for coming up and appearing here today. As I said, I congratulate you on those safety features. They are impressive. However, I will say that in the beginning that I have grave concerns about the idea of arming the security forces in VA hospitals. And we have some I think very straightforward and candid questions. We would appreciate answers likewise.

Mr. BAFFA. Yes, sir.

Mr. EVERETT. While myself and Jim, the ranking member of this Committee, are the only two here, I can assure you that that does not indicate the interest in this subject. This is a small Committee, but it is a Committee made up of Floyd Spence who is the Chairman of the National Security Committee, Bob Stump, the full VA Chairman, and as you heard just a moment ago, ranking member of the full Veterans' Committee who has gone for the QRD hearing which is going on along with this hearing, and of course that's where Chairman Stump and Chairman Spence are also. Let me begin by saying, if you would, explain to me why VA believes it's necessary at this time to have a pilot program to arm VA hospital police.

Mr. BAFFA. Mr. Chairman, we do not look at the weapon as a cure-all. We look at it as an additional tool. If you remember from my opening statement, we've done a lot of other things. We have instituted a K-9 program.

Mr. EVERETT. Excuse me just a moment.

Mr. BAFFA. Yes, sir.

Mr. EVERETT. I'm going to dispense with the 5-minute rule. Only myself and our ranking member are here and I'm going to allow each of us as much time as we would like to explore this subject.

Mr. BAFFA. Yes, sir. As I was saying, I realize that the issuing of firearms is a very sensitive issue. It is with me and with the Secretary and Dr. Kaiser. I look at the firearm as an additional tool to help the police officer accomplish the goal of providing safety and security at a VA hospital. As I indicated, we have K-9 pro-

grams. We instituted a program a couple of years ago which was vigorous patrol and getting out into the community, and if you'll note by reading the papers, the city of Washington and the city of New York have gone to the same theory, that if you get out there and meet with the people and you prevent crime, you don't respond to it. And our philosophy is you stop crime before it begins by not letting people who don't belong into the hospital into the hospital.

I'd like to give you an illustration of how I think the weapon helps, and there's three things with the weapon, and it's not shooting somebody. That's the final, ultimate thing that nobody wants it to. The VA police officers don't want to do it, I don't want it. Nobody in this room wants this to happen. But again, I like to use examples, and again, these are three examples, if they don't satisfy you, I will go on. In Richmond, VA, at our hospital, VA police around midnight approached a vehicle that was in the parking lot. These people had no reason being there. They were not veterans. They just consummated a drug deal and they were sitting there counting their money. They both had long criminal histories. The VA police approached them, asked them what they were doing and they immediately surrendered. After they were arrested, the one felon who was more than a three-time loser said, "You know, if I had known these people were not armed I would have killed them because I have nothing to lose." So, the fact that an individual is armed is a deterrent, just that he's carrying the weapon.

Number two, and I'd like to give you a second illustration, I mentioned to you about Officer Hoerst Woods who was killed in Albuquerque, NM. After he was killed the assailant took the keys off of his belt and tried to steal the car and could not get the car. People heard gun shots go off and he started flailing his hands and no one could get to the injured officer because he was threatening to shoot them. The Air Police, and this is a joint facility, who are armed responded, drew their weapons, told them to surrender, and he finally did surrender. Again, a case where the weapon was used but it was not fired. The third case that I would like to use is Lake City, FL, where our police officers approached an individual who I believe the nursing staff had complained about was harassing them outside. He went up to the car. As he approached the car the man pulled a weapon out. The officer had nothing to do but turn and run and was shot in the back. After the officer was shot, who was the line of defense to gaining entry into the hospital, the individual then got into the hospital and shot the hospital up. So, I think those are three different areas where the use of a firearm probably would have been used, in the third case would have prevented those incidents from happening.

Mr. EVERETT. The question was, why is it necessary at this time to have a pilot program? I gather from that answer that you're saying—

Mr. BAFFA. Times are changing, sir. We're having more violent crime.

Mr. EVERETT. More violent crime?

Mr. BAFFA. More violent crime at our facilities. I've given you three examples of what's occurring on our facilities.

Mr. EVERETT. Let me ask you about that. Perhaps the figures I've seen are incorrect, but the figures I've seen of total crime in-

cluding everything, violent crime, has dropped really about 20,000 instances from 1990 to 1994. Have I been given some wrong information? I think there were about 60,000 instances reported in 1990. Has the staff got that stuff somewhere? In 1994, about 40,000 instances.

Mr. BAFFA. I think those were disturbances. I don't think the title was violent incidents. I may stand corrected.

Mr. EVERETT. My information is it's all-inclusive.

Mr. BAFFA. All-inclusive. That's correct, sir. And again, that goes to the whole package that we're talking about. The more vigorous patrol, the use of the K-9 program. We're getting too many people injured and killed and I think that the thing is, we want to serve our veterans and give them good health care, but we want to make sure our veterans and our staff feel safe and are willing to come to work to take care of that issue.

Mr. EVERETT. I'm sorry, the figures are 1990 to 1993, and this includes disturbances including bomb threats and threats to employees, manslaughter, rape, assaults, weapons possession, illegal drug cases, robberies, liquor possession. And in addition to that, further information that I had not seen until now shows that it's gone down from 1990 to 1996 from roughly 59,995 to 25,983. So, it's more than half the amount of violent crime that we've seen in the past.

Mr. BAFFA. Sir, I don't know if you have the same one that I have, and I'm checking it right now. If you look at 1994, it says, "Disturbances including bomb threats and threats to employees," that has gone down. That is correct. That has gone down.

Mr. EVERETT. My staff tells me this information that I'm looking at and reading from was provided by the VA.

Mr. BAFFA. Right. Well, I'm not denying that. What I'm saying to you though, the one that you looked at, the major decreases in disturbances, and that's an all-fitting category. If you look at assaults, I'd like you to look at assaults, you will see that the assaults have remained pretty much consistent. In 1994 I have 1,660; in 1995 I have 1,551; and in 1996 I have 1,624. If you look at the liquor possessions, you look at the illegal drug cases. The crimes of violence—

Mr. EVERETT. Let me stop you there because our figures just aren't jibing. I show in 1990 that you had 5,217 assaults.

Mr. BAFFA. Okay, sir, 5,217, that's correct. But what I'm saying to you, last year when we implemented these new programs, that's what has caused the decrease. And do you have 1994, 1995 and 1996?

Mr. EVERETT. Yes, I do. Let me read my figures and the you tell me where I'm wrong.

Mr. BAFFA. Okay, sir.

Mr. EVERETT. In 1990 assaults/all, 5,217; 1991, 4,624; 1992, 4,181; 1993, 3,738; 1994, 3,399; 1995, 3,315; 1996, 3,205.

Mr. BAFFA. Yes, sir. I understand that, but I think I had told your Committee before, and if I hadn't I apologize, but some of the information contained on this and the preceding pages are of questionable accuracy. In 1989 the VA Office of Inspector General issued a report highly critical of the accuracy of the information contained in the VA's crime reporting system. During inspections con-

ducted by the Office of Security and Law Enforcement since 1990, it was found that many facilities were overstating and some were understating crime statistics which were recorded manually.

Mr. EVERETT. So, what you're telling me is that the VA's system of reporting these crimes is not accurate?

Mr. BAFFA. At that time it was not. It is accurate today.

Mr. EVERETT. That report was in 1989. Did the VA wait all these years to correct it?

Mr. BAFFA. No, sir, it did not. As soon as I came on and found that there was a deficiency, we went and got—

Mr. EVERETT. You've been there 7 years?

Mr. BAFFA. Pardon me? Seven years.

Mr. EVERETT. I'm sorry. You said you've been there—

Mr. BAFFA. Yes, sir, and I obtained funding and we do have a computer package now that is accurate.

Mr. EVERETT. Let's move a little past that because I want to give Mr. Clyburn some time too. Let me ask you a couple things on this. Will VA hospital police be subject to drug screenings such as urinalysis?

Mr. BAFFA. Sir, all VA police that are hired now are subject to random drug testing.

Mr. EVERETT. Urinalysis?

Mr. BAFFA. That's correct, sir.

Mr. EVERETT. How about previously-hired security officers?

Mr. BAFFA. It is my understanding that at some time during the summer the VA drug testing program which includes police officers will be implemented and they will be subject to drug testing. If during the course of business we have reason to believe a police officer is acting suspiciously, we can mandate that he be drug tested.

Mr. EVERETT. Let me get into this, and what we may do, Jim, with your permission, we may have two rounds here because I want to ask another question and I want to turn it over to you. Why does VA seem to be about the only federal department or agency that does its own police training? Everybody else that we can discover does it at the FBI or the Federal Law-Enforcement Training Center. Why can't the VA train there also?

Mr. BAFFA. Yes, sir, that is a very good question and I'd like to expand upon that. I'm not sure that Justice does any training of federal police officers, but I could stand corrected on that. The VA police have duties beyond traditional law enforcement. They're also part of the patient care health team. I'm going to go on record as saying that I think what FLETC does, which is Glyngo, does an outstanding job in training their police officers. They have an eight-point program in training and the sum of their training equals the parts of their training, and that training is broken down into many different facets one of which is firearms training.

Up until this date we have not had firearms training as a standard procedure. It is my feeling that when you expose our VA police, and you have to understand that at Glyngo in these training classes which I believe are made up of 40 students per class in basic training or thereabouts, that only a small percentage of them would be VA police, four, five, six, maybe as little as one or two. They would go in there with the expectations of seeing other police officers trained in the use of weapons, and again, that's one part

of the big equation and the expectation is when they return back to their station would not be there because we do not arm our police.

In addition, Title 38, Chapter 9, states that training, referring to police officers, will have emphasis on situations dealing with patients, patient health care. We're a unique team. Again, I'd like to give you an example of what I'm referring to instead of just words. Recently I took the Chief of Staff up to the Bronx to witness the pilot program and what we were doing. A gentleman came through the magnetometer carrying a knife, highly intoxicated, large man. Caused a lot of programs. If we can have the police officers trained in patient care, under most circumstances he probably would have been arrested. But the fact is, he is there at that hospital seeking treatment for what he was manifesting. As soon as he was subdued, and I don't mean physically, I mean just talked about giving his weapon away, he was put in a wheelchair and taken to the emergency room where he got treatment. They would not teach that at FLETC. You know, some would argue that—and it's not an argument. Again, I take that word back. Some would say, well, why don't you do like other law-enforcement agencies do, after the initial 8-week course then send them to the VA and train them for 3 weeks? I would do that and will entertain doing that if in fact some barriers are taken down, one being which the VA decides to arm all of its police officers because then the training would be congruent and conducive to having a second phase of training.

Mr. EVERETT. Let me just close this round by saying that I don't know if you're familiar with the term "Q Courses," which the military uses that very same option. They do primary training in a number of fields, helicopter training, fixed-wing training, etc., etc., and then they send people on to specialized training, and they've found that quite cost-effective. At this point let me turn it over to my friend the ranking member, Mr. Clyburn.

Mr. CLYBURN. Thank you very much, Mr. Chairman. Let me begin, Mr. Chairman, by stating that in preparation for this hearing this morning the subcommittee staff contacted the American Hospital Association to try to understand the degree to which private-sector hospitals arm its law-enforcement and security personnel and the steps taken by private hospitals to decide whether it's necessary to arm its officers. In this regard, the AHA suggested we contact Mr. Fredrick Roll, a member of the American Society of Health-Care Engineering who has extensive expertise in the field. Scheduling conflicts precluded Mr. Roll from testifying in person before the subcommittee this morning. We are especially grateful to Mr. Roll, however, for agreeing to provide a letter and supplemental materials relating to work place violence and health-care security issues to be included in the record for today's hearing. Mr. Chairman, I move that Mr. Roll's correspondence and supplemental materials be included in the record of today's hearing.

Mr. EVERETT. Without objection, so ordered.

(See p. 92.)

Mr. CLYBURN. Thank you, Mr. Chairman. Mr. Baffa, the main thrust of Mr. Roll's concerns with arming law-enforcement personnel at VA facilities appears to be a belief that any decision to arm VA hospital officers should be based on a thorough case-by-case

needs-based analysis of the individual VA facilities. In Mr. Roll's view, and I might add, in my view as well, a blanket plan to arm officers at each VA hospital would be ill-advised. Do you share Mr. Roll's concerns in this regard?

Mr. BAFFA. Sir, I'm not going to comment on Mr. Roll's view point because I haven't seen anything he has to say, but I will comment on what your view point is, and I agree with you 100 percent. We are not out to mass arm everybody nationwide in the VA police. One of the reasons we developed a pilot program was to take five hospitals, five geographical areas, that had high crime rates and test the system out. It's an ongoing testing system. No decision has been made to blanketly arm all VA police nationwide. We're not ready for that, and I will be the first one to tell you we're not ready for that. That has never been my intention, that has never been the Secretary's intention. Again, it's called a pilot program because we're exploring possibilities. We've done the same thing with the K-9 program. Not all VA hospitals have dogs, and it's a voluntary program.

Each hospital that's participating in the pilot program volunteered to participate in the program because they just felt that they had needs and issues that only an armed police officer could handle. I have one of those directors right here who maybe would like to expand upon it if you'd like, sir. But to answer your question, I agree with you.

Mr. CLYBURN. Absolutely. Let me say this is the director of the Jackson facility.

Mr. BAFFA. That's correct. Yes, sir.

Mr. CLYBURN. You came to this conclusion by using a regional approach wherein there were—I'm assuming that you're saying that the areas around the medical centers are areas of high crime rates is what you're saying? Or did you mean high crime rates in the region?

Mr. BAFFA. Well, on all accounts that's correct, sir. When we started thinking about arming our police officers, I wanted to choose five hospitals geographically located across the country by region. I wanted to have five hospitals that I knew that the police force was where I thought it should be before we would commence or begin a pilot program. We also looked at the crime rate at those facilities. We don't determine the crime rate. The Federal Bureau of Investigation does that. What they do is, they have a statistical, and I don't have the formula with me, sir, that shows how many crimes are committed per 100,000 population and it comes with a figure.

I personally chose New York City as kind of like the base line, the border line, and their crime figure came as 7. All five facilities that we chose had a crime rate higher than the 7 as I articulated to you just a few seconds ago.

Mr. CLYBURN. Did all these places have incidents? I know about the incident at Jackson. I think you mentioned one that I'm familiar with in 1992 I saw in something here at the Columbia, SC facility.

Mr. BAFFA. That's correct. Yes, that was looked at also. They had incidents, and we have to rely on the local staff, i.e., the directors and what-have-you. I can come into any facility and make a rec-

ommendation, but you have to know the pulse of the facility and that's why we work with the local community as well as the police forces involved.

Mr. CLYBURN. I guess that's what I'm getting to here. You mentioned you selected facilities where the police forces were ready. What do you mean ready?

Mr. BAFFA. Well, you issued your concern. That was just one of the criteria. The criteria was that the local hospital director and staff wanted to participate, number one. We do a cyclical inspection. Every 3 to 4 years we check the hospitals and how they're operating their police force. Obviously, we have 169 hospitals, some are better than others. Of the people that volunteered, I picked what in my view point was the best facilities and best police officer management program in the nation because I want like you to succeed and I did not want to jump in and just randomly pick some people and arm them. I figure if we can make it work with the best of people, then we can look and give it to the Secretary to look beyond.

Mr. CLYBURN. I guess what I'm trying to get to here, if you're using as part of the criteria crime rates, incidents, a well-managed hospital, I guess my question is, what methods of evaluations did you use to determine the readiness levels at each of these facilities?

Mr. BAFFA. We do a series of program reviews. I send my people who are not affiliated with the hospital out to that hospital to review how the police are operating both administratively and technically. And that deals with everything, the proper training, they are doing their proper training they're required to do, they are rotating their shifts, everyone is getting the opportunity to perform the same duties on a 24-hour-a-day, per week basis, 24 hours a day, i.e., we change shifts every 3 or 4 months, we look at management's philosophy about the police, we talk to the local police community. After we have done that and it meets the first check point, makes the first cut, we then do physicals on all the police officers, we do psychological testing of all the police offices. We come back in and we give them a boiler plate standard operating procedure. We talk to the unions, we talk to the staff, and we talk to everybody, the veterans, the service organizations, everybody that's going to be involved. At that point and that point alone do I then give the blessing that that would be one of the pilot sites, and that all happens before we begin starting the training of our police officers.

Mr. CLYBURN. So, that was in preparation for this, but this is not standard operating procedure?

Mr. BAFFA. The cyclical visits to see if the hospitals are working is done every 3 to 4 years. In addition to that we do the other things. You're talking about the arming of the police officers. Correct?

Mr. CLYBURN. What I'm trying to determine is in your initial determination here you indicated that one of the criteria right at the top of your list was the readiness of the police officers.

Mr. BAFFA. Of the police officers.

Mr. CLYBURN. And I'm trying to determine how you got to that conclusion that this group is ready and that group is unready.

Mr. BAFFA. By all of the above, sir. By all of the above. I do that at each facility.

Mr. CLYBURN. Yes, and I ask is this standard operating procedure or is this something you did in preparation for being here this morning in arming your police officers? Is this something that you do? Now, you say you do it every 3 or 4 years, and all I'm saying to you, sir, is it seems to me, and I'm sorry, I'm one of the few guys who came to this Congress outside of the legislative process. I came here from management.

Mr. BAFFA. Yes, sir. Right.

Mr. CLYBURN. And so when it comes to administration and management you're going to find me a little bit different from a lot of people who are in elected office. And so what I'm trying to do is determine whether or not you got to this point this morning through standard operating procedure or whether or not you decide that this is where I want to get, let me go out and find some places that will get me there.

Mr. BAFFA. It is standard operating procedure for us to do cyclical inspections of the hospitals to see if they are operating in a satisfactory manner. Now, there's different levels of satisfactory. It is standard operating procedure for a police officer to go through a physical on an annual basis. It's standard operating procedure to do psychological testing on whether an individual could be a police officer on an annual basis. What I did to implement the pilot program is go above that and do all the things that I previously articulated to you to assure in my own mind that these police officers at this facility were ready to be armed which is a question that a lot of people—how do you know these police officers are qualified to be armed. Based on all the things I just articulated which is above and beyond what we do is how I made that determination. Yes, sir.

Mr. CLYBURN. How was the determination made to use in the future, whether it's near future or I don't know, but I understand that one of the facilities selected for the future is Hampton, VA.

Mr. BAFFA. That's correct. I did the same thing. I knew from previous experience and previous inspections as I referred to you that that police department was operating in a top-rate fashion that fulfilled my requirements of what I think a police department should be.

Mr. CLYBURN. They've never had any incidents?

Mr. BAFFA. No, sir. But you have to understand that what I wanted to do because it is a pilot, it was not something cast in stone, we have 169 hospitals in 169 different locations. We have some hospitals that are very large. We have some hospitals that are very small.

Mr. CLYBURN. Is this a very small hospital?

Mr. BAFFA. Yes, sir, it is.

Mr. CLYBURN. And I understand that the crime rate in and around this hospital is very low.

Mr. BAFFA. It depends on what your definition of low, sir, is. It's below the 7.

Mr. CLYBURN. All things are relative. It's relative to what you'd find in New York.

Mr. BAFFA. That's right. It is below the 7 of Manhattan.

Mr. CLYBURN. Right.

Mr. BAFFA. Yes, it is below the 7.

Mr. CLYBURN. Is it 5, 6, 8?

Mr. BAFFA. Sir, I'll have to get that information back to you. It's on the tip of my tongue. I don't have what the crime rate was there.

Mr. CLYBURN. Thank you. I guess once again what I'm asking, we're now walking through all this criteria that you've laid out here and I'm trying to see how Hampton, VA fits.

Mr. BAFFA. Okay. I chose Hampton, VA, and sir, I hope I don't confuse or muddy the waters any more. If you were to ask me places that I thought that we would have armed confrontation at our facilities, I would have never chosen Lake City, FL, and we had a police officer shot there. I would never have chosen Albuquerque, NM. We had a police officer killed there. I would never have chosen Brecksville, OH, which is a two-facility hospital, we have one in Wade Park which in down in the inner city where all the police officers around—you know it's a hospital complex, the vast majority of the police officers at facilities other than VA are armed. I would have thought that that would have been the place that the police officers would have been shot. They were not shot in Wade Park. They were shot out in the suburbs at Brecksville.

Mr. CLYBURN. Go right ahead. I just don't want to encroach upon my Chairman's time.

Mr. BAFFA. If I had a crystal ball, that's where I would put the armed police officers. Matter of fact, if I had a crystal ball I'd be at the Preakness Stakes Horse Race—you can't determine that. The statistics will lie to you is what I'm saying.

Mr. CLYBURN. We understand that, and I think what our concern is is that we don't initiate some emotional reactions to things. None of us want to see any police officer shot, injured in any way. What we also do not wish is for us to in search of a remedy that would create greater harm. And I'm not too sure that we've not had these kinds of situations in Sunday school on Sunday mornings. I read of somebody being shot while sitting in Sunday school or something. Things like this happen. That's part of the problem we have in our society today, but we don't want to arm all the ushers in church to make sure no one gets shot on Sunday morning. And so we've got to be very careful. That's what I'm saying, that we have to be very measured in this, and I have two big problems, one expressed by the Chairman, and that is, those of us on the subcommittee, we want the best VA system that we can have and we are very concerned that if we are looked upon as having some entity out there separate and apart from everybody else doing its own thing, that can cause us some real problems here in this Congress and also with the public as well, to have your own training.

And as the Chairman has said, there are some things about being a police officer that are standard, and I don't see anything wrong with having that training standard and everybody having the same training in the same way by the same groups and having supplemental training for the hospitals. But to have everything over here and have some incident come up and have us coming in here and having people from Quantico or other places and come in here and say, well, that's not the way you do that, you're supposed

to do it this way, this way and this way. And have somebody from the other academy telling us——

Mr. BAFFA. Yes, sir.

Mr. CLYBURN. Do you see what I'm saying?

Mr. BAFFA. Sir, I agree with you 100 percent, and I want to tell you that all the concerns that you have articulated here in front of me and as the Chairman has done, I have the same concerns you do. I'm not talking about the training. I'll discuss the training. But everything you've discussed before the training, I agree with you 100 percent, and I know the Secretary agrees with you 100 percent. What we're trying to do, and remember, this is a pilot program. This is not cast in stone. It is a measured, I hate to use the term experiment, but if you want to use the term experiment, that we're trying to see if in fact this will provide a safer hospital community or VA community. It's not cast in stone. I have the same concerns.

If anybody thinks that I think the answer to the question of crime on VA property is to arm everybody, that's not the issue. That's not where I'm coming from. That's not where the Secretary is coming from. It's a measured study that we're looking at. I am not saying I disagree with you so much on the core aspects, but what I do have a problem with is Congress and legislation telling me in Chapter 38, Title IX that training referring to VA police officers will have emphasis in situations dealing with patients. I agree with you that after the basic training course that you're talking about the core courses we could send our police officers to VA finishing school, for lack of better words. But my feeling is, and maybe my colleagues here from FLETC will disagree with me, and I will review it again. I looked at this issue in 1989 when I first came here. I thought it was a no-brainer. I came from an agency that trained at FLETC and I said, yeah, why not, and I wanted to look at it. Later it came to me that the functions that they perform are different than what the standard police officer performs on the street.

In addition to that, when you send somebody to a training academy, and you can talk of peer pressure and you say anything you want and you're teaching them one way of training which includes firearms which is a volatile issue. It's a volatile issue to this Committee; it's a very, very contentious issue with the police officers themselves. And you give them their basic training which includes firearm training or you omit the firearm training so you have 4 or more people who do not participate in police training, you graduate them, then what I would have to do I believe is send them to re-tread school. I would have to disengage some of the things they've learned and teach them the VA way.

I don't like the separatist status, what-have-you. If in fact we did arm the police officers, to me in total, the Secretary would make that decision, then to me that obstacle to include the training at FLETC would make FLETC very, very attractive to me and I would very, very highly consider it, and as I said, send my people after that to the finishing school. Poor choice of words, but what do they call the secondary? Follow-up finishing. Same thing.

Mr. CLYBURN. Follow-up?

Mr. BAFFA. Follow-up training at that perspective agency. I think FLETC does a great job. I totally agree with you.

Mr. CLYBURN. Let me yield to the Chair.

Mr. EVERETT. Thank you, Jim. At this point I'd like to introduce another member of our Subcommittee who also like myself and Jim does not come from a political background, and that's Dr. Snyder. Do you want to jump in here?

#### OPENING STATEMENT OF HON. VIC SNYDER

Mr. SNYDER. Yes, thank you, Mr. Chairman. Being on the National Security Committee I have to choose between paying attention to the active side of the military when we have meetings at the same time or the veterans' side of it and what I end up learning about is the traffic patterns on Pennsylvania Avenue as I run back and forth between meetings. So, I apologize for not being here, although I looked over some of the statements that we were given earlier this morning and have some familiarity I think with what's going on. Just a couple of questions or comments. As having both at medical school in Portland, Oregon and then in my residency in Little Rock, I trained at VA's and my experience there is that in both those campuses as far as I was concerned and the civilian world was concerned, you couldn't tell when you slopped over from VA property onto State hospital grounds onto the medical campus that was run by the State.

In Little Rock I do ride along with a police officer sometimes and we had a little fender bender and the police officer had to spend time on the phone for about 15 minutes trying to determine was it State grounds, federal grounds or city-run streets. Those of us who roamed through those campuses, we have two or three law-enforcement folks that we run into. You run into your city folks, you have your State medical center police, and then you have the VA folks, and frankly, I didn't realize until the last 48 hours that the VA police were not armed, and I think there has to be a certain consistency there. I guess what I'm saying in a big way, I don't see much problem with you going ahead with your VA police carrying firearms because frankly I think that would have been the expectation at those campuses since you already have officers from the other facilities carrying weaponry. That's just a comment. Any comments you want to make would be appreciated.

The second point I wanted to make is, and now I am somewhat biased I think, Mr. Chairman, being a family practitioner who trained on those facilities, I think regardless of where the geography is where they're trained at, the facility is in North Little Rock I think, I think the treatment model needs to be part of the training from the get-go on these officers. For example, and you all I think have discussed one example, that of the inebriated fellow who comes through the door. But obviously if you see a naked guy on the street in downtown Washington, DC, your attitude toward him is going to be different than if you see a naked guy staggering out the front door of a VA hospital. I mean, hopefully we will approach those fellows differently, and I think that from the get-go you've got to have a different imprint in the minds of your hospital-oriented police officers, and I'll have to leave to your training experts whether that means unlearning some things that traditional police officers would learn. But I know that at the facility now, wherever it is, that they currently are actively using people from

the VA hospital that come over and talk and they stage simulations of incidents that are going to occur in the hospital from the very beginning, and I'm sure that that's going to be a different type of training than if you're training people for 72 other agencies. But that's a lot of rambling. Any comments you might have on any of that I'd appreciate.

Mr. BAFFA. Sir, I'm very glad that you made those statements because that is exactly the philosophy I have. I think that people talk and statistics being given about unarmed percentages I think Mr. Clyburn gave me, in a lot of cases security guards aren't armed. But I will use Miami or Cleveland, they have a security guard force and they're supplemented by the Miami Police. In one case it's a substation of the Miami Police on the hospital grounds. We have to understand that the VA police are there as much for patient care as they are for law enforcement, and it's a different type of law enforcement.

You used an example, and I'd like to use another one, of my days in the Secret Service. If we're outside the White House and you saw somebody inebriated or naked, as you say, you had three choices. You could tell them to move on and hope that his family would take of him; you could arrest him for disorderly conduct; or you would send him to St. Elizabeth's. But most of those kinds of manifestations that happen on VA grounds are by veterans who are there for that very treatment and we combine law enforcement with the health-care community, and it has been my opinion but I will readdress it again, that if we send people down to a training academy first learning street police work for lack of better words, street police work, and we build up their expectations and we don't allow them to carry firearms or participate in firearms training, then I'm going to have a heck of a time when you bring them back to try to debrief them and get them into the health-care mode.

Mr. SNYDER. But by the same token, if we have any evidence that the training that you all are doing is not adequate to deal with a true street situation—I mean for example, I know that there are sometimes nurses coming off work at hospital facilities are kind of preyed upon—

Mr. BAFFA. Right.

Mr. SNYDER (continuing). By some bad actors out there.

Mr. BAFFA. Right.

Mr. SNYDER. Have we had any indication that the training you all are doing on your VA police has not been adequate to handle those kinds of situations, and if so that certainly is a dike that needs to be plugged.

Mr. BAFFA. Sir, when I first came to the VA we were inadequate because we were only giving them 64 hours training per year. We were absolutely, positively inadequate. We have developed a training course now which is 160 hours, and other than not being able to respond to a patient or an individual because we can't get close to them because we're being shot at, I know of no cases where we have not effectively responded to a situation.

I guess I'm going to tell you if I might have the liberty of one of the grievous cases that very, very concerns me totally when you talk about arming the officer or not arming the officer, what-have-you, and it happened a couple months ago in Dallas, Texas. And

we had an ambulance driver, ambulance team, bring a patient in on a routine case for surgery on a Monday morning. This was Sunday night; it was Monday morning. After they dropped him off, an individual came on the grounds with a shotgun and burst into the emergency room. This ambulance driver was there, had nowhere to go. He was a male, his accomplice was a female—not accomplice, his partner was a female, and this man was brandishing a shotgun. The VA police responded. They evacuated. As they tried to get near the guy or talk him out of it, I'm not going to use the language he used, put the gun to the female's head, "If you get any closer I'm going to . . ."—I'm not going to go any farther, but you can imagine what he said to her. They backed off and they called the police to respond. During that time he told the female ambulance attendant, "Go out and get the ambulance and bring it here." The male ambulance attendant said, "Let me do it." He said, "I'll kill her." The male went out. At that time the guy let one round off in the hospital with the shotgun. Our police could not get any closer because every time they got closer he pointed the weapon at them.

To make a long story short, he kidnapped her before armed police could respond. He tortured her and raped her. Now, to me that is wrong and we should not allow that to happen. And I think that if we do this right, and Mr. Chairman and Mr. Clyburn, I want to do what you want to do and I want to do it right. I think we can prevent things like that from happening without endangering our veterans or our customers, and I fully believe that.

Mr. CLYBURN. If I may, Mr. Chairman.

Mr. EVERETT. Certainly. Go ahead, Jim.

Mr. CLYBURN. I've always had a real, real problem with making laws and rules and regulations based upon anecdotal stuff. That's a horrible situation, but you know, at the VA Hospital Center in Columbia the incidents like that were domestic. We've had a few of those. Now, I don't know if that was the 1992 instance you're talking about here, but were the husband and wife causing the problem?

Mr. BAFFA. No, that's another incident. The one in Columbia that I'm familiar with is when the niece called and said the patient had gotten the bus and was coming to kill the doctor because he didn't give him the right prescription that he was looking for. The bus stopped right in front of the hospital as you're familiar with.

Mr. CLYBURN. Right.

Mr. BAFFA. The VA police called the Columbia—have them help respond. Unfortunately, he was on the bus. He was literally on the bus. The VA police confronted him and a police officer was shot.

Mr. CLYBURN. Well, that's what I'm talking about. When the wife called why was not the Columbia Police Department called?

Mr. BAFFA. They were. They were busy and could not respond. They did respond. The Columbia Police Department did respond too late. That's not the fault of the Columbia Police Department. They had their police officers doing other things.

(See attached letter.)

DEPARTMENT OF VETERANS AFFAIRS,  
DEPUTY ASSISTANT SECRETARY FOR SECURITY AND LAW ENFORCEMENT,  
Washington, DC, June 24, 1997.

Hon. TERRY EVERETT,  
Chairman, Subcommittee on Oversight and Investigation, Committee on Veterans'  
Affairs,  
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: After reviewing the transcript of my testimony of May 22, 1997 during the hearing on Safety and Security. I realized that there was an error in my testimony relative to the events of the police officer that was shot in Columbia, South Carolina. I confused this incident with another shooting incident that occurred at one of our facilities in the South.

In my testimony, I stated to Congressman Clyburn that the City of Columbia Police Department was notified but they responded too late to avert the shooting. This was incorrect. The VA Police did not have time to call the Columbia Police Department as they had to rush to the main hospital entrance where the alleged subject was to arrive on the scheduled bus, as telephoned in by the suspect's niece a minute earlier.

The Columbia Police Department responded within a few minutes after they were notified of shooting. I am sorry for any inconvenience this error might have caused.  
Sincerely,

JOHN H. BAFFA

Mr. CLYBURN. I understand. I remember the incident and I did not believe, once again to deal with it anecdotally, that that incident although it's mentioned here, I think there was a much better response than the VA officer having a gun. Now, my mind is not made up about whether or not they ought to be armed. That's not my problem here.

Mr. BAFFA. I understand that, sir.

Mr. CLYBURN. My problem here has to do with training—

Mr. BAFFA. Yes, sir.

Mr. CLYBURN (continuing). Has to do with recruitment.

Mr. BAFFA. Yes.

Mr. CLYBURN. It has to do with whether or not the officers that you have hired when you recruit them where they come from. Drug testing. Training. All of those things that ought to go into trying to determine whether or not this is the kind of person that ought to be a police officer.

Mr. BAFFA. I agree with you, sir.

Mr. CLYBURN. And then once the decision is made on this person, what kind of training this person will have before having this supplemental training I like to call it that would be required for the VA. Because let me tell you something. It may not be in your records, and you may not recall these incidents, but I know of more than one incident on a facility at the VA that had absolutely nothing to do with anybody that wanted to rape anybody, it had to do with a husband and wife that wanted to get rid of one another, and one of them happened to work at the VA hospital and the incident occurred.

Mr. BAFFA. Absolutely. Domestic disputes are horrible.

Mr. CLYBURN. That's right. Now, the problem here is that we all know that that's the worst kind of situation to be in with a gun.

Mr. BAFFA. Absolutely. Absolutely.

Mr. CLYBURN. I certainly know that. And there's a lot of that going on at the VA's. So, I want to be very, very careful and measured about this, and that's my real concern here. So, I certainly don't want us without any empirical data to get into this just be-

cause we've had some incidents, just because somebody's emotions are running high, just because we have a lot of handcuffs to throw around. I just am very careful.

Mr. BAFFA. Sir, I agree with you and I would like to make one comment, and the Director of Jackson would like to say something. The decision to arm VA police officers was made well over a year ago and before any of these incidents, i.e., what happened in Albuquerque, NM, what happened in Jackson, MS occurred. That decision was made I believe a year and a half ago to begin the implementation of pilot test sites. So, it wasn't a knee-jerk reaction type situation. And I will say that, and I personally tell you that I agree as does the Secretary with all your concerns. I'd like to turn over one thing to Mr. Miller.

#### STATEMENT OF RICHARD MILLER

Mr. MILLER. Thank you, Mr. Baffa. I'm Dick Miller. I'm the Director of the G.V. "Sonny" Montgomery VA Medical Center in Jackson, MS, and I too, Mr. Clyburn, have the same concerns about arming VA police. And I can say that yes, there was some emotion involved in that, but we went through an awful lot of agony and looking at our organization, a lot of fact-finding before I asked Mr. Baffa to present our consideration to the Secretary for arming our police. We have 17 police officers presently at the Jackson, G.V. "Sonny" Montgomery VA Medical Center. Sixteen of those have prior police experience. Eleven of those have been with the VA for under 6 years. Sixteen of those have been at the VA for under 10 years. Combined they have 247 years and 2 months of police experience. Of that 247 years and 2 months, they have 67 years and 7 months in the VA. Our average experience of our police force is 14.5 years. They have all or will in addition to having that experience in recognized police organizations in the country, they will go or have gone through the now 5 weeks training at our police academy.

One of the significant considerations was the quality of the police force at Jackson that helped me in changing my opinion about arming our police force in the hospital. A hospital is a place of healing. There's no doubt about that. But in some areas when the sanctity and the sanctuary of that has been violated as it has been, our staff and our community cry out for something.

Mr. CLYBURN. May I ask you a few questions about your police force? Tell me a little bit about how you hire those people.

Mr. MILLER. Ironically, sir, it started about 5 years ago, just a couple years after Mr. Baffa started to initiate a lot of changes. We had a police force that did not have very good, effective leadership. It was not very schooled, did not have a lot of experience, and it happened before I got there. I've been there just about 3 years. It will be 3 years this August. But the then chief operating officer, my associate director, had already started to initiate the change in the improvement. We started by being very fortunate in hiring a man that had extensive military experience, 22 years, as our police chief.

As I mentioned to you, we have 11 police officers that have less than 5 years' experience in the VA. We have 16 police officers that have less than 10 years' experience in the VA. So, with our search-

ing for those experienced personnel and having those people that qualify but also came to us with tremendous experience, we were fortunate to select very talented, well-trained, formerly exposed to the academy police officers.

This is ironic, but since the terrible event February 19th of this year with the murder of Dr. Carter and the suicide of Mr. Bowles, a veteran, the number of applicants in the OPM area in Georgia has gone up. The type of quality that we are receiving has gone up. We've hired three police officers with experience from the City of Jackson. Quite frankly, they came to us I believe because of the unfortunate press we had about the questions we had of why weren't our police officers armed and the fact that I said that I was going to increase my police force by at least 50 percent. And I just talked to one of them the other day who had 14 years of police experience in the Jackson Police Department, and I chatted with him, asked him about his family. And he said, "You know, Mr. Miller, I can't believe how wonderful a place this is and how caring the people are. And I'm so happy to be here because it's the first time in 12 years I feel good about coming to work." So, our mission is a healing mission, and that is what we're there for.

Mr. CLYBURN. But didn't he carry a gun when he was with the Jackson Police Department?

Mr. MILLER. Yes, he did. And every one of these people I'm talking about carried guns in some police force.

Mr. CLYBURN. That's maybe why he feels so good about coming to work.

Mr. MILLER. No, he's referring to what he was going through when he was on the streets.

Mr. CLYBURN. I'm just being a little bit facetious.

Mr. MILLER. Incidentally, I'm remiss in that I'm late in coming here and just presented the Committee with a statement and I'd like to have that included in the record if I could.

Mr. CLYBURN. Without objection.

[The prepared statement of Mr. Miller appears on p. 239.]

Mr. CLYBURN. Do you have drug tests and that kind of stuff for the police officers?

Mr. MILLER. The present system of drug testing that we have in the Veterans' Administration for our employees are for new hires by random pulling of their social security number, and I'm remiss in remembering the date, but sometime this summer we will go to the random testing for all employees. So, it won't be just new hires. But our police officers go through an extensive physical once a year, and they also go through a psychological assessment and if that psychological assessment indicates concern for further psychological testing, that's done.

Mr. CLYBURN. Is that done annually?

Mr. MILLER. Yes, sir.

Mr. CLYBURN. The psychological testing?

Mr. MILLER. Yes, sir.

Mr. EVERETT. In the previous question did I understand that it is for new hires but you would also include people on the force?

Mr. MILLER. Sir, right now all new hires are randomly tested.

Mr. EVERETT. How about out of the folks that have been there a while?

Mr. MILLER. Beginning this summer all—and I don't know all the different categories, but the police officers are included in that category, will be subject to random drug testing. In addition with police, if the chief of police notices something unusual about that behavior pattern of that officer, he can mandate that that police officer be drug tested.

Mr. EVERETT. I'm going to ask you to notify this Committee when that happens, and notify this Committee in any event in 90 days.

Mr. MILLER. Yes, sir.

Mr. EVERETT. Mr. Miller, I recognize that you don't have a crystal ball and perhaps you've not talked to all hospital directors across the nation or done a survey, but if I asked you today to make an educated guess or an opinion, would you say that other directors are in favor of arming their police officers, the majority of them, or the majority of them would be in disfavor?

Mr. MILLER. I can speculate that those directors perhaps are at the same position I was prior to February 19th of this year and maybe would not do that. But I also feel very strongly that, again, it wasn't an emotional reaction. It was a very thorough, studied reaction. We talked to our complete medical staff, our nursing staff, other staff, members in the community, opinion leaders in the service organizations and in the community, and I lost a lot of sleepless nights debating. But I can tell you that one thing that continuously rings in my head is that staff physician looked at me and said, "Mr. Miller, something may happen to us outside the walls and doors of this institution, but we have 120 physicians, the system has 26,000 physicians. The two most violent acts against physicians in our system in the last 5 years, and indeed in the last 3 years, happened at the Jackson VA Medical Center." We can't look anyone else in the face, I can't look at another wife and a 12-year-old and a 6-year-old child in the face and say I didn't do everything I possibly could to make the environment a sound and safe one. And I'm not foolish to think that guns are going to stop things like that. If somebody wants to do that, they're going to do it. But I think for the psychology of the organization that's been wounded gravely and will have a tough time going through this, that those steps are necessary at the Jackson VA Medical Center.

Mr. EVERETT. While I appreciate the position that you're in, the ranking member and I are both very sensitive though about this camel getting his nose under the tent, frankly.

Mr. MILLER. Right.

Mr. EVERETT. And these things have a way, and this is my third term. As Jim said earlier, we both come from nonpolitical backgrounds. I spent 30 years in the newspaper business and the business world before coming here, and I'm not sure that we can in the society we live in today have everybody walking around with guns to protect society. And I understand the heartbreak, I know some of it personally, that comes along with having to look a wife in the face and tell her or her loved one, the patient, and tell them what's happened. I understand we've got five test pilot programs underway right now with three others planned.

Mr. BAFFA. Sir, effective today we have six. We just started Hampton today. And I'm looking at with Jackson, they'll on line in a couple of weeks. That would be seven. And the Secretary has au-

thorized me to look to do up to 10. The only decision I have made has been on those seven. I have not made a definite decision on the additional three at this time. I haven't had time, to be honest with you.

Mr. EVERETT. I would also request to you that if as you begin or make the decision to put any other facilities on line that this Committee be notified.

Mr. BAFFA. Absolutely. Yes.

Mr. EVERETT. In addition to that, I would like to know prior if a decision is made to expand this program, the pilot program, beyond its current confines.

Mr. BAFFA. Yes, sir. Yes, sir.

Mr. EVERETT. Let me get a couple quick questions and then if Jim doesn't have any more to answer we'll move on to a couple other things. The VA policy on the pilot programs says shooting incidents will be reported immediately.

Mr. BAFFA. Absolutely.

Mr. EVERETT. Who are they reported to and what does immediate mean?

Mr. BAFFA. Immediate means as soon as the situation is neutralized and everybody is safe, they are to pick up the phone and notify the local FBI, my office which has a 24-hour answering capability with an answering service. We have Mr. Harper who works for me and a duty agent assigned, rotating duty agent, and the Secretary of Veterans Affairs will be notified.

Mr. EVERETT. I would ask that in the immediate notification that this Subcommittee which has oversight in investigation be notified and given full details of any such occurrence and that we be put on the immediate notification list.

Mr. BAFFA. Yes, sir.

Mr. EVERETT. I want to ask. I recognize it's hypothetical and I don't like answering hypothetical questions myself, but nevertheless it is one I think like that we must bring forth. That is, what circumstances would it be proper for an armed VA police officer to kill a veteran in a VA hospital? And don't tell me that that's not a possibility because we all know that it is a possibility.

Mr. BAFFA. No, sir, I know it's a possibility. As I said, I have been in law enforcement for 27 years and unfortunately was involved in a shooting and it's not a pleasant site.

Mr. EVERETT. I understand. I have relatives that are in law enforcement too and I know exactly where you're coming from.

Mr. BAFFA. Mr. Chairman, I am going to answer that question. I'm not going to try to sluff it. I'm going to give you an answer. But the first thing I'd like to say is that our VA police officers, we've come a long way and I think we've got a good force and I know it's not always important what I think, but it's what you think, and I invite you to come out to our facilities at any time and look at them. Our VA police don't want to kill anybody, and I don't think there's a law-enforcement agency anywhere that wants to kill anybody.

Mr. EVERETT. I would suggest to you that no law-enforcement officer would want to kill anybody.

Mr. BAFFA. That's correct.

Mr. EVERETT. Let me finish, please.

Mr. BAFFA. Sorry. Excuse me.

Mr. EVERETT. My question is very direct. Do you have criteria of when a VA armed officer would be allowed to kill a veteran in a VA hospital? And be as direct as you can.

Mr. BAFFA. All right, sir, I'll be very direct with you. Officer Hoerst Woods was a police officer and a veteran. I think it would have been proper for him to shoot at his assailant who was a veteran.

Mr. EVERETT. And anytime we shoot we assume that we're going to kill someone——

Mr. BAFFA. That's correct. We shoot to neutralize.

Mr. EVERETT (continuing). And we should not shoot otherwise.

Mr. BAFFA. That's correct.

Mr. EVERETT. Jim, before we leave his do you have anything else you'd like to——

Mr. CLYBURN. Yes, sir, I have two——

Mr. EVERETT. Certainly. Go right ahead.

Mr. CLYBURN (continuing). Issues I'd like to cover. First of all, Mr. Chairman, due to last minute notice, the International Association of Fire Fighters has asked to submit testimony by Friday. They will discuss the status of fire departments at VA facilities. I ask you now to accept that their testimony be part of the hearing.

Mr. EVERETT. Without objection. So ordered.

[The testimony of the International Association of Fire Fighters was not received by the subcommittee.]

Mr. CLYBURN. Also Mr. Chairman, we had this information submitted to us. There are some things in here that I think may be of assistance to us with this hearing here today. I ask that this document be made a part of the record.

Mr. EVERETT. And that is a document from the Department of Veterans Affairs?

Mr. CLYBURN. Yes, sir. It's in the record.

Mr. EVERETT. It's in the record now? Yes.

(See p. 92.)

Mr. CLYBURN. Thank you. Let me ask if I may about the incidents. When you have a pilot project you're trying to gather information and that information is to be used for the purpose of establishing first of all whether or not you're going to go forward with a broad application of this and if so how you're going to do it. I'm a little bit concerned as to how will you determine whether or not this pilot has been a successful pilot and the conditions that you will find which will determine whether or not you go with a measured program, that is, a center-by-center program, or a program for all of the centers. Have you all developed an instrument that we could have or that we would know would assist us in being a little more intelligent about what it is you're doing?

Mr. BAFFA. Absolutely, sir. We're in the process of developing the criteria used to be made in the evaluation. It will include at this present time but not limited to the amount of activity, i.e., more police stops, more proactive law enforcement being accomplished. We will talk to the service organizations at the facilities. We will talk to the veterans at the facilities. We will talk to the local communities, the local police. We will talk to the staff. And we will then document all incidents as you articulated. We will compile

that. We will meet with Dr. Kaiser and the Secretary, give him the information now that you've asked, we will give you the information, and that's how we will make the determination.

Mr. CLYBURN. When you're saying incidents, let's just suppose that during this time frame, I don't know what the time frame is.

Mr. BAFFA. Sir, initially it was going to be a year which would have ended October 1, but inasmuch as we've added five facilities, I'm going to ask the Secretary if we could extend it to February.

Mr. CLYBURN. February 1998?

Mr. BAFFA. Yes, sir.

Mr. CLYBURN. And then at the end of that period you're going to do some kind of evaluation of all those. Let's just suppose no incidents occur during that period. I would say that by most methods we use to measure things, we say, hey, outstanding program, exactly what we intended to achieve, no incidents, the thing is working, let's do it everywhere. Now, the problem with that is 5 years ago there may have been a period of 12, 18 months where no incidents occurred. So, tell me which one was successful, that period of time with no guns, or a period of time with guns?

Mr. BAFFA. Sir, that's an excellent question, and I think that I agree with you. If we went in with this preconceived notion of what we wanted to do as far as arm all the police officers you articulated, you would be absolutely correct and it would be valid for you to come back and say, well, what about 5 years ago when you didn't. That's not how we're looking at this. My goal is to protect the veteran the best way possible, and I assume you that before we make the evaluation we will give you all the information and give you the criteria and you being on the Oversight Committee, I'm sure you'll want to look into the criteria and have questions about it. This is an open, honest attempt. There's nothing under the blanket here. I'm not going to tell you that, yes, I think I would like to arm the police officers. But I do not believe, have never believed, that I want to go out en masse and arm police officers. I'm looking at this like I've looked at everything else as an action that needs to be taken and looked at.

I'll tell you, sir, when we developed the K-9 program and started putting dogs on campus, people accused me of being a brown-shirted Nazi because we were introducing dogs on campus. They had visions of Alabama and Birmingham. Our dogs aren't like that. They're passive-aggressive dogs. The problem we have now is the veterans want to feed the dogs and take care of them and keep them from doing their business. So, we have no preconceived notions of this, sir. I don't know if I'm under oath or not, but I am telling you we have no preconceived notions and we will allow this Committee to look at what our criteria is and how we made the decision.

Mr. CLYBURN. Do you have K-9's at every facility?

Mr. BAFFA. No, sir. It's an optional program.

Mr. CLYBURN. So, that was something left up to each director—

Mr. BAFFA. That's correct.

Mr. CLYBURN (continuing). As to whether or not he or she wanted K-9's?

Mr. BAFFA. That's correct.

Mr. CLYBURN. And the purpose of the K-9's, of making that option, what were the purposes?

Mr. BAFFA. You mean why did we leave it an option?

Mr. CLYBURN. Yes. Why did you even introduce it?

Mr. BAFFA. Well, for two reasons. I'm a firm believer, and as I go back to before, it doesn't do me any good to shoot somebody after they've already shot somebody else: I mean, I've shot the person who shot somebody. What we want to do is have preventive law enforcement.

Mr. CLYBURN. That's what I'm asking. So, the K-9's are part of some kind of prevention program.

Mr. BAFFA. Preventive.

Mr. CLYBURN. They're not sniffing in lockers to see whether there—

Mr. BAFFA. Excuse me, sir. Their primary functions are, number one, missing patient searches. We have a lot of campuses that are very large.

Mr. CLYBURN. True.

Mr. BAFFA. A dog is very effective in that.

Mr. CLYBURN. Right.

Mr. BAFFA. The second function is drug interdiction. Illegal drug interdiction.

Mr. CLYBURN. Right.

Mr. BAFFA. Those are the two primary functions of dogs on VA campuses.

Mr. CLYBURN. Well, that's what I was trying to get to.

Mr. BAFFA. Yes, sir. I'm sorry. I didn't understand the question.

Mr. CLYBURN. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you, Jim. Let me ask this one final question. As you know, the Veterans' Benefits Administration is co-locating some regional offices in VA medical center campuses. Am I correct in understanding that the co-located regional offices are contracting for their own security when the VA hospital police are already providing security on the same campus?

Mr. BAFFA. You're partially correct, sir. What has happened is that we had some facilities that were contracting out their services. They found out it wasn't working properly and they're now being monitored by VA police. There are two other facilities that I became aware that that was an upcoming issue that they were planning to do that. It was last November I became aware of that. I sent a document to General Counsel for some clarification on the legalities of that. I have not gotten a final response. I have Mr. Hall from General Counsel. And it is my belief that that whole issue has been resolved and is being resolved and that it's a co-located facility. We are one VA and that facility will be secured by VA police to the best of my knowledge at this date.

Mr. EVERETT. And you're telling this Committee that the VA security people will at some point assume all the responsibility for all of VA?

Mr. BAFFA. That is correct, sir, and if anything changes on that I will notify the Committee.

Mr. EVERETT. I appreciate it because I'll be honest with you, I don't know if this is a turf battle or what, but this member has had

about all the turf battles he can put up with during the last 4 years.

Mr. BAFFA. I agree with you, sir.

Mr. EVERETT. Let me move on quickly to—we will submit some other questions, by the way. We're very interested in the cemetery situation, the security there, and because of the length of this hearing and we still have panels to go to, we will submit some more questions for record concerning that. Mr. Ogden, if I may, in 1992 the VA's Inspector General made several recommendations for improving security at VA hospital pharmacies. Please briefly describe his recommendations and what you've done to implement them.

Mr. OGDEN. Good morning, Mr. Chairman, and I'd be happy to do that. In our testimony we elaborated on the issues that the Inspector General and the General Accounting Office and this Subcommittee identified in that time period, and the testimony I think articulates what we've done. What I would like to do is just summarize and say that the VA program today regarding, specifically, controlled substances and, less so but just as significant, noncontrolled substances, is certainly changed—it's a different world in 1997 than it was in 1991, and I think you'll see that what we said we were going to do we have done to the greatest extent possible. Some of the issues haven't been totally resolved because some of them are software driven, but I think we have procedures, policies, etc., concerning controlled substances accountability that are very stringent. Some of them are onerous to the staff, but I think you'll see by looking at the Inspector General cases that have occurred in the last few years that no significant volumes of controlled substances have been diverted, and we're confident that as we change the VA health-care system and move from a hospital-based emphasis to community-based clinics, etc., etc., that we will reassess our system and continue to address these very important issues.

Mr. EVERETT. Let me ask you, where do stolen VA drugs typically wind up, say from any particular institution? Does it stay in that community?

Mr. OGDEN. Well, I can just give you my opinion, maybe Mr. Baffa might give you his opinion. My opinion would be that probably both. It depends, if the stolen property is for personal use or for family members, or if it was large scale it would probably be for resale on the street.

Mr. EVERETT. Do you concur?

Mr. BAFFA. Yes, sir, and I will note that since the last hearing on drugs which I believe was 1992, we have not had a successful break-in burglary of any VA pharmacy. Any drugs that have gone away have been through diversion.

Mr. EVERETT. Is the problem generally inside though and not break-in's? Inside the VA itself?

Mr. OGDEN. You mean the problems of missing drugs probably has been, yes, sir.

Mr. EVERETT. How about security of prescription pads?

Mr. OGDEN. Well, I think the prescription pad issue is always going to be with us just like it's with society in the health-care system at large. We have modified the VA prescription form twice since 1991-1992. And in addition to that, we also have encouraged other alternative method of writing prescriptions to include elec-

tronic prescriptions as well as prescriptions specifically as written on computer forms that come out of our DHCP health-care system.

Mr. EVERETT. I appreciate the indulgence of this panel. We will have additional questions on a number of issues that we've discussed here today, and at this point I want to thank you again for showing up and we will now move to the next panel.

Mr. BAFFA. Thank you, Mr. Chairman.

Mr. EVERETT. Mr. Baffa, I realize that the VA's pilot program has essentially an evolving process. You've heard our concerns about arming hospital police, the department's undertaking an experiment and allowing the use of lethal force at its hospitals as a deterrent. Constant vigilance, close supervision by the VA during this pilot project is an absolute necessity. This Committee wants to be notified of any shooting incident as we mentioned immediately. Also please provide for our review your 6-month and 12-month evaluation of your pilot facts.

And with that we do welcome the next Committee, Mr. Joseph Wolfinger, the Assistant Director of Training Division, Federal Bureau of Investigation, and if you would please introduce your fellow panel members.

**STATEMENT OF JOSEPH WOLFINGER, ASSISTANT DIRECTOR OF THE TRAINING DIVISION, FEDERAL BUREAU OF INVESTIGATION; STATEMENT OF CHARLES F. RINKEVICH, DIRECTOR, FEDERAL LAW ENFORCEMENT TRAINING CENTER, DEPARTMENT OF TREASURY**

**STATEMENT OF JOSEPH WOLFINGER**

Mr. WOLFINGER. Well, my name is Joe Wolfinger. I'm the Assistant Director in Charge of Training for the FBI, and Charlie Rinkevich who is the Director of the Federal Law Enforcement Training Center at Glynco, GA, is with me.

Mr. EVERETT. If you will, Mr. Wolfinger, proceed with your testimony and if you would limit it to 5 minutes, we'll put your complete testimony into the record.

Mr. WOLFINGER. Certainly. Good morning Mr. Chairman and members of the Committee. I understand that I am here today to provide this Committee with information about FBI training, and specifically our firearms training program. The FBI's new agents training program is a 16-week course of instruction focusing in four core areas: academics, physical training, practical application, and firearms training. This equates to approximately 654 hours of instruction of which firearms training accounts for approximately 116 hours divided into 28 sessions. I think it is important to note that in general the mission of Special Agents of the FBI is different than that of a federal police officer and therefore our training is different. Agents are generally not first responders, nor do they routinely patrol. Likewise, our basic qualifications and selection process are different from other law-enforcement organizations.

A Special Agent's training does not stop at the conclusion of new agent's training. After reporting to their first office of assignment, a Special Agent begins a 2-year probationary period during which the new Special Agent receives on-the-job training from Senior Special Agents. During this period the new Special Agent is expected

to perform specific functions of his or her job to include testifying, writing affidavits and so on, and is evaluated on performance. If for any reason the probationary Agent is dismissed, there is no appeal. Additionally, all Special Agents are required to qualify four times a year with their issued weapons and the weapons they have subsequently been authorized to carry.

I would also like to clarify that the FBI does not certify or approve of the organization's instructions to include firearms training. We have in the past offered and provided FBI instructor training to personnel from other organizations. Having said that, I'd like to provide you with an overview of the new agent firearms training curriculum.

The primary mission of the firearms training unit is to train new Agents to become safe and competent shooters with Bureau-issued handguns, shotguns and carbines through a 16-week, three-tiered training program consisting of fundamental marksmanship training with all three weapons systems, combat survival shooting incorporating all three weapons systems on progressively complex and challenging courses, and judgmental shooting.

The firearms training unit at Quantico also administers firearms-related training programs for Agents assigned to FBI headquarters, the Bureau's 56 field offices, and the law-enforcement community.

During firearms training students will fire a total of 4,395 rounds. Nearly 3,000 rounds will be fired during the course of 19 sessions as students master basic marksmanship skills and qualify for the first of two required times with a shotgun, handgun and carbine. During the remaining nine sessions students will fire approximately 1,400 rounds as their skills are challenged during combat survival training in their preparations for final qualification.

The combat survival portion of the firearms curriculum includes judgmental training along with combat courses which include no shoot targets and other courses where students must work as teams to resolve complex shooting problems. Students are exposed to at least 12 computer-driven scenarios with which they must interact and if appropriate employ deadly force. Unsafe, unprofessional or inappropriate behavior during these scenarios or at any other time during firearms training may result in a recommendation for a new agent review board or outright dismissal.

Student performance is assessed constantly during firearms training. When appropriate, students are given individualized instruction. If a student should fail to qualify, they are given 2 weeks of intensive remedial training after which they are afforded another opportunity to qualify. Failure at this juncture would result in dismissal from training. I'm very proud to note that the Training Division of the FBI has not lost a student because of a firearms-related failure since 1990.

In addition to successful completion of the initial firearms training, all Agents are required to attend firearms training and qualify four times a year throughout their careers. A minimum of 1,000 rounds is budgeted for each Agent for this purpose during each year to ensure that our Agents maintain this critical but perishable skill.

Agents who fail to satisfy minimum requirements lose their authority to carry firearms until the deficiency is resolved and the risk of availability pay should that deficiency persist. Because the loss of pay is such a strong incentive, this has not been an issue.

As I said earlier, the new Agent firearms training curriculum consists of 116 hours of classroom and range instruction broken down into 28 sessions. These sessions are very much interrelated and complement training conducted by physical training, practical applications and our legal instructions unit. Our firearms training is multi-dimensional. It is concerned not only with an Agent's accuracy and proficiency with weapons, but also focuses on the relationship inherent to having the power and authority of applying deadly force. It is an intense, integrated training program focusing on awareness, judgment and skill.

[The prepared statement of Mr. Wolfinger appears on p. 44.]

Mr. EVERETT. Thank you, Mr. Wolfinger. Mr. Rinkevich.

#### STATEMENT OF CHARLES RINKEVICH

Mr. RINKEVICH. Thank you, Mr. Chairman and members of the subcommittee. It's a pleasure for me to be here to discuss with you the operations of the Federal Law Enforcement Training Center. As you know, the FBI is a Bureau of the Department of Justice, but the Federal Law Enforcement Training Center is a Bureau of the United States Department of the Treasury.

Conceived as part of the great urban and police reforms of the 1960's, the FLETC opened its doors in 1970. Its headquarters have been housed since 1975 on a 1,500-acre former Navy training base located just outside the city of Brunswick, GA, on Georgia's southeast coast, at Glynco, GA. The FLETC also operates two satellite training facilities, an owned facility at Artesia, NM, and recently opened a licensed temporary facility at Charleston, SC.

Born from the need to provide federal law enforcement with consistent, high-quality training and nurtured through its infancy by a combination of interagency cooperation and support, the FLETC has matured into the largest, most cost-efficient center for law-enforcement training in the nation. Center facilities at Glynco include a modern cafeteria, regular and special-purpose classrooms, dormitories capable of housing more than 1,200 students, office and warehouse space, and state-of-the-art specialized training facilities for physical, driver/marine and firearms training. Our Artesia site has much the same facilities but on a much smaller scale.

The FLETC's mission is to conduct basic and advanced training for the majority of federal government's law-enforcement personnel. We also provide training for State, local and international law-enforcement personnel particularly in specialized areas and support the training provided by our participating agencies that are specific to their needs. The Department of Treasury has been the lead agency for this facility and provides the day-to-day administrative oversight and direction to FLETC since its creation.

Using a multidisciplinary faculty that includes criminal investigators, lawyers, auditors, researchers, education specialists, police and physical security personnel, the center provides entry-level programs in basic law enforcement for police officers and criminal investigators along with advanced training programs in areas such as

marine law enforcement, antiterrorism, financial and computer fraud, and white-collar crime. Currently, 70 federal agencies participate in more than 200 different programs at the center.

Both the center and its work load have grown tremendously over the years as more agencies have come to realize the many benefits of consolidated training. In 1975 when FLETC relocated from Washington, DC, a staff of 39 employees moved with the center. Today the FLETC has an authorized staff of 512 permanent employees. Additionally, there are more than 150 personnel detailed to the center from its participating organizations. Several of the center's participating organizations also maintain offices at Glynco with a total staff complement of over 600 employees, and employees of the center's facility's support contractors total more than 700.

Training is conducted at either the main training center in Glynco, GA, our satellite training center in Artesia, NM, or the temporary facility I mentioned at Charleston. The temporary training center at Charleston was established in 1996 to accommodate an unprecedented increase in the demand for basic training, particularly by the Immigration and Naturalization Service and the Border Patrol. In addition to the training conducted on-site at one of FLETC's residential facilities, some advanced training, particularly that for State, local and international law enforcement, is exported to regional sites to make it more convenient and/or cost-efficient for our customers.

Over the years the center has become known as an organization that provides high-quality and cost-efficient training with a can-do attitude and state-of-the-art programs and facilities. During my association with the center I've seen first hand the many advantages of consolidated training for federal law-enforcement personnel, not the least of which is an enormous cost savings to the government. Consolidated training avoids the duplication of overhead costs that would be incurred by the operation of multiple-agency training sites. Furthermore, we estimate that consolidated training will save the government over \$180 million in per diem costs alone during 1998. That estimate is based on our projected 1998 work load and the per diem rates in Washington and other major cities of \$152 a day versus the cost of housing, feeding and agency miscellaneous per diem at Glynco of slightly more than \$25 a day. Consolidation also ensures consistent high-quality training and fosters interagency cooperation and camaraderie. Students from the different agencies co-mingle, thus learning about each other and each other's professional responsibilities. These networks establish at the center last throughout their careers.

We view FLETC and consolidated training as a National Performance Review concept ahead of its time. Quality, standardized, cost-effective training at state-of-the-art facilities, interagency cooperation and networking are indisputable results of consolidation. The Administration and Congress can be proud of the quality of training being produced at the center and the cost savings realized.

FLETC is essentially a voluntary association with each agency's participation governed by a memorandum of understanding and bolstered by the commitment of the participating agencies, the Department of Treasury and the Congress. Particularly in these times

of several budget constraints, a single agency cannot afford the sophisticated facilities and staff which are required for state-of-the-art training necessary to adequately prepare our nation's law-enforcement personnel. Only by consolidation at a centralized location are programs and facilities like those at FLETC economically feasible. We estimate that it would cost in excess of \$175 million just to duplicate the facilities available at Glynco.

Mr. Chairman, in closing I'd like to emphasize that the Department of Treasury and the FLETC management are strongly committed to providing high-quality training at the lowest possible cost. Substantial savings are being realized by the government through the operation of our facility. And now I'm available to answer any questions you may have. Thank you.

[The prepared statement of Mr. Rinkevich appears on p. 54.]

Mr. EVERETT. Thank you very much, gentlemen. Mr. Wolfinger, in your oral testimony it indicates that the FBI does not certify or approve other organizations' instructions including firearms training. Has the FBI ever actually observed VA's firearms training or instruction?

Mr. WOLFINGER. Last year there was some dialogue between our firearms training unit and the VA over their training and we consulted with them and looked over their outlines and materials. I do not believe that there was any actual on-the-scene observation of their training.

Mr. EVERETT. If asked, would you make an observation?

Mr. WOLFINGER. We certainly have tried to work with the other federal agencies and local agencies over law-enforcement issues. Certainly. We'd be happy to work with them. We really should not be put in a position though of certifying it or approving it. The firearms training really should be dependent on the nature of the job that the officer is asked to do, and our job is considerably different than the uniformed police officer in the VA.

Mr. EVERETT. Do you know if any other federal law-enforcement entity that conducts firearms training?

Mr. WOLFINGER. We do, I know that FLETC does. Congressman, we have uniformed police at the academy and we send them to FLETC, to the Federal Law Enforcement Training Center, in Glynco for their initial training because the nature of being a uniformed police type person in the FBI is different than being an FBI agent.

Mr. EVERETT. I assume your answer is then that you do not know of any other government agency.

Mr. WOLFINGER. No. I'm sorry.

Mr. EVERETT. Mr. Rinkevich, I would like to highlight actually some of your testimony that you've given and then I'll follow it with a question. You point out that yours is the largest, most cost-efficient center for law-enforcement training in the nation; that currently 70 federal agencies participate in more than 200 different programs at the center; that consolidated training avoids duplication and overhead costs that would be incurred by operating multiple agencies at different training sites; and that it is estimated that the government would save almost \$110 million in per diem costs in fiscal year 1998. And you point out that a single agency cannot afford the sophisticated facilities and staff which are re-

quired for the state-of-the-art training necessary to adequately prepare our nation's law-enforcement personnel. You also point out it would cost approximately \$175 million to duplicate what you've got there. My question is, could the FLETC offer VA specialized training that they have testified here today that they need.

Mr. RINKEVICH. Mr. Chairman, are you referring to the kind of training that is peculiar to the Veterans' Administration police?

Mr. EVERETT. Yes.

Mr. RINKEVICH. It is a common method of operation at our center at FLETC to accommodate that kind of agency-specific training. If I could take just a minute and explain to you, the program that the FBI police participate in is our 8-week basic police training program. In addition to the FBI police we have the uniformed division of the Secret Service, we have the United States Capitol Police. Your own police force here participates in that program. The Defense Protective Force, those folks that protect the uniformed folks that protect the Pentagon. The folks that protect the CIA and the National Security Agency. They all participate in that program.

The way the center works is that we provide the basic training skills that any of those police officers need to have in order to perform the duties of a uniformed police officer. It is then up to each individual agency to take those students after we've given them the basic skills, if you will, the undergraduate work, and give them the agency-specific skills and knowledge that they need to have, and most agencies do that. It takes a special training session for the Capitol Police for example to understand the particular laws and the way in which they perform their functions at the United States Capitol.

The uniformed division of the Secret Service does a special follow-on agency-specific training to deal with the specific mission, the specific authority, the specific policies of the uniform division. So, the answer to your question is yes. The system is designed that way, and it is used that way by most of the agencies; basic training by the center at Glynco and that agency-specific training by the agency instructors perhaps with assistance from our own instructions, but nonetheless agency-specific training.

Mr. EVERETT. Well, thank you very much, and I want to thank you gentlemen for your testimony here today, and at this point we'll call the next panel. I'm sorry. I did not recognize that Dr. Snyder had returned to the room. I was kind of listening to the testimony, and I do apologize, Dr. Snyder.

Mr. SNYDER. Well, I've been sneaking in and out, Mr. Chairman, running back and forth. I appreciate your—

Mr. EVERETT. And I did not mean to dismiss—you'll get an opportunity.

Mr. SNYDER. Just really one question, Mr. Rinkevich. I'm a big fan of well-trained law enforcement and I think that that's been lacking in our nation. I think most of us have figured out that that has been a gap, and frankly I think one of the reasons that crime rates have come down is States and local communities have really put a lot of money into good training for police officers. So, if you ever need any help from anything I can do for you, I would be a fan of that.

But I do want to quibble at little bit about your fairly broad statement about consolidation, and if I can, just the only question I want to ask, on page 2 of your statement you say, "Using a multi-disciplined faculty that includes criminal investigators, lawyers, auditors, researchers, education specialists, police and physical security professionals," you provide entry-level and basic law enforcement. But there's nobody in there remotely related to medical, and probably some of the most painful episodes for communities is when law enforcement ends up killing a schizophrenic. Very difficult situations. Or somebody who's on drugs and when they're dried out they're just fine. I mean, you know those terrible things that you all try to prepare people for. But isn't it a fair statement to say if I'm the VA people trying to make a decision about where to get my training and I read materials like this that doesn't even mention the word medical, is it not reasonable for them to think since we want our folks to be focused on our patients and the folks roaming through the campus there and the patients that come and go and the drugs addicts that will show back up in the middle of the night saying I need back in that, I mean, wouldn't this be a little bit of a flare for them when you all don't put any emphasis on medical? Now, I know that you provide medical training. I mean, I bet you do. I'd be shocked if you didn't. But this certainly tells me that your focus is not on it at all.

Mr. RINKEVICH. Well, it's quite true, Mr. Snyder, that we don't have a focus in the sort of specific area that the Veterans' Administration police would need it on dealing with the law-enforcement responsibility in a medical environment, and the reason for that is we don't train any police that guard medical facilities or are responsible for medical facilities.

Our system is designed so that our campus houses the agency personnel from the agencies that we train so that they can then take the student after they've been given the basic skills and give them what they need to know to be a Secret Service Agent or an FBI police officer. The Veterans' Administration could house at our campus its personnel that would be needed in order to provide that agency-specific training, and if they needed medical personnel or other folks that were imbued with the culture of the Veterans' Administration and a hospital system, that would be the way in which to accomplish it.

We of course do provide medical training. We have extensive training in trauma management. We have extensive training in dealing with behavioral issues, disoriented people and mental cases and that sort of thing because other police officers confront those things on a regular basis on the street as well.

Mr. SNYDER. Right. And I knew you did, but I'm just saying you chose not to focus on that in your statement here. With regard to your comment about they could house those personnel, but the situation now is they get on the phone and say Dr. Jones, are you free tomorrow afternoon? We've changed our schedule. Dr. Jones is a psychiatrist who's working—I just made up Dr. Jones—can you stroll over here this afternoon? We need to change the date of that simulation. We need our schizophrenia lecture moved up. I mean, they're using medical people from a VA facility. It's right on the same grounds, it's on the back half of the campus, and I mean,

they think they've got a pretty nice situation right now. They can pull their nurses and do simulations and not having to fly in faculty and house them somewhere. They see that as part of their responsibility as a VA employee. But anyway, I appreciate your comments and I know everybody here is trying to do a good-faith job of good training in law enforcement in the most cost-effective way. Thank you, Mr. Chairman.

Mr. RINKEVICH. If I could, Mr. Chairman, just one quick comment, Mr. Snyder, and that is that our other agencies confront that same inconvenience. In other words, when the Secret Service needs to have someone come in that is posted here in headquarters in Washington, DC because of a special skill area, they make arrangements for that. So, it does work. You're right, it's much more convenient if it's right across the street on the same campus, but it is possible for those arrangements to be made.

Mr. EVERETT. Thank you, Dr. Snyder, and my apologies once again. I might point out to this panel and the other panel that all members of this Committee with the exception of our ranking member are members of the National Security Committee also. And you can appreciate the fact that the Chairman himself would probably be going back and forth if he were not Chairman. So, thank you for rejoining us, and we all recognize the fact that QDR is one of the most important things that we're doing this year as far as national security is concerned and that's the reason that the members are there.

Again, I thank this Committee and I now call the next Committee. Mr. John Vitikacs of the American Legion, and Mrs. Barbara Zicafoose of the Nurses Organization of Veterans' Affairs, Mr. Ernest Little, a fire fighter at Perry Point, Maryland, Veterans' Affairs Medical Center, who will be representing AFGE. And I'll point out the National Association of Government Employees will also submit a statement for the record.

[The statement of National Association of Government Employees appears on p. 90.]

Mr. EVERETT. We have tons of paper up here and I'm trying to get them all together. And at this point I'd recognize John Vitikacs to go ahead and if you will make your statement. Again, I ask all panel members to keep statements at 5 minutes, and your complete statements will be made a part of the record. Thank you.

**STATEMENTS OF JOHN VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; BARBARA FRANGO ZICAFOOSE, MSN, RNCS, ANP, LEGISLATIVE CO-CHAIR, NURSES ORGANIZATION OF VETERANS AFFAIRS; ERNEST W. LITTLE, FIRE-FIGHTER, PERRY POINT VETERANS AFFAIRS MEDICAL CENTER; ACCOMPANIED BY SANDRA CHOATE, ASSISTANT GENERAL COUNSEL, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES**

#### **STATEMENT OF JOHN VITIKACS**

Mr. VITIKACS. Thank you, Mr. Chairman, Dr. Snyder, members of the subcommittee. Thank you for inviting the American Legion to testify on safety concerns within the Department of Veterans Af-

fairs. I will limit my remarks to the issue of arming VA security officers.

First of all, I would like to commend Mr. John Baffa and Mr. Bill Harper for the professionalism, competence and expertise they have provided the VA Security Service over the past several years.

Mr. Chairman, over the past 13 years the American Legion testified on two previous occasions concerning arming VA security officers. On both occasions for a combination of reasons the American Legion did not support armed VA security officers. Today the American Legion is more flexible on this matter. As stated in our prepared testimony, the American Legion supports completing the VA Security Service pilot program on arming security officers and fully evaluating the program prior to deciding the future of this important subject.

Mr. Chairman, the world today is a much more dangerous place than it was 13 years ago. Crime in the inner cities has increased, and that is where a majority of VA medical centers are located. There is strong testimony on the pros and cons of arming VA security officers. However, adequate documentation on the objectiveness of each position is absent. The pilot program currently underway can help answer many questions.

The American Legion believes that training, supervision and quality of individuals recruited by VA Security Service has improved in recent years. This is due to competent leadership and improved pay and performance standards. Mr. Chairman, there are many factors to consider in the ultimate recommendation VA makes on arming security officers.

In the final analysis, VA medical centers and regional offices must be safe and secure for patients, staff and visitors. Recent tragic events throughout the country and within VA have left all of us shocked and uncertain about our own safety and security. It is with this conviction that the American Legion looks forward to reviewing the results of the pilot program now underway prior to developing an official position on this issue. Mr. Chairman, that completes my statement.

[The prepared statement of Mr. Vitikacs appears on p. 57.]

Mr. EVERETT. Thank you very much. I will now recognize Ms. Zicafoose for your statement.

#### STATEMENT OF BARBARA ZICAFOOSE

Ms. ZICAFOOSE. Mr. Chairman and members of the subcommittee, I am Barbara Zicafoose, a nurse practitioner in the Center for Outpatient Services at the Veterans' Affairs Medical Center in Salem, VA. As Legislative Co-Chair for the Nurses' Organization of Veterans' Affairs, I am pleased to present testimony on safety and security in the Department of Veterans Affairs on behalf of NOVA. I speak for our own membership and for the more than 40,000 professional nurses employed by the DVA.

NOVA is a professional organization whose mission is shaping and influencing the professional nursing practice within the DVA health-care system. We are very much interested in assuring that the VA is a safe, secure place for patients, employees and visitors. Work place violence has emerged as a critical safety and health hazard nationally.

The magnitude of the problem is well documented in the literature. The statistics account not only for the actual deaths that occur, but for an additional innocent bystanders and nonemployees killed yearly. The Bureau of Justice Statistics in a report in 1994 reported that 1 million individuals are victims of some form of violence in the work place each year. Health-care providers are at an increased risk for violence because they are caring for individuals and families during a time of illness which can precipitate stress and the sense of loss of control leading to inappropriate or violent behavior. One study found that nursing staff at a psychiatric hospital sustained 16 assaults per 100 employee per year. Therefore, it is timely that this Subcommittee and the DVA investigate work place safety.

NOVA recognizes that the most frequent recommendation for controlling violence at our medical centers is to arm our VA police with guns. We support Secretary Jesse Brown and the DVA's reluctance to place firearms in our hospitals. The very presence of a weapon in a work environment for whatever reason can contribute to a triggering event for violence. Many of our veterans suffer long-term complications, disabilities and/or emotional trauma related to these weapons. Guns are for killing and have no place in institutions developed to promote health and wellness and the treatment of disease.

NOVA supports an alternative strategy. We recommend staff education and training along with knowledge of evaluation and intervention techniques to reduce work place violence. One problem with the successful use of staff education and training as a successful intervention method is a lack of awareness, and in many cases a belief system that denies the very possibility that violence does exist in our DVA environment. However, experts agree that the best approach to reducing work place violence is prevention and protection.

The Occupational Safety and Health Administration in 1996 published a voluntary generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs which includes work place violence prevention program. The literature supports this belief that education and prevention for work place violence would be the first intervention. Recurring prevention themes include staff education and training, tighter security methods, adopting a zero-tolerance policy toward unacceptable behavior, developing a crisis management team which could evaluate any warnings and decide what to do about them, and the creation of a trauma team.

One intervention in particular, tighter security measures, is critical for the DVA because of the location of some of our medical centers in high-crime areas, and the growing implementation of satellite and mobile clinics. Some physical security measures recommended in the literature which we feel would be very beneficial to our facilities include increased security of personnel on the premises, improved lighting, beepers for human resources and security personnel, bulletproof glass especially in our E.R.'s and our high-profile areas, hidden panic buttons, closed-circuit television cameras to monitor common areas where outbreaks of violence occur, metal detectors in high-crime areas, and badges for all visi-

tors. The use of firearms was not included in the literature that recommended improvement in tighter security measures.

Another invention is the adoption of a zero-tolerance policy toward unacceptable behavior. NOVA applauds Secretary Brown on his recent comments in putting veterans first where he addresses in the work place and reports that violence, threats, harassment, intimidation and other disruptive behavior in our work place will not be tolerated. Work place violence is not limited to homicide, but to those behaviors identified by Secretary Brown.

A third intervention is the creation of a crisis management team. This team would be made up of the Director, a psychologist with special training in this area, the head of security, and legal counsel for special training. The team would have a written plan to be followed when a crisis occurs or there are signs of a crisis; would evaluate the warnings and decide what actions would be taken.

And then a potential life saver in work place violence that the literature strongly supports and one most often overlooked is development of a trauma team. This team would be assigned specific jobs such as first aid, media control, management of onlookers and notification of families.

Work place violence is a problem of epidemic proportions. It can include violent, threatening, harassing, intimidating and disruptive behaviors. The literature supports that there are tactics for evaluating and diffusing work place violence issues without the use of weapons. Staff education and training along with knowledge of evaluation and intervention techniques can substantially reduce the possibility of work place violence. Initiating prevention and intervention techniques as identified can make the work place safer by stopping a crisis before it begins.

I would like to thank NOVA's president, Dr. Maura Miller and legislative co-chair, Dr. Sarah Myers for their assistance in the preparation of this testimony.

Mr. Chairman and Subcommittee members, thank you for the opportunity of presenting this testimony on behalf of NOVA.

[The prepared statement of Ms. Zicafoose appears on p. 61.]

Mr. EVERETT. Thank you. Mr. Little.

#### STATEMENT OF ERNEST LITTLE

Mr. LITTLE. Good morning, Mr. Chairman. Mr. Chairman and members of the subcommittee, my name is Ernest Little. I'm a fire fighter employed by Department of Veterans Affairs Medical Center at Perry Point, Maryland. I'm here today on behalf of the American Federation of Government Employees, and particularly for AFGE's federal fire fighter members.

AFGE represents 21 out of 31 Veterans' Affairs fire departments. With me is Sandra Choate. She is Assistant General Counsel and staff person for AFGE responsible for fire fighter issues. I might also add that AFGE works closely with the five major organizations representing federal fire fighters all of whom concur with our testimony.

I'm particularly pleased to have this opportunity to appear before you and share our concerns over the fire protection afforded to our nation's veterans and the employees of the Veterans' Affairs Medical Centers.

Today I'll focus on two main points. First, millions of dollars in savings would be achieved if the Department of Veterans Affairs would emulate fire services around the country and take advantage of the full range of emergency services of which fire fighters are uniquely qualified to provide. Secondly, at the present time, veterans who are patients at medical centers as well as employees are at great risk at most facilities because of the VA's inattention to its fire services.

With regard to the first point, missed opportunities, we believe the Department of Veterans Affairs would emulate fire services around the country and take advantage of a full range of emergency services which fire fighters are uniquely qualified to provide, it could save millions of dollars and provide a needed and necessary service to the veterans of this country and to the Veterans' Affairs employees.

There is already a shining example of this within the system. AFGE Local 1119, the Montrose VA in New York, submitted a proposal last December to take over the emergency medical services functions. The director agreed and the existing ambulance service contract estimated to cost between \$260,000 and \$270,000 annual was canceled. An ambulance was purchased for \$75,000 and the fire fighters took over the ambulance EMT service. There's no increase in staff and they are certified as emergency medical technicians. That justified a grade increase which cost to the VA was about \$95,000. Response time from the fire department under 4 minutes as contrasted with the half hour to 2 hours for the contractor. In summary—EMS functions at Montrose will save approximately \$200,000 after the first year, will provide a much higher quality of service.

At the same time, it was a job easily assumed by employees already trained to respond. This same proposal including providing EMS service to adjacent federal buildings on a reimbursable basis was submitted by IAFF Local in Minneapolis. The director concluded he was not interested. In fact, he has indicated that he is not interested in keeping fire departments. He simply wants to out-source regardless of the impact on veterans or the cost.

AFGE's written testimony provides a background for a second point with references to the science of fire suppression. It is important to understand the several factors when analyzing the need for fire service. Sprinkler in the buildings reduce the fire loss but not the fire risk at most VA facilities that are not fully sprinkled anyway. Further, when there is a fire today even in a sprinkler building, the high use of plastics and other materials, particularly at medical center facilities, result in extremely hot, fast-burning fires which produce an increased amount of toxins and smoke. Let me add, Mr. Chairman, sprinkler systems normally don't put out a fire. They're designed to keep a fire in check. Why would the VA grant a waiver to staffing levels if the facility is sprinklered? The highest injury and death rate occurs from smoke inhalation, and the most vulnerable are people who are unable to evacuate buildings such as the type of VA patient population. The elderly, sick, or those who are easily confused such as the mentally ill, the mentally retarded and those suffering from Alzheimer's or who have damage from substance abuse.

Both fire suppression and emergency services should always be discussed in terms of response times. It is well known how long it takes before a fire results in total loss. The National Fire Protection Association has produced a film which shows 40 seconds by the dropping of a lighted cigarette between two sofa cushions. The cushions will begin to smolder and give off toxic fumes and flammable vapors. Within 5 minutes there is total flash-over resulting in heat so hot it becomes impossible to enter the room which is roughly around 1,100 degrees.

Within 10 minutes the room is totally filled with vapors creating the back-draft condition that results in a total loss. Thus, it is critical that a response can be made well within the 10-minute limit. Mr. Chairman, when critical response times cannot be met, the VA must take needed action to ensure that the veterans and employees are protected adequately by meeting minimum staffing standards without the wide-spread use of temporaries which has been prevalent through the VA over the last 4 years. Further, that dual-hatting should not be practiced where it provides inherent conflict such as the dual-hatting police and fire fighter proposal being considered by Battle Creek, the protective services concept.

In addition, the Montrose VA example should be given serious consideration as an appropriate adjunct to services offered by the fire department. AFGE would welcome the opportunity to work with the Committee and explore ways in which the Department of Veterans Affairs fire and emergency services and provide all the Department of Veterans Affairs facilities in the most efficient and effective manner guaranteeing quality service for its customers and our nation's veterans at the most realistic cost. Again, we thank you for the opportunity to appear today and we'd be happy to respond to any questions you might have.

[The prepared statement of Mr. Little, with attachments, appears on p. 65.]

Mr. EVERETT. Thank you very much, and I assure you we'll make sure all your complete testimony is entered into the record. We have a situation here. I do not have a lot of questions for this panel. I don't know that the other members will have some I'm sure. But we have a vote going on and we can either try to get through in a hurry and not have to come back. My ranking member agrees that we should do it in a hurry. Let me just very briefly, and if you would keep your responses brief I would appreciate it because I know you don't want to be around here another hour. Ms. Zicafoose, your testimony clearly indicates that NOVA's position in opposition to arming VA police. Briefly can you tell me if there's any situation where a local high-crime rate would justify arming VA police?

Ms. ZICAFOOSE. I think what we would have to do is really look at what's in place already and if there are other measures that have been taken previously that could potentially have steps that wouldn't require the use of firearms. I'm not saying that they wouldn't be necessary, but I think we need to look at what's in place to see if they have gone through every other recommended method of reducing violence before that we put the guns in play.

Mr. EVERETT. Thank you. Mr. Little, we are going to ask VA to respond to specific concerns you raised in your written testimony

about VA's fire protection at particular facilities, and I can assure you that we'll do that. I'll ask Mr. Clyburn now if he has any questions.

Mr. CLYBURN. Thank you, Mr. Chairman. I apologize for having to be out of the room.

Mr. EVERETT. I perfectly understand.

Mr. CLYBURN. I do have one question I would like to ask. I'm thinking about your remarks this morning, Mr. Chairman, and the figures laid out about the tremendous drop in incidents that we've had. And we all know by reading all the reports that crime is decreasing in our society. However, you can't tell it by watching TV and reading the newspapers. We all know what sells newspapers, gruesome headlines and the lead story on the news every evening is going to be about some crime because that's what seems to arouse people and get numbers up. But the actual incident numbers are dropping. In view of that, I would like to know, and I think historically the American Legion has been sort of against arming the Veterans' Police. You seem now to have changed that position. Why?

Mr. VITIKACS. On previous occasions when this organization testified on this subject was 1984 and 1989, over the past 13 years. At that time both of the hearings were oversight. There wasn't any discussion at that time about a pilot program. As I believe, the issue was will we or will we not do this, and I think that we were opposed to unilaterally arming VA security officers without having adequate systems in place to assure that the training, the supervision, the quality of the individuals recruited on the police forces. We weren't certain at that time that all of the criteria that we would have liked to have seen in place was in fact in place. I think that this issue has certainly improved in the past half-dozen years and the number of violent incidents have increased. And we haven't done a 180-degree change in our views, we've done a 90-degree change, and that is we support the pilot program and that's as far as we've gone in changing our position on that subject.

Mr. EVERETT. Dr. Snyder?

Mr. SNYDER. Is it Zicafoose?

Ms. ZICAFOOSE. That's right.

Mr. SNYDER. I liked your statement. I think I agree with about everything that was in it. But, you know, I live five blocks from a VA hospital in Little Rock and we're just coming from different perspectives I think. Even though I trained in one I'm too old now to have recollections of that. You're coming from the perspective of what's going on inside the hospital and I see the parking lot as an extension of my neighborhood and the security and safety factors out there, and it's my neighborhood so I know that we have had some occasional problems with houses on the edges of the parking lot and so on. So, it may be that the VA can draw the line at the door or something. I think we all agree if you have a lengthy walk, bus trip, from the parking lot that that's a different situation than what you're concerned about inside the work place environment. But I thought it was interesting when you were talking, I thought, wait a minute, she's talking about inside and I was thinking in my mind the parking lot outside. That's not really a question, but you're welcome but you're welcome to comment any way you like.

Ms. ZICAFOOSE. That is a very good point, and I think the thing that we really have to be careful of is how we determine where these guns are going to go, in what facilities, and when they're being used because if you look at the statistics, in 1994 Labor reports that there were 1,071 work place deaths, but when you look at the number of actual deaths within the DVA, we probably don't make up 1 percent of that. So, does that really justify putting guns, and how do we limit where those guns are put when?

Mr. EVERETT. Thank you, and I want to thank all the panel members and the members for their participation today. I want to conclude the hearing with a couple of observations. First, we all recognize that this is a much different world than most of us grew up in. Now, all of us gentlemen are much older than you ladies here, but the world has changed. It is a more dangerous place. Having said that, however, let me say that we've heard serious questions about arming of VA police. I do not think at this point we are persuaded arming is prudent or necessary. The subcommittee will continue to review the progress of this pilot program. We'll hold another hearing at its conclusion. Second, how the VA trains its police warrants further examination in my opinion. I do not understand why the VA has its own training program when the FLETC and the FBI do the same training on a much larger scale and with probably a greater savings to the taxpayers. Finally, I would be most interested to see the VA's response for the record on the adequacy of fire protection at particular VA facilities. Safety must come first. All members will have 5 legislative days to submit questions for the record. The hearing is adjourned.

[Whereupon, at 11:55 a.m., the subcommittee was adjourned.]

## APPENDIX

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### PREPARED STATEMENT OF CONGRESSMAN CLYBURN

As the ranking democratic member of this subcommittee, I am pleased to join Chairman Everett in holding this very important hearing.

I know that the safety and security of our VA hospitals is of the utmost importance to the VA and to the members of this committee. In my view, we would not be accomplishing our mission of providing the highest possible health care service to our veterans if we were unable to protect the safety and integrity of our VA hospitals.

I am greatly interested in hearing testimony from the VA on its pilot project to arm VA police officers at certain VA hospitals. I am aware that the tragic shooting of a doctor in Jackson, MS earlier this year has caused renewed concern over the adequacy of the safety and security of our VA hospitals.

I must say, however, that I believe the VA ought to be taking a measured approach when it comes to making any final decision to arm its police officers. Very few private hospitals, even in some of the most dangerous, crime-ridden areas of our country, allow the officers who guard their facilities to carry guns. I believe there is a reason for this.

As the written testimony of the nurses association suggests, hospitals are for making sick people healthy; guns are for killing people. The VA should be extremely cautious in its approach to this issue. There should be an extensive, well thought-out, hospital-by-hospital analysis of the feasibility and propriety of arming VA officers before jumping into such a course of action.

To my mind at least, it is just as easy to imagine a situation where a VA officer accidentally kills or seriously injures somebody during the course of his duties as it is to imagine a situation where the officer's gun keeps a killing or serious injury from occurring.

I welcome the opportunity to hear testimony on this extremely sensitive issue, as well as the chance to get an update on the status of VA fire departments and the VA's accountability of controlled substances.

Thank you again, Terry, for working with us to put together such a timely and important hearing.

### PREPARED STATEMENT OF CONGRESSMAN EVANS

Mr. Chairman, I want to thank you and Mr. Clyburn for calling this extremely important hearing today. As you know, the VA is right in the middle of its pilot program to arm VA police officers at selected hospitals across the country. There could be no more appropriate time to conduct diligent oversight of this program.

I share this subcommittee's concern over the recent violent episode at the Jackson, Mississippi VA hospital in which a VA doctor was killed by an angry patient. I am also deeply troubled by the deaths of four VA police officers in the last five years.

There should be no more important priority than to ensure the safety and security of hospital patients and law enforcement personnel at VA facilities. We should closely consider the means by which we can best accomplish this mission. I look forward to hearing testimony this morning concerning the pilot program to arm VA police, as well as other safety and security issues relating to VA fire departments and the security of prescription drugs at VA pharmacies.

Thank you again Terry and Jim for taking a closer look at these vital issues.

STATEMENT OF JOSEPH R. WOLFINGER, ASSISTANT DIRECTOR,  
FEDERAL BUREAU OF INVESTIGATION

Good morning Mr. Chairman and members of the committee, I am Joseph R. Wolfinger, Assistant Director of Training for the FBI. I understand that I am here today to provide this committee with information about FBI Trainina and specifically our Firearms Training Program. The FBI's New Agents Training program is a 16 week course of instruction focusing on four core areas: academics, physical training, practical application, and firearms training. This equates to approximately 654 hours of instruction of which firearms training accounts for approximately 116 hours divided by 28 sessions. I think it is important to note, that in general, the mission of Special Agents of the FBI is different than that of a federal police officer, and therefore, our training is different. Agents are generally not "first responders" and do not routinely "patrol". Likewise, our basic qualifications and the selection process are different from other law enforcement organizations.

A Special Agent's training does not stop at the conclusion of the New Agents training. After reporting to their first office of assignment, the Special Agent begins a two year probationary period, during which the new Special Agent receives on-the-job training from senior Special Agents. During this period, the new Special Agent is expected to perform specific functions of his/her job, to include testifying, writing affidavits, and so on, and is evaluated on performance. If for any reason the probationary Agent is dismissed, there is no appeal. Additionally, all Special Agents are required to qualify four times a year with their issued weapons and the weapons they have subsequently been authorized to carry.

I would also like to clarify that the FBI does not "certify" or "approve" other organizations' instruction, to include firearms training. We have, in the past, offered and provided FBI instructor training to personnel from other organizations. Having said that, I would like to provide you with an overview of our New Agent Firearms Training curriculum.

The primary mission of the Firearms Trainina Unit (FTU) is to train new Agents to become safe and competent shooters with Bureau-issue handguns, shotguns, and carbines through a 16 week, three tiered training program consistine of:

- (1) fundamental marksmanship, trainina with all three weapon systems;
- (2) combat/survival shooting incorporating all three weapon systems on progressively complex and challenging courses, and;
- (3) judgmental shooting.

The FTU also administers firearms related training programs for Agents assigned to FBIHQ, the Bureau's 56 field offices, and the law enforcement community. These programs are supported by ongoing research, and the testing and procurement of weapons, ammunition, and related equipment appropriate to the needs of modern law enforcement. The unit also maintains the FBI's arsenal of issued and approved weaponry.

During firearms training, students will fire a total of 4,395 rounds. Nearly 3,000 rounds will be fired during the course of 19 sessions as students master basic marksmanship skills and "qualify" for the first of two required times with the handgun, shotgun, and carbine. During the remainine nine sessions, students will fire approximately 1,400 rounds as their skills are challenged during combat/survival training, and their preparations for final qualification.

The combat/survival portion of the firearms curriculum includes "judgmental" training. Along with combat courses which include "no shoot" targets, and other courses where students must work as teams to resolve complex shooting problems, students are also exposed to at least 12 computer driven scenarios with which they must interact and, if appropriate, employ deadly force. Unsafe, unprofessional, or inappropriate behavior during these scenarios or at any other time in firearms training may result in a recommendation for a New Agent Review Board or outright dismissal.

Student performance is assessed constantly during firearms training. When appropriate, students are given individualized instruction. If a student shouldd fail to qualify, they are given two weeks of intensive remedial training after which they are afforded another opportunity to qualify. Failure at this juncture results in dismissal from training. The Training Division has not lost a student because of a firearms related failure since 1990.

In addition to successful completion of their initial firearms training, all FBI Agents are also required to attend firearms training and "qualify" four times per year throughout their careers. A minimum of 1,000 rounds/Agent/year is budgeted for this purpose to ensure that Agents maintain this critical, but perishable skill. Agents who fail to satisfy these minimum requirements lose their authority to carry

firearms until the deficiency is resolved, and risk loss of availability pay should the deficiency persist. Because the loss of pay is such a strong incentive, this has not been an issue.

As I said earlier, the New Agent *firearms* training curriculum consists of 116 hours of classroom and range instruction broken down into 28 sessions. These sessions are very much interrelated and complement training conducted by our Physical Training, Practical Applications, and Legal Instruction Units. So yes, our firearms training is multi-dimensional, and is concerned not only with an Agent's accuracy and proficiency with weapons, but also focuses on the relationship inherent to having the power and authority of applying deadly force. It is an intense integrated training program focusing on awareness, judgement, and skill.

**STATEMENT OF  
JOHN H. BAFFA  
DEPUTY ASSISTANT SECRETARY  
OFFICE OF SECURITY AND LAW ENFORCEMENT  
DEPARTMENT OF VETERAN AFFAIRS  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
OF THE  
U.S. HOUSE OF REPRESENTATIVES**

**May 22, 1997**

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss issues related to safety and security at VA facilities.

**Police matters**

The Office of Security and Law Enforcement was established in December 1989 to consolidate all of the Department's security and law enforcement functions under one department-wide program. Responsibilities of the office include training VA police officers, as well as establishing policy and providing oversight for police operations at department medical centers.

Immediately following my appointment in 1989, I prepared a four-year strategic plan outlining needed improvements and a time-line for their accomplishment. This plan, which was approved by the Secretary in 1990, included goals of significantly expanding and improving training for police officers at all levels. Also addressed in the plan was expanding and improving program oversight and other goals designed to ensure improved local services. One of the areas that required careful attention was how VA police officers would defend patients, employees, property and themselves.

Prior to 1971, VA maintained a "security guard" force. When we converted to police operations in 1971, a decision was made to equip our police officers only with a chemical irritant projector, utilizing CN (Mace) as the active ingredient. Subsequently, approximately 15 facilities were authorized to also equip their police officers with the

straight stick baton because of the limited effectiveness of Mace and because of increasingly violent encounters between police officers and intruders at those locations. With these limited weapons at their disposal, VA police, at great personal risk, performed admirably and dealt successfully with most violent encounters.

Several incidents drew much attention to the fact that VA police officers were at a distinct disadvantage when faced with an armed individual --two separate incidents in the late 1980s at Brecksville, Ohio and Bronx, NY, in which three unarmed VA police officers were shot and killed in the line of duty, and in 1992 there was a serious wounding by gunfire of another police officer at VAMC Columbia, SC.

Since becoming the Secretary of Veterans Affairs, Jesse Brown has played a direct role in issues relating to security at VA facilities. In August 1995, after giving serious consideration to the various and differing opinions on the matter, Secretary Brown elected to initiate a one-year pilot project to arm police officers at no more than six VA medical centers. The purpose of the pilot is to determine the feasibility of arming officers at additional facilities. Section 904 of title 38, United States Code, authorizes the Secretary to furnish Department police officers with such weapons as the Secretary determines to be necessary and appropriate to ensure the maintenance of law and order and protection of persons and property on Department property. Following the preparation and staffing of a VA directive, and consultation with the Attorney General and representatives of the FBI Academy, VA initiated the pilot program in September 1996. The Office of Security and Law Enforcement conducted on-site reviews and firearms training at five pilot sites: Bronx, NY; Richmond, VA; North Chicago, IL; Chicago (West Side) IL; and West Los Angeles, CA. These sites were selected because of the support of local managers and because of a desire to have as broad a geographical representation as possible.

The five pilot sites initiated the program as they completed all the prerequisites, with the first being North Chicago on September 30, 1996, and the last being Chicago West Side on January 1, 1997. We originally intended to conduct an initial evaluation of the program at the sixth month, but because of the shooting death of a physician at VAMC Jackson, MS, the Secretary directed that a preliminary evaluation be provided to him by April 1, 1997. The report of the evaluation, conducted by the Office of Security

and Law Enforcement, judged the program to be successful to date. All actions taken by officers were appropriate and there was evidence that officers were exercising more vigilance in the key areas of investigative stops and car stops. Comments from staff and patients were overwhelmingly positive. Based upon this positive report, and in order to develop a broader base of experience, the Secretary decided to expand the number of facilities in the pilot program

The on-site firearm training program for the officers participating in the pilot was developed with the assistance of the Chief of the FBI Academy Firearms Training Unit, who reviewed the final training plan and concluded that our training exceeded or was equivalent to that offered by most federal agencies. Also, at our request, the Chief of the Academic Affairs Section at the FBI Academy reviewed our basic police officer training course. Although this Section does not certify or accredit basic law enforcement training, it was their conclusion in April 1996, that VA's 160-hour basic course appeared to be consistent with the standards established at the Federal Law Enforcement Training Center and at several state academies.

Title 38 authorizes the Secretary to prescribe the scope and duration of training required for Department police officers. Immediately after my appointment, I focused attention on improving both the quality and quantity of training given to VA police. At that time there was a small, but dedicated, staff providing a basic police officer training course of only 68 hours at the Little Rock VAMC. The Department of Justice had recommended to VA that the training course be 160 hours. In August 1992, we expanded the basic police officer course to 160 hours, added highly qualified instructors in the important areas of law and human behavior, and greatly improved the classroom facilities. In the basic course, we emphasize the specialized and specific needs of policing in a health care environment and the participation of VA police officers as a part of the medical care team.

VA's law enforcement training program is now funded through the Franchise Fund and provides basic police officer training to police officers from the National Gallery of Art, the Indian Health Services of the Oglala Sioux Indian Tribe, Pine Ridge, SD, and Walter Reed Army Medical Center. These organizations have chosen our

training center, in part, because of our focus on training our officers to deal with difficult persons, utilizing the minimum amount of force necessary.

Finally, I wish to emphasize that we see the firearm as another tool for the officer. We do not see that its addition, in any way, changes the philosophy that Department officers use only the minimum amount of force necessary to de-escalate violent encounters.

#### **Controlled substances**

Since the 1992 House Veterans' Affairs Committee hearing on controls over addictive drugs and drug diversion, VA has made significant progress. Working with the Office of the Inspector General, the General Accounting Office, and the Office of Security and Law Enforcement, the Veterans Health Administration has instituted regulations over the accountability of controlled substances that are more strict than any state or any other health care system's requirements. Mr. Chairman, I would like to briefly review some of the major actions taken by the Department to address the diversion issue.

In 1991, the Secretary reported controls over lower scheduled drugs as a material weakness under the Federal Managers' Financial Integrity Act report. Subsequently, a series of actions were planned to correct the material weakness. Resources were identified and approved for both the software development and the necessary hardware to support the movement to requiring perpetual inventory of all controlled substances. To improve accountability and automate manual processes, three versions of controlled substances software have been released to VA medical centers. Today all VA medical centers and clinics are required to maintain perpetual inventory of all controlled substances dispensed. These requirements will result in controls that exceed the community standards. In 1997, VA will recommend that the material weakness be closed.

To deter and detect diversion, VA required that access to controlled substances be limited within the pharmacy and that documentation be maintained regarding employees who have that access. Storing and dispensing of controlled substances must occur within locked areas and electronic access control devices must be installed on all locations within pharmacy where controlled substances are stored or dispensed.

This includes all cabinets, vaults, drawers, and carts where controlled substances are stored or from which they are dispensed.

To verify the accuracy of inventories and identify any discrepancies in a timely manner, verification of all controlled substances is required every 72 hours. Prior to this requirement, inventory was verified monthly during the monthly narcotic inspection. While this verification process is time consuming, automation has offset some of the human resource requirements. There are examples where the 72-hour verification has identified discrepancies, losses and thefts. These verifications continued to support detection and deterrence of diversion.

To reduce the likelihood of diversion after an outpatient prescription is filled, a tamper proof seal must be affixed to all controlled substance prescription vials after filling the prescription, all completed prescriptions must be stored in locked cabinets, and positive patient identification and patient signature is required before the medication is handed to the patient or his/her agent.

These are just some of the actions taken as part of a comprehensive plan to improve the ability to deter and detect diversion of controlled substances within VA facilities.

VA has also taken actions to improve the ability to deter and detect the diversion of non-controlled substances from VA facilities. VA has implemented a "just-in-time" inventory and delivery system utilizing private sector prime vendor distributors. This distribution system has dramatically reduced inventories within VA pharmacies for both controlled and non-controlled substances and has removed all inventories of pharmaceuticals that were stored in VA medical center warehouses. VA has developed and implemented Drug Accountability software that will assist VA medical centers in verification of inventory. Requirements regarding verification of high cost pharmaceuticals was established in 1991 and are still in effect. Additional software development is ongoing. VA has established an interface with private sector prime vendors that will allow for the automated downloading of goods received into VA inventory. The software is undergoing testing and planned release is in the summer of 1997. After the software is released and implemented, VA will reassess current inventory accountability requirements.

VA currently operates six Consolidated Mail Outpatient Pharmacies (CMOPS). These CMOPS dispense millions of prescriptions a year and maintain the largest inventories of pharmaceuticals in the VA system. At all the CMOPS there is a requirement that the private sector software allow VA managers to track and account for their inventory, thereby automating the process and increasing their ability to deter and detect diversion.

VA continues to review all reports of diversion received by VHA, Security and Law Enforcement, and OIG investigations. While the temptation to divert both controlled and non-controlled substances will always exist and individuals will continue to attempt diversion, VA has substantially improved its ability to deter and detect diversion. We will continue our efforts and work with all parties to identify opportunities for improvements.

#### **VA fire departments**

At the vast majority of the Department's medical centers, fire fighting services are provided by local community fire departments. When local fire fighting services do not meet VA's minimum level of requirements, VA operates in-house fire departments. The minimum level fire fighting services acceptable for VA medical centers is an initial response from four paid firefighters and one fire fighting apparatus meeting the criteria of National Fire Protection Association Standard 1901 with a minimum pumping capacity of 750 gallons per minute. This response must be available 24 hours a day, seven days a week and must be capable of responding to the medical center in eight minutes or less, which is equal to a distance of approximately 3-1/2 miles.

Currently only 30 VA medical centers are operating in-house fire departments, with approximately 387 FTEE. The total operating costs for all 30 fire departments for FY 1996 was \$16,289,215. The majority of these remaining 30 VA fire departments are located at VA medical centers in rural areas served by small, all volunteer fire departments. While many local communities depend upon volunteer fire departments, such departments, by their nature, cannot guarantee VA's minimum level of response in a given time.

Thirty years ago, more than 65 VA medical centers operated in-house fire departments. As conditions have changed over the past several decades, local

communities have expanded and their fire departments have grown in size and quality. As the local fire fighting services expanded, fire fighting responsibility was transferred from VA medical centers to the local community whenever possible. In the past ten years, 6 VA medical centers have closed their fire departments.

One of the objectives of the Under Secretary for Health's Prescription for Change is to focus management attention on VHA's key business of providing health care. With this in mind, we are exploring opportunities for contracting out fire fighting services wherever possible. However, the potential for contracting out of fire fighting services at VA medical centers in the future is limited. Because VA fire departments typically perform a number of non-fire fighting duties, such as inspecting and maintaining fire protection equipment, conducting fire drills, or serving as part of the hazardous response team, in addition to providing fire fighting services at their medical centers, the actual cost for their fire fighting services is significantly less than the cost to establish an outside source for this service. This cost differential has been documented by the numerous A-76 cost comparison studies.

VA policy is meant to ensure an adequate level of fire fighting response for buildings housing patients overnight and reflects nationally-accepted practices. There are no Federal laws or regulations or other fire codes or standards requiring VA to establish, operate or maintain in-house fire departments.

A typical VA in-house fire department is staffed with 15 FTEE, including a fire chief to provide a minimum of 4 fire fighters on duty for each tour of duty. VA maintains a up-to-date fleet of fire pumpers with sufficient pumping capacity and equipment. Each in-house VHA fire department has, as a minimum, a fire pumper that is less than 17 years old with the average age being 8 years old. VHA has a Fire Department Program Manager who coordinates the activities of the VA fire department program.

While VA continues to pursue options which would enable us to focus on the primary role of providing health care to our patients, the Department remains dedicated to ensuring a safe environment for our patients, employees and visitors.

#### **Vandalism at National Memorial Cemetery of the Pacific (NMCP)**

In the late evening of April 19 and early morning of April 20, 1997, the National Memorial Cemetery of the Pacific, or "The Punchbowl," was one of seven cemeteries in

the State of Hawaii to be desecrated by vandals. Vandals spray painted profane and racist words on all 22 walls in the Columbarium Courts and desecrated the Chapel, grave markers, railings and walls throughout the cemetery. Neither the Federal Government nor VA appeared to be specific targets of the vandals as the unauthorized entry by an unknown number of persons affected VA, State and private cemeteries.

The attack on NMCP, the Kaneohe State Veterans Cemetery and several private cemeteries on Oahu was organized, as vandals used stencils and red spray paint to publicize their racist and hateful messages. The cost of repairs at NMCP was estimated at \$20,000, donated by the Paralyzed Veterans of America. I am pleased to report that the damaged areas in NMCP have been restored and all graffiti has been removed. Federal, state and local law enforcement officials continue to work together and are still seeking the suspects.

Mr. Chairman, this concludes my prepared statement. My colleagues and I will be happy to answer any questions.

Statement of Charles F. Rinkevich  
Director of the Federal Law Enforcement Training Center  
For Presentation to the Committee on Veterans Affairs  
Subcommittee on Oversight and Investigations

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to provide you with an overview on the operations of the Federal Law Enforcement Training Center (FLETC).

Conceived as part of the great urban and police reforms of the 1960s, the FLETC opened its doors in 1970. Its headquarters have been housed since 1975 on a 1,500 acre former Navy training base located just outside the city of Brunswick on Georgia's southeast coast. The FLETC also operates two satellite training facilities, an owned facility in Artesia, New Mexico, and a licensed temporary facility in Charleston, South Carolina.

Born from the need to provide Federal law enforcement with consistent, high quality training and nurtured through its infancy by a combination of interagency cooperation and support, the FLETC has matured into the largest, most cost-efficient Center for law enforcement training in the nation. Center facilities at Glynco include a modern cafeteria, regular and special purpose classrooms, dormitories capable of housing more than 1,200 students (single occupancy), office and warehouse space and state-of-the-art specialized facilities for physical, driver/marine and firearms training. The Artesia satellite Center has facilities similar to those at Glynco but on a much smaller scale.

The FLETC's mission is to conduct basic and advanced training for the majority of the Federal Government's law enforcement personnel. We also provide training for state, local and international law enforcement personnel in specialized areas and support the training provided by our participating agencies that is specific to their needs. The Department of the Treasury has been the lead agency for the United States Government in providing the administrative oversight and day-to-day direction for the FLETC since its creation.

Using a multi-discipline faculty that includes criminal investigators, lawyers, auditors, researchers, education specialists, police and physical security professionals, the FLETC provides entry level programs in basic law enforcement for police officers and criminal investigators along with advanced training programs in areas such as marine law enforcement, anti-terrorism, financial and computer fraud, and white-collar crime. Currently 70 Federal agencies participate in more than 200 different programs at the Center.

During FY 1996 the FLETC trained 19,352 students, representing 88,792 student weeks of training and had an average resident student population of 1,708. April 1996 projections by

our participating agencies indicate that during FY 1997 the Center will train 29,351 students, representing 135,691 student weeks of training, with an average resident student population of 2,609.

Both the Center and its workload have grown tremendously over the years as more agencies have come to realize the many benefits of consolidated training. In 1975, when FLETC relocated from Washington, D.C., a staff of 39 employees moved with the Center. Today the FLETC has an authorized staff of 512 permanent employees. Additionally, there are more than 150 personnel detailed to the FLETC from its participating agencies. Several of the FLETC's participating agencies also maintain offices at the Center with a total staff complement of over 600 employees and employees of the Center's facility support contractors total more than 700.

In 1970 the FLETC graduated 848 students. By FY 1976, the first full year of training at Glynco, that total had grown to 5,152, and in FY 1996, as I mentioned earlier, the Center graduated more than 19,000 students. The Center graduated more students in the last three years than it did in its first 10 years of operations, a graphic example of the tremendous growth experienced by the Center in the last few years. In all, the FLETC has graduated in excess of 325,000 students since its creation.

Training is conducted at either the main training center in Glynco, Georgia, our satellite training center in Artesia, New Mexico, or the temporary training facility in Charleston, South Carolina. The temporary training site in Charleston was established in FY 1996, to accommodate an unprecedented increase in the demand for basic training by the participating agencies, particularly that of the Immigration and Naturalization Service (INS) and United States Border Patrol (USBP). It is the direct result of recent Administration and Congressional initiatives to control illegal immigration along the United States borders and to protect Federal workers in the workplace. We expect the Charleston temporary facility to be needed through FY 1999. However, after FY 1999, sufficient capacity should exist at the Glynco and Artesia Centers to accommodate the training requirements of all our participating agencies and the Charleston facility will be closed.

In addition to the training conducted on-site at one of the FLETC's residential facilities, some advanced training, particularly that for state, local and international law enforcement, is exported to regional sites to make it more convenient and/or cost efficient for our customers.

Over the years, the FLETC has become known as an organization that provides high quality and cost efficient training with a "can do" attitude and state-of-the-art programs and facilities. During my association with the Center, I have seen first-hand the many advantages of consolidated training for Federal law enforcement personnel, not the least of which is an enormous cost savings to the Government. Consolidated training avoids the duplication of

overhead costs that would be incurred by the operation of multiple agency training sites. Furthermore, we estimate that consolidated training will save the Government \$108,100,000 in per diem costs alone during FY 1998. This estimate is based on the Center's projected FY 1998 workload and per diem rates in Washington and other major cities of \$152/day versus the cost of housing, feeding, and agency miscellaneous per diem of \$25.26/day for a student at Glynco. Consolidation also ensures consistent, high quality training and fosters interagency cooperation and camaraderie. Students from the different agencies commingle, thus learning about each other and each other's professional responsibilities. The networks established at the Center last throughout their careers.

We view FLETC and consolidated training as a National Performance Review concept ahead of its time. Quality, standardized, cost-effective training in state-of-the-art facilities, interagency cooperation, and networking are indisputable results of consolidation. The Administration and Congress can be proud of the quality of the training being provided at the FLETC and the savings realized through consolidation

The FLETC is essentially a voluntary association with each agency's participation governed by a Memorandum of Understanding, and bolstered by the commitment of the participating agencies, the Department of the Treasury and the Congress. Particularly in these times of severe budget constraints, a single agency cannot afford the sophisticated facilities and staff which are required for the state-of-the-art training necessary to adequately prepare our nation's law enforcement personnel. Only by consolidation at a centralized location are programs and facilities like those at the FLETC economically feasible. We estimate that it would cost in excess of \$175,000,000 just to duplicate the facilities available at the FLETC.

#### Closing

Mr. Chairman, in closing, I would like to emphasize that the Department of the Treasury and FLETC management are strongly committed to providing high quality training at the lowest possible cost. Substantial savings are being realized by the Government through the operation of the Center as a consolidated training facility.

I am available to answer any questions you may have concerning this appropriation request.

**STATEMENT OF JOHN R. VITKACS, ASSISTANT DIRECTOR  
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
SAFETY AND SECURITY IN THE DEPARTMENT OF VETERANS AFFAIRS**

**MAY 22, 1997**

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to present its views on the Security Program of the Department of Veterans Affairs (VA) -- Veterans Health Administration (VHA).

On May 19, 1988, The American Legion testified before this Subcommittee that inadequate salaries and the lack of special salary rates contributed to high turnover and high vacancy rates within VA Security Service. At that time, The American Legion opposed arming VA security officers. Then, as now, the issues of training, supervision, pay and job performance are important qualifying factors to arming VA security officers.

Over the past several years, a gradual improvement occurred in the recruitment and retention of VA security officers. The security service vacancy and turnover rates dropped considerably as a result of increasing most pay grades, along with the expansion of special pay rates. Sadly, vacancy and personnel turnover rates have recently increased. However, this is due more to the recent uncertainties about government reductions-in-force and other occupational concerns.

The American Legion believes VA security officers should be paid commensurably with the federal law enforcement pay scale. Adequate salaries and other benefits improve VA security officer recruitment and retention. However, the question of whether to arm all VA police officers is more important than simply receiving a larger paycheck. The recruitment and retention of a competent security staff and providing proper police training and supervision creates the key conditions for alleviating concerns about the arming of VA security personnel. A weapon does not make a competent security officer; rather the officer must be able to diligently and competently carry-out their responsibilities.

Mr. Chairman, VHA is in the process of conducting a test program of arming security officers at six medical centers. The program will be completed about the end of 1997, with a full evaluation in early 1998. At this time, the pilot program is too current for any substantial assessment. The VA is learning valuable information in relation to the pilot program and The American Legion supports the program.

It is the conviction of The American Legion that VA medical centers and clinics are totally responsible for the safety and security of patients and staff; protection of Government property; the property of patients and staff; and the orderly conduct of affairs at VA installations. It is equally important that VA employees be able to carry out their important duties and responsibilities without the apprehension of worrying about their own safety and the safety of the patients to whom they are providing care and services.

Recent tragic events at certain VA medical facilities support these concerns. Over the past ten years, four VA security officers have died in the line-of-duty and others have been seriously injured. Additionally, a medical doctor was recently killed at VAMC Jackson, MS; and a nurse was raped at VAMC Manhattan, NY. Other serious incidents could have produced equally tragic outcomes.

The American Legion recognizes that VA security officers face the same dangers as any other city or county law enforcement officer, and often times more than other federal departments. On an average day, VA security officers respond to assaults, disturbances, fleeing suspects, motor vehicle stops, etc. Officers not only patrol buildings but also grounds and streets. If VA ultimately makes a recommendation to permanently arm security officers, the implementation of that decision should be gradual and measured, with close supervisory controls.

The VA Little Rock Training Academy must be capable of providing security officers responsible training in the conduct and use of firearms. If a recommendation is made to arm VA security officers it must be certain the best training is available, along with a continuous instruction and assessment program.

Mr. Chairman, in all instances, a security officer's quick thinking and proper training cannot neutralize someone intent on committing a violent crime. Thirteen years ago, The American Legion testified before the House Veterans Affairs Committee that the potential ramifications of VA security officers carrying firearms far outweighs its justification. The tragic and nearly tragic events within VA facilities over the past ten years are very serious. The American Legion believes the current pilot program on arming VA security officers should be completed and fully evaluated prior to deciding the future policy of this important subject.

Mr. Chairman, that completes my statement.



For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★  
(202) 861-2700 ★ FAX (202) 861-2728 ★

May 19, 1997

Honorable Terry Everett, Chairman  
Subcommittee on Oversight and Investigations  
Committee on Veterans' Affairs  
337 Cannon House Office Building  
Washington, DC 20515

Dear Chairman Everett:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the May 22 hearing on Safety and Security in the Department of Veterans Affairs.

Sincerely,

A handwritten signature in cursive script, appearing to read "John Vitkacs".

John Vitkacs, Assistant Director  
for Resource Development  
National Veterans Affairs and  
Rehabilitation Commission

**JOHN R. VITIKACS  
ASSISTANT DIRECTOR FOR RESOURCE DEVELOPMENT  
NATIONAL VETERANS AFFAIRS AND  
REHABILITATION COMMISSION**

Mr. Vitikacs' service with The American Legion commenced on November 1, 1982. He was assigned as a Field Service Representative with the National Veterans Affairs and Rehabilitation Commission (VA&R). Assuming new responsibilities in January 1990, John applied his Field Service experience in the capacity of Resource Development Specialist, preparing Congressional testimony on a wide variety of veterans' related legislation. In April 1993, he was promoted to the position of Assistant Director for Resource Development.

Mr. Vitikacs' duties with The American Legion include oversight of Veterans Health Administration medical care programs, medical construction, the National Cemetery System, State veterans' programs, and Department of Veterans Affairs budgetary analysis.

John was born in Frederick, Maryland on September 10, 1952. He graduated from Brownsville Area High School, Brownsville, Pennsylvania in May 1970. He served on active duty in the U.S. Army from June 1970 until June 1973. He received training as a combat intelligence analyst at Fort Holabird, Maryland, and served a tour of duty with the 525th Military Intelligence Group, MACV Headquarters, Saigon, Vietnam. Upon completion of his Vietnam service until discharge, he was assigned to Supreme Allied Headquarters Europe, Brussels, Belgium as a personnel security analyst. Mr. Vitikacs' military decorations include the Bronze Star Medal (meritorious), Army Commendation medal, and Good Conduct Medal.

Mr. Vitikacs obtained a Bachelor's Degree in Public Administration from George Mason University in Fairfax, Virginia and a Graduate Certificate in Legislative Affairs from George Washington University, Washington, DC. He belongs to American Legion Post #364, Woodbridge, Virginia.

**NOVA**

NURSES ORGANIZATION OF VETERANS AFFAIRS

1726 M Street, N.W., Suite 1101  
Washington, D.C. 20036  
Phone (202) 296-0888  
Fax (202) 833-1577

**Statement of  
the Nurses Organization of Veterans Affairs  
(NOVA)**

**By  
Barbara Frango Zicafoose, MSN, RNCS, ANP  
Legislative Co-Chair**

**Before the  
United States House of Representatives  
Committee on Veterans Affairs  
Subcommittee on Oversight and Investigations**

**On  
Safety and Security in the Department of Veterans Affairs**

**May 22, 1997**

Mr. Chairman and Members of the Subcommittee, I am Barbara Zicafoose, Nurse Practitioner in the Center for Outpatient Services at the Veterans Affairs Medical Center in Salem, Virginia. As Legislative Co-Chair for the Nurses Organization of Veterans Affairs (NOVA), I am pleased to present testimony on safety and security in the Department of Veterans Affairs (DVA) on behalf of NOVA. I speak for our membership and for the more than 40,000 professional nurses employed by the Department of Veterans Affairs (DVA).

**Introduction:**

NOVA is a professional organization whose mission is: *Shaping and influencing professional nursing practice within the DVA healthcare system.* NOVA is very interested in assuring that the DVA is a safe, secure place for patients, employees, and visitors. Workplace violence has emerged as a critical safety and health hazard nationally.

Workplace violence is a problem of national scope which can effect everyone. The magnitude of the problem is well documented in the literature. The 1994 U.S. Department of Labor report notes that 1,071 workplace deaths occur every day of the year. These statistics to an average of three individuals dying at the workplace each and every day of the year. These statistics do not account for the additional several hundred innocent bystanders and non-employees killed yearly. The Bureau of Justice Statistics, in a report released in July 1994, reported that one million individuals are victims of some form of violent crime in the workplace each year. This represents approximately 15 percent of all violent crimes committed annually in America. Health care providers are at an increased risk for violence because they are caring for individuals and families during a time of illness which can precipitate stress and the sense of loss of control, leading to inappropriate or violent behavior (Boucher, 1993).

According to one study (Goodman, 1994), between 1980 and 1990, 106 occupational violence-related deaths occurred among health care workers, 18 of these being registered nurses. Another study found that nursing staff at a psychiatric hospital sustained 16 assaults per 100 employees per year. At a time when homicide is the second leading cause of death to American workers and violence in the workplace is increasing, it is timely that the this Subcommittee and the DVA investigate workplace safety.

**Considerations:**

NOVA recognizes the most frequent recommendation for controlling violence at medical centers is to arm our VA police with guns. We support Secretary Jesse Brown and the DVA's reluctance to place firearms in our hospitals. The very presence of a weapon in a work environment, for whatever reason, can contribute to a triggering event for violence. Many veterans suffer long-term complications, disabilities, and/or emotional trauma related to these weapons. Guns are for killing and have no place in institutions developed to promote health and wellness and the treatment of diseases. The passage of the Brady Bill in 1994 further indicated that with concerted efforts at public education, more stringent measures could be passed.

NOVA supports an alternative strategy. Staff education and training, along with knowledge of evaluation and intervention techniques can reduce workplace violence. The problem with the successful use of staff education and training as a successful intervention method is a lack of awareness, and in many cases, a belief system that denies the possibility violence existing in our environment (Kelleher, 1996).

Another consideration related to workplace violence is its cost to the system. Following a violent incident in the workplace, there is generally loss of productivity, a drop in morale, people are physically injured, and frequently dozens of individuals are severely traumatized by the event. Additionally, it is estimated that violent crimes in the workplace (in 1994) caused some 500,000 employees to miss 1,751,000 days of work annually, or an average of 3.5 day per incident. This missed work equated to approximately \$55,000,000. Experts agree the best approach to reducing workplace violence is prevention and protection (Brow, 1993; Ducan, 1995; Kelleher, 1996; Labig, 1995; McClure, 1996; McVey, 1996; and Smith, 1994).

***Prevention and Protection:***

The Occupational Safety and Health Administration (OSHA) in 1996 published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include a workplace violence prevention program. A review of the literature supports this belief that education and prevention for workplace violence should be the first intervention. Recurring prevention themes include (but are not limited to): staff education and training; tighter security measures; adopting a "Zero Tolerance" policy toward unacceptable behavior; developing a Crisis Management Team which would evaluate any warning and decide what to do about them; and creating a Trauma Team.

One intervention mentioned, tighter security measures, is critical for the DVA because of the location of some Medical Centers in high crime areas and the growing implementation of satellite and mobile clinics. Some physical security measures recommended in the literature include: increase security personnel on the premises during off duty hours; improved lighting; beepers for human resources and security personnel; badges for all visitors; metal detectors in high crime areas; bullet proof glass (especially in ER's and high profile areas); hidden panic buttons; and closed-circuit television cameras. These cameras would monitor common areas like stairwells, lobbies, reception areas, smoking and break areas, and warehouses, where many outbreaks of violence occur. If new mobile clinics are visiting high crime areas, then NOVA recommends that a security escort be sent with that clinic.

Another intervention is the adoption of a "Zero Tolerance" policy toward unacceptable behavior. NOVA applauds Secretary Jesse Brown on his recent comments in *putting veterans first* (March 20, 1997) where he addressed safety in the workplace and reports that, "Violence, threats, harassment, intimidation, and other disruptive behavior in our workplace will not be tolerated." Workplace violence is not limited just to homicide but to those behaviors identified by Secretary Brown. The "Zero Tolerance" policy identifies and provides a solid

definition of workplace violence It includes: any act which is physically assaultive; behavior indicating potential for violence (such as shaking fists and throwing objects); any substantial threat to harm another individual or endanger safety of employees; a significant threat to destroy property; and aberrant behavior that okay signal emotional distress. Staff need to be trained to be aware of the warning signs of a potentially violent individual and the method of reporting such an individual.

A third intervention identified is the creation of a Crisis Management Team. This team would include the Director, a psychologist with special training in this area, the head of security, and legal counsel with special training. This team would have a written plan to be followed in a crisis or when there are signs a crisis may occur, evaluate any warnings of potential violence and decide what actions need to be taken.

A potential lifesaver in workplace violence and one most often overlooked is the development of a Trauma Team. This team would be composed of trained personnel with specific "jobs" in the event of a tragedy. It would include such assignments as first aid, media control, management of onlookers and notification of families.

***Summary:***

Over one million employees will be victims of workplace violence this year according to the Department of Justice. Over one thousand will be murdered at work, and this number may be conservative. Workplace violence is a problem of epidemic proportions. The probability of being the victim of workplace violence in some form is about fifteen percent and growing each year. Violence inflicted upon employees may come from many sources, including patients, third parties such as robbers, and even coworkers. It can include violent, threatening, harassing, intimidating, or disruptive behavior. Current literature supports that there are tactics for evaluating and defusing workplace violence issues without the use of weapons. Staff education and training, along with knowledge of evaluation and intervention techniques, can substantially reduce the possibility of workplace violence. Initiating prevention and intervention techniques as identified can make the workplace safer by stopping a crisis before it begins.

I would like to thank NOVA's President, Dr. Maura Farrell Miller, PhD, ARNP, CS, and Legislative Chair, Sarah V. Myers PhD, MSN, RNC, for their assistance in the preparation of this testimony. Thank you for the opportunity of presenting this written testimony on behalf of NOVA.

**AFGE**



**American Federation of  
Government Employees, AFL-CIO**

**80 F Street, N.W.  
Washington, D.C. 20004  
(202) 737-8100**

STATEMENT BY

ERNEST W. LITTLE

FIRE FIGHTER, DEPARTMENT OF VETERANS AFFAIRS

AND

MEMBER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES LOCAL 331

PERRY POINT, MARYLAND

BEFORE

THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HOUSE COMMITTEE ON VETERANS' AFFAIRS

ON

SAFETY AND SECURITY IN THE VA

MAY 22, 1997

**CONGRESSIONAL  
TESTIMONY**

I am Ernest W. Little, a fire fighter employed by the Department of Veterans Affairs (DVA), at Perry Point, Maryland, and a member of AFGE Local 331. I am here today on behalf of the American Federation of Government Employees (AFGE), which represents 700,000 employees, many of whom work for DVA. We are particularly pleased to have this opportunity to appear before you.

Currently, DVA maintains 31 fire departments and AFGE represents the employees at 21 of those departments. There are five major organizations representing federal fire fighters--AFGE, the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Association of Government Employees and the National Federation of Federal Employees. These five organizations work closely together on all federal fire fighter issues. We have discussed this testimony and all agree that if each were to testify, they would present the same views.

In preparation for today's hearing, we surveyed the 21 fire departments which AFGE represents. We had only a few days to do this but were pleased with about a 35% response rate and will refer to the information obtained throughout this testimony.

We will focus our remarks on DVA fire service and present the views of our DVA fire fighter members. Their particular concerns are the fire protection afforded our nation's veterans at DVA medical centers throughout the country and the opportunities which exist to utilize the fire service to provide needed services at great cost savings to DVA.

I want to stress that AFGE has been working closely with the Administration in its reinvention efforts. We endorse the goal of an efficient, cost effective service which places its customers first. To this end, we have met with Secretary Jesse Brown and discussed the advantages to DVA of having the authority to enter into sharing arrangements. Our position has been that prior to entering into such arrangements, the full scope of the work must be determined, its cost calculated and an accurate comparison between in-house performance and performance by outsourcing must be made. In addition, AFGE has long been an advocate for seeking new ways to do business which will both improve the service provided to customers and be cost effective. Unfortunately, the DVA fire service has not benefited from any in-depth analysis and in fact, appears to be viewed solely as a source of revenue drain rather than a critical component of caring for our nations veterans.

Today, we would like to focus on two main points. First, millions of dollars in savings could be achieved if DVA would emulate fire services around the country and take advantage of the full range of emergency services which fire fighters are uniquely qualified to provide. Second, at the present time, veterans who are patients at Medical Centers as well as employees are at great risk at most facilities because of DVA's inattention to its fire service.

To fully understand the importance of these points, some background may be necessary.

#### Today's Fire Service.

Beginning in the early 1980's, fire incidents were drastically reduced. This was directly attributable to the fire services' public education efforts, widespread prevention and protection measures, and the establishment and enforcement of better fire safety codes.

At the same time, communities nationwide began calling upon their fire departments to respond to all types of emergencies--hazardous materials incidents, crash/rescue efforts, and emergency medical services--and most now have even changed their names to reflect that they are now no longer just fire departments but rather,

emergency services departments.

This also coincides with the changes taking place in the medical profession. The provision of both Basic and Advanced Life Support by Emergency Technicians is saving communities millions of dollars by utilizing fire fighters for this function. There is now widespread recognition of the need for on-the-scene immediate care prior to transport; an emergency service which fire fighters can easily fulfill and which enables hospitals to significantly reduce emergency room services and personnel. In addition, it is now well established that immediate emergency medical attention not only saves lives but reduces the time and attendant costs needed for recovery.

Unfortunately, the federal government has not completely recognized these changes, although the Department of Defense (DoD), which employs 98% of all federal fire fighters, has taken the first step. Its Fire and Emergency Services Quality Working Group adopted a five-year strategic plan which included the goal of having DoD fire departments assume full responsibility for all emergency medical services at DoD facilities.

#### Fire Fighting Is A Science.

Over the years, research has yielded certain scientific facts pertaining to fire suppression. Most important among those facts is that sprinklered buildings reduce fire loss but not fire risk. When there is a fire, the high use of plastics and other synthetic materials, particularly at medical facilities, results in an extremely hot, fast-burning fire which produces an increased amount of toxin-carrying smoke.

For example, articles which contain polyvinylchloride (PVC's) can melt when exposed to heat, creating a highly toxic vapor. As fire fighters say: one whiff and you wonder what it is; but you'll never know because after the second whiff, you're dead.

Today, there are more deaths from smoke inhalation than there are from fire burn. The highest injury and death rate from burns and smoke inhalation occur to people who are unable to evacuate buildings such as the elderly, the sick or those who are easily confused such as the mentally ill, mentally retarded, those suffering from Alzheimer's or who have damage from substance abuse--the very type of patients at VA Medical Centers.

#### Response Times Are Critical.

Both fire suppression and emergency medical services should always be discussed in terms of response times. It is well known how long it takes before a fire results in a total loss. A graphic example of this can be seen in a film developed by the National Fire Prevention Association (NFPA) which promulgates national consensus standards pertaining to the fire service. This film shows that within 40 seconds of dropping a lighted cigarette between two sofa cushions, the cushions will begin to smolder, giving off toxic fumes. Within 5 minutes there is a total flash-over--resulting in heat so high that it becomes impossible to enter the room. Within 10 minutes, the room is filled with vaporous fuel, creating a backdraft condition that results in total loss. Thus, failure to respond within 10 minutes is extremely dangerous.

#### Staffing Of Fire Departments Can Be Determined With Accuracy.

Perhaps more so than for any other occupation, the absolute minimum staffing levels for fire departments can be determined with precision and accuracy. It is based on the basic equipment needed and the number of men needed to operate the equipment safely.

The starting point for determining staffing levels is the risk assessment. Risk assessments force you to go beyond the narrow confines of fire suppression. They incorporate the functions provided by the Federal fire service today by considering factors

such as EMS, HazMat and fire prevention and maintenance—all of which are vital if the risk to people and property is to be contained.

Once the risk assessment has been undertaken, then the equipment needs can be determined. After decisions are made on the number of companies needed to meet response times and the number of units of mobile equipment which are required to meet relevant standards, then proper staffing levels can be determined.

The national consensus standards adopted by both OSHA and DVA recognize the need for four fire fighters to respond to a fire. Two go in and attack the fire; one serves as a back-up in case the first two go down; and one operates radio command, the pumper, etc. To have fewer fire fighters means the fire fighters and the patients they are trying to protect are placed at an even greater risk.

As an example, we call your attention to the recent incident which occurred in neighboring Prince Georges County, Maryland. A fire alarm went off in early April. Because the county fire department was underfunded, the closest fire station was closed. The next closest station could not meet and did not meet the minimum 10 minute response time. When the fire fighters arrived, the fire was so advanced that nothing could be saved. However, the more tragic part of this story is that because only two fire fighters responded, the small child trapped inside the burning building could not be saved. This could have been the story at a lock-down psychiatric unit at a VA medical center.

Not only is it recommended that a minimum of four men respond to a fire incident, but NFPA 1200, which is currently being considered by the committee, proposes that a fire department be able to have 10-12 men at the scene of a fire within 10 minutes of a fire alarm and that the initial response be made within 4 minutes.

After the number of individuals needed to operate the equipment in accordance with the regulatory staffing requirements has been determined, this number should be multiplied by the appropriate Manpower Staffing Factor. This factor is the number of men needed to insure 24 hours per day staffing after taking into account annual and sick leave, jury duty, reserve guard duty, training, etc.

For example, if the risk assessment determines a need for one pumper and the relevant staffing standard for that pumper is 4 men, and each of those men worked shifts of 24 hours on and 24 hours off, then you would need a total of 8 men to cover 24 hours per day, seven days per week. After taking into account, holidays, jury duty, etc., you probably need 2.8 to 3.4 men.

Now let's see how the operation of the DVA fire departments stack up against these facts.

#### Millions of Dollars In Savings Could Be Achieved.

If DVA would emulate fire services around the country and take advantage of the full range of emergency services which fire fighters are uniquely qualified to provide, it could save millions of dollars and provide a needed and necessary service to the veterans of this country and to DVA employees.

There is already a shining example of this within the system. AFGE Local 1119 at the Montrose VA, New York, submitted a proposal to management last December to cancel the contract with an ambulance service and to permit the fire department to take over this service. The Director agreed and here is what happened:

The contract for ambulance service—costing \$207,000 per year (and estimated to increase by \$50,000 to \$60,000 annually because of the facility's closure of its ICU unit which means that more patients would have to be transported off-site)—was cancelled.

An ambulance (demo model) was acquired for a cost of \$75,000.

The fire service took over the ambulance function—with no increase in staff—on April 4.

Those fire fighters operating the ambulance are certified emergency medical technicians and because basic life support is now one of their primary duties, they are entitled to a grade increase which increased the salary costs to the VA by approximately \$95,000 annually but which still meant that the VA will save \$160,000 or more annually after the first year.

The in-house response time is under 4 minutes as contrasted with the contractor service which was between 1/2 and two hours.

At the present time, the fire department is manned by a staff of six. This enables four men to be ready to respond to a fire while two can operate the ambulance. Obviously, this does not allow for employees on leave. In that case as well as in the case when the ambulance needs to leave the facility to transport to another hospital, a nurse is used in the ambulance. Recognizing this shortfall, the fire fighters are suggesting increased staffing in the fire department and a corresponding reduction in the nursing unit. This too will save money because nursing personnel are paid more than the fire fighter/EMTs and receive overtime after 40 hours whereas fire fighters do not receive overtime until after 53 hours per week.

Finally, assumption of the emergency medical service and providing basic life support to those at the Center not only will save over \$160,000 per year and provide a much higher quality service to those at the facility but it was a job easily assumed by current employees who are already trained to respond. (Copies of the Montrose fire fighters' proposal to take over this function is attached.)

The same type of proposal including providing EMS service to adjacent federal buildings on a reimbursable basis was submitted by an IAFF Local in Minneapolis. The Director concluded he was not interested. In fact, he has indicated that he is not interested in keeping the fire department. He simply wants to outsource regardless of the impact on veterans or of the cost. How can the VA justify a failure to take advantage of cost savings which include providing quality service to our Veterans and how can it justify the risk understaffing of fire departments places everyone at a VAMC in?

#### DVA Patients, Employees and Fire Fighters are at Great Risk.

The second point we want to discuss today is the risk veterans and employees face at most facilities now and the likelihood that this risk will increase if recommendations for sharing arrangements or other outsourcing measures currently proposed are actually implemented.

The situation at most DVA fire departments is so egregious that it can only be characterized as a "disaster waiting to happen". As always, staffing and response times should be considered first and foremost.

Last September, the award for the best DVA Fire Department was given to American Lake, in Tacoma, WA. Now, a sharing arrangement with Ft. Lewis is all but finalized.

This facility consists of 60 structures on 380 acres including a lake. Beside the medical facilities, there are ten residential houses. The medical unit houses psychiatric patients many of whom must be kept in a locked unit, and geriatric, Alzheimer, post traumatic stress, substance abuse and blind rehabilitation units housing some 350 patients at any given time. It has one fire department staffed with five fire fighters and one chief plus four temporary fire fighters for a total of 10 personnel or 5 on duty at any

given time if no one is on leave, attending training, on jury duty or reserve military duty. It has two vehicles. As currently configured, it cannot meet the required staffing of 14 fire fighters and a Chief. The fire department cannot meet the requirement of a four-man response but it does the best it can.

The department costs approximately \$464,000 per year to operate. In addition to providing fire suppression services, this undermanned department also provides police back-up equal to 2 FTE's, sprinkler and fire alarm maintenance equivalent to 2 FTE's, patient transport via ambulance/escort equivalent equal to one FTE, and estimates that by handling snow removal it saves the facility \$20,000 in overtime. These savings are not reflected in the operating budget nor were they considered when the cost of the Ft. Lewis sharing arrangement was determined.

Consonant with DVA's policy of pursuing sharing arrangements, American Lake approached the county. County officials were not interested but did say: (1) fire suppression only would cost in excess of \$300,000 per year, (2) their best boat response time would be one-half hour although fire suppression might be around 10 minutes, (3) they would respond to a call within the county before responding to the VA facility, and (4) would leave the scene of a VA fire incident to respond to one within the county.

Next, the facility contacted Ft. Lewis, which has offered to take on fire suppression services only at a cost in the neighborhood of \$165,000. Its normal response time would be in the 12 to 14 minute range.

Using Ft. Lewis would cost less than what is required to operate the American Lake fire department. But is the risk worthwhile? Let's look at what will be lost:

The five positions now backfilled by the fire fighters will have to be filled.

The estimated \$20,000 in overtime for snow removal will have to be paid.

If there is a fire, it is doubtful that Ft. Lewis can respond within the critical 10 minute period so it could result in loss of property and perhaps even lives.

A contractor will have to be hired to maintain the sprinkler and fire alarm systems.

The fact that Ft. Lewis will not provide boat rescue for patients who wander into the Lake was brought to the facility's attention and they indicated this could be handled by the County. Any water rescue delayed for the one-half hour county response time is likely to result in death.

Elevator rescues will no longer be done by the fire department but will instead be handled by the contractor who services the elevators. The contractor will do his best to respond within one hour. Just last week, the fire department responded to three elevator emergencies in one day. One of the incidents involved a patient being moved from surgery to ICU. Should patients wait for an hour or more in a stuck elevator before rescue?

Quite honestly, the facts indicate that a sharing arrangement will yield little if any cost savings but the impact will adversely and seriously disadvantage patients and others. The American Lake fire fighters are puzzled, to put it mildly, by this decision. We ask: is this the reward for being the best DVA Fire Department?

Other VA fire departments report much the same thing. The Chillicothe, Ohio, DVA fire department reports that it has 60 buildings on its 307 acres including 14 housing units. It is currently staffed with 13 fire fighters and 1 Deputy Chief. This means, at a maximum, 7 men are on duty at any given time—which is certainly not enough to operate the equipment. Chillicothe, to the best of the fire fighters' knowledge, including the Deputy Chief, has never undertaken a formal risk assessment. But, even under any assessment or under any standards, its current level of staffing is far short of the number

of men required to perform the job at all. In short, it would be almost humanly impossible to control and extinguish a major fire. During 1996 the department responded to 516 fire alarms, 84 code oranges (disturbances), 24 code blues, 20 helipad response stand-bys, 99 ambulance runs, and 227 patient transports. That's 670 responses. The closest fire department is totally out of date and its response time is 15 to 20 minutes. Certainly, reliance on it for fire suppression would be pure folly. Chillicothe has a lake and it does boat rescues. It has multi-storied buildings and does elevator rescue. It has wards housing psychiatric, Alzheimer's, geriatric, hospice, cancer, and substance abuse patients. It must continue to have its own fire department which must be staffed at a level to meet the most minimal standards.

At Ft. Meade VAMC, South Dakota, the facility encompasses almost 8,000 acres with 878,600 gross square feet of occupied space including hospital, workshop, offices and housing including shelter for up to 400 National Guardsmen. At any given time, there may be as many as 1,600 people on the facility. The fire department currently has a staff of 12: one fire Chief, 3 captains, 3 driver/operators and 5 line fire fighters—which is insufficient to meet any applicable standards. The last risk assessment was done in 1993, which is totally out of date unless there have been absolutely no changes at the facility in the last four years. The closest fire department which could enter into a sharing arrangement is the Sturgis *Volunteer Fire Department*, which is all volunteer and does not operate an ambulance. The response time for this Department is 15 minutes after the volunteers have responded. Veterans and other, including the fire fighters, at Ft. Meade should not be placed at great risk simply because the VA fails to meet staffing standards nor should they be placed at even greater risk by relying on the Sturgis Volunteer Fire Department which cannot meet any reasonable response times and which uses only volunteers who may or may not be available at any given point in time.

Battle Creek VAMC in Michigan is contemplating dual-hatting its fire fighters and police. Under the proposal, these men would become Public Safety Officers. We recognize that there are certain law enforcement functions easily and currently performed by the fire fighters, but these are generally confined to inspection and enforcement of codes and regulations. The apprehension and detention of those violating criminal statutes is not something a fire fighter would routinely do but more importantly, if an emergency alarm were sounded during the search for a suspect, to which of these serious incidents would a fire fighter's obligation lie? Battle Creek has approximately 600 patients with a current fire fighter staff of 10, plus 3 temporary employees. Their staffing meets no applicable standards. The nearest fire department (Battle Creek) can respond to the facility in 12 minutes or more. As pointed out above, this is too long particularly when you have non ambulatory patients and those in locked psychiatric wards.

Sheridan, WY VAMC is staffed so that it can operate its three pieces of equipment—on Tuesdays—when staffing off days overlap. Let's hope Sheridan's emergency calls are limited to Tuesday occurrences but that's unlikely given its average of over 370 emergency responses per year. Sheridan is fortunate in that the Sheridan City Fire Department can respond in eight or more minutes. Thus, a fire incident might not result in a total loss. The City can respond under the mutual aid agreement. Notwithstanding this, we ask why the DVA is placing everyone at Sheridan VAMC at such great risk simply by understaffing the fire department?

In addition to these facts, we point out to the Committee that at each VA Fire Department, the fire fighters perform an incredible array of necessary duties all of which must be performed and will continue to have to be performed either by a contractor or by hiring additional personnel. The following are just some of the examples: fire and safety inspection; fire alarm and fire suppression system (sprinkler and fire extinguisher maintenance and inspections); confined space assessment for hazardous atmosphere and confined space rescue; emergency medical response which, at some facilities, includes both basic and advanced life support; patient transport to other facilities or airports; hazardous materials response, assessment and cleanup; vehicle extrication for accident victims; sole answering point for 911 calls; after hours inspection of facilities and construction sites; employee fire and safety training, fire drills and new employee

orientation; engineering service call taking and assessment after duty hours, weekends and holidays; alternative answering point for hospital after hours, weekends and holidays; security runs off station; police backup; snow removal; maintenance of fire vehicles and equipment; and assisting engineering in clearing roadways blocked by natural disasters.

Mr. Chairman and members of the Committee, we bring these facts to your attention in the hope that you will pursue this issue. Our recommendation is quite simple. Where critical response times can be met by a fire service located near a DVA facility, sharing or outsourcing arrangements should be explored. Exploration should include not only comparing the full scope of work currently performed by the fire department but the additional functions such as EMS, which the fire department could perform without an increase in staff above those needed to meet staffing standards and which would save money and provide a quality service. Montrose VA is a prime example of the assumption of additional duties at a great savings to the DVA.

Where critical response times cannot be met, then the VA must take needed action to insure that veterans and employees are protected adequately. This includes meeting minimum staffing standards without the widespread use of temporaries which has been so prevalent throughout the VA over the last four or more years. Further, dual-hatting should not be practiced where it provides an inherent conflict such as the dual-hatting (police/fire fighter) proposal being considered by Battle Creek. In addition, the Montrose VA example should be given serious consideration as an appropriate adjunct to the services now offered by the fire department.

AFGE would welcome the opportunity to work with the Committee to explore ways in which the Department of Veterans Affairs' **FIRE AND EMERGENCY SERVICES** can be provided at all DVA facilities in the most efficient and effective manner--providing a quality service for its customers--our nations veterans--at the most realistic cost.

Again, we thank you for this opportunity to appear today.

AFGE has no grants or contracts to declare.

## BIOGRAPHY

of

**ERNEST W. LITTLE**

Ernest W. Little is a fire fighter employed by the Department of Veterans Affairs at Perry Point, Maryland. In addition, he is a part-time support instructor for the Maryland Fire and Rescue Institute, special programs section.

He has 12 years experience as a fire fighter including six years with the Department of Veterans Affairs. He has served as a lieutenant and a captain in the fire service.

Ernie highly proficient and skilled at fire suppression, fire inspection, confined space rescue, high angle rope rescue and vehicle rescue.

He holds many certifications including Fire Fighter II, Fire Officer II, Fire Service Instructor III, and Hazardous Material Technician.

Mr. Little is an active member of AFGE Local 331 Perry Point, Maryland and participates in many union activities. He is a member of the AFGE Fire Fighters Steering Committee which consists of all federal fire fighters who are also members of AFGE. The coalition recommends policy to AFGE's National Executive Council on issues directly impacting federal fire fighters.

In addition to his work at Perry Point, Mr. Little utilizes his experience and skills as a volunteer for his local community volunteer fire department.

Mr. Little and his wife, Sharon, reside in Elkton Maryland.

# National Board on Fire Service Professional Qualifications

*It is hereby confirmed that*

**ERNEST WILSON LITTLE**

*having been examined by an accredited agency in the  
National Professional Qualifications System is certified as*

**FIRE FIGHTER II**

June 26, 1995



*W. R. Zeil*  
Secretary to the Board

*Jim Ester*  
Chairman of the Board

Certificate # 27682

# National Board on Fire Service Professional Qualifications

*It is hereby confirmed that*

**Ernest Wilson Little**

*having been examined by an accredited agency in the*

*National Professional Qualifications System is certified as*

**FIRE OFFICER II**

January 22, 1997



*[Handwritten Signature]*  
Secretary to the Board

*[Handwritten Signature]*  
Chairman of the Board

Certificate # 35803

# National Board on Fire Service Professional Qualifications

*It is hereby confirmed that*

**ERNEST WILSON LITTLE**

*having been examined by an accredited agency in the  
National Professional Qualifications System is certified as*

**FIRE INSTRUCTOR III**

June 24, 1986



*[Signature]*  
Secretary to the Board

Certificate # 31843

*[Signature]*  
Chairman of the Board

TRAINING RECORD  
ERNEST W LITTLE 215-80-6522

COURSE	HOURS	INSTITUTION
BASIC FIREFIGHTING	80	MFRI
FIREGROUND OPERATIONS 1	24	MFRI
FIREGROUND OPERATIONS 2	24	MFRI
TRUCK COMPANY OPERATIONS	24	MFRI
PUMPS	24	MFRI
AERIAL OPERATOR	12	MFRI
RESCUE TECHNICIAN	45	MFRI
FIRE COMMAND 1	27	MFRI
FIRST RESPONDER	50	MIEMSS
HAZARDOUS MATERIAL TECHNICIAN	40	GM
HAZARDOUS MATERIAL TECHNICIAN REFRESHER	8	GES
NFA LEADERSHIP 1	12	NFA
NFA LEADERSHIP 2	12	NFA
NFA LEADERSHIP 3	12	NFA
MARYLAND CHIEF OFFICERS SEMINAR 1993	12	MFRI
MARYLAND CHIEF OFFICERS SEMINAR 1994	12	MFRI
CONFINED SPACE RESCUE	40	WVFA
GOVERNORS FIRE AND BURN CONFERENCE 1993	8	MFRI
GOVERNORS FIRE AND BURN CONFERENCE 1994	8	MFRI
FIRE PREVENTION AND SUPPRESSION	80	DVA
INCIDENT SAFETY OFFICER	12	NFA
HEALTH AND SAFETY OFFICER	12	NFA
PORT AND MARINA FIREFIGHTING	12	MFRI
SPRINKLERS AND STANDPIPES	8	MFRI
RADIOLOGICAL EMERGENCY MANAGEMENT	12	FEMA
NFA BUILDING CONSTRUCTION 1	12	MFRI
NFPA 25 SPRINKLERS	8	MFRI
MANAGING COMPANY TACTICAL OPERATIONS	12	NFA
NFA FIRE ARSON DETECTION	16	HACC
NFPA 101 LIFE SAFETY CODE UPDATE 1995	4	DVA
LEADERSHIP AND SUPERVISION	18	MFRI
CODES AND STANDARDS RESEARCH SEMINAR	8	MFRI
EXECUTIVE DEVELOPMENT SEMINAR NFPA 1021		
2-2.1,2-2.2,2-2.3,3-2.2,4-2.2,4-2.3,4-5.1,4-5.4,4-5.5	6	MFRI
NATURAL GAS EMERGENCIES	4	HACC
EASTERN UNITED STATES TECHNICAL RESCUE SCHOOL	87	FIRES
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HACC	HARRISBURG ARFA COMMUNITY COLLEGE
MRFI	MARYLAND FIRE AND RESCUE INSTITUTE
MIMSS	MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES
GM	GERAGHTY AND MILLER COMPANY
GES	GUARDIAN ENVIRONMENTAL SERVICES
NFA	NATIONAL FIRE ACADEMY
DVA	DEPARTMENT OF VETERANS AFFAIRS
FEMA	FEDERAL EMERGENCY MANAGEMENT AGENCY
FIRE	FIREFIGHTING AND RESCUE EDUCATIONAL SERVICES
SA	SCOTT AVIATION
PADI	PROFESSIONAL ASSOCIATION OF DIVING INSTRUCTORS
PECO	PHILADELPHIA ELECTRIC COMPANY
USEPA	UNITED STATES ENVIRONMENTAL PROTECTION AGENCY
	MARYLAND CERTIFIED FIREFIGHTER II JUNE 30, 1995
	MARYLAND CERTIFIED FIRE OFFICER II FEBRUARY 25, 1997
	MARYLAND CERTIFIED FIRE SERVICE INSTRUCTOR III JUNE 16, 1996
	NATIONAL CERTIFIED FIREFIGHTER II JUNE 26, 1995
	NATIONAL CERTIFIED FIRE OFFICER II JANUARY 22, 1997
	NATIONAL CERTIFIED FIRE SERVICE INSTRUCTOR III JULY 15, 1996

SANDY  
FROM - WARREN CLACK  
AFGE-L-1119

DEPARTMENT OF VETERANS AFFAIRS  
**FRANKLIN DELANO ROOSEVELT**  
**VA HOSPITAL**  
**P. O. BOX 100**  
**MONTROSE, NY 10548-0100**

**FTS FAX:** 700-887-\_\_\_\_\_  
**COMMERCIAL FAX:** 914-737-4400, x2543  
**FTS TELEPHONE:** 700-887-\_\_\_\_\_

TO	FAX NUMBER	FTS	COMMERCIAL	DATE	NO. PAGES ATTACHED
SUBJECT					
FROM			TELEPHONE NUMBER	FTS	COMMERCIAL

VA FORM

10-1

FAX NO. 555

MAY-20-97 TUE 11:50 AM A

## **FIRE DEPARTMENT PROPOSAL**

December 10, 1996

**PROPOSAL TO TAKE OVER TRANSPORTATION OF PATIENTS OFF STATION BY V.A. FIRE DEPARTMENT AMBULANCE. THE FOLLOWING WOULD BE NEEDED TO ACCOMPLISH THIS:**

- 1) THREE (3) ADDITIONAL FIREFIGHTERS, ONE FOR EACH SHIFT WOULD BE NEEDED TO BE HIRED AS FIREFIGHTER EMT-D. THESE FIREFIGHTERS ARE NEEDED TO PROVIDE THIS SERVICE AND STILL MAINTAIN THE PRESENT STANDARD OF LIFE SAFETY FOR THE PATIENTS AND EMPLOYEES. THIS ALSO WOULD ALLOW US TO CONTINUE TO MEET VA-(M23), N.F.P.A. AND O.S.H.A. STANDARDS ON MINIMUM FIRE DEPARTMENT MANNING LEVELS, FOUR FULLY TRAINED MEN ON STATION TO RESPOND TO FIRE EMERGENCIES AND STILL ALLOW FOR SCHEDULED A/L.
  
- 2) THE FIRE DEPARTMENT PRESENTLY HAS TEN EMT'S INCLUDING THE FIRE CHIEF. ALL PRESENT FIRE DEPARTMENT PERSONAL WOULD BE GRANDFATHERED IN AND ALL NEW HIRES WOULD MEET THE NEW CERTIFICATION REQUIREMENTS FOR THE DEPARTMENT. THIS WOULD KEEP A MINIMUM OF TWO MEN ON DUTY AT ALL TIMES. PRESENTLY EMT CLASSES RUN FOUR TO SIX MONTHS, ALL FIREMEN ATTENDING THIS TRAINING WOULD BE GIVEN THE TIME OFF IF THEY ARE WORKING ON THE DAY OF CLASS AND BE GIVEN COMP. TIME FOR THE HOURS ON THEIR DAYS OFF.
  
- 3) THE ADDITIONAL TRAINING EXPERTISE AND WORK LOAD WOULD BE EXTENSIVE, BECAUSE OF THIS WE RECOMMEND THAT THE V.A. AUTOMATICALLY GIVE EACH FIREFIGHTER A PERFORMANCE AWARD OF \$3,000.00 PER YEAR. THIS WOULD BE IN LIEU OF STEPS. THIS AMOUNT WOULD BE GIVEN ONCE A YEAR IN THE FIRST PAY PERIOD IN DECEMBER. THIS WOULD AFFORD THE V.A. MORE CONTROL OVER THE CERTIFICATION AND RE-CERT PROCESS, NO CERTIFICATION NO AWARD. ADDITIONALLY, THE V.A. WOULD BE RESPONSIBLE FOR ALL INCURRED COSTS RELATING TO TUITION, ON GOING TRAINING, BOOKS AND MATERIALS.
  
- 4) WHEN THE FIRE DEPARTMENT TRANSPORTS A PATIENT OFF STATION THE FIREFIGHTER EMT (IE-DRIVER) WILL BE ACCOMPANIED IN THE AMBULANCE BY AN RN, THE DOCTOR TREATING THE PATIENT WILL DETERMINE IF THIS TRANSPORT IS A.L.S. OR B.L.S. IF DETERMINED A.L.S. AN RN MUST BE ON BOARD THE AMBULANCE.
  
- 5) THE HOSPITAL WOULD NEED A SECOND AMBULANCE TO MEET THE NEEDS OF TRANSPORTING PATIENTS OFF STATION. THE PRESENT AMBULANCE WOULD STILL BE ASSIGNED TO IN STATION CALLS, CODES, FIRES AND OTHER EMERGENCIES. THE PRESENT AMBULANCE AT CASTLE POINT V.A. WOULD BE USED AS A BACK UP RIG TO COVER AN AMBULANCE BEING OUT FOR OR OF SERVICE.
  
- 7) THIS WOULD MEET THE TRANSPORTATION NEEDS OFF STATION 24 HOURS PER DAY. IT WOULD CONTINUE TO MAINTAIN THE PRESENT LIFE SAFETY REQUIREMENTS FOR PATIENT AND STAFF AND BE ABLE TO MAINTAIN THE COVERAGE OF CALLS ON STATION. THE HOSPITAL COST WOULD NOT EXCEED AND BE FAR LESS THAN THE PRESENT CONTRACT COST OF \$207,000.00 WHICH WILL MOST LIKELY INCREASE ABOUT \$50 - 60,000.00 DUE TO THE ESTIMATED INCREASE OF 50 - 70 PATIENTS BEING SHIPPED OUT A YEAR DUE TO ICU CLOSING. (NUMBERS AQUIRED FROM MEDICAL SERVICE)

**TOTAL ESTIMATED COST TO THE HOSPITAL ARE AS FOLLOWS:**

- A) \$95,000.00 - THREE FIVE FIREFIGHTER EMT POSITIONS
  - B) \$45,000.00 - ANNUAL PERFORMANCE AWARDS (BASED ON 15 EMTS)
- \$140,000.00 - TOTAL COST PER YEAR**

**IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT US AT EXTENSION 2332 OR 2792.**

**RESPECTFULLY SUBMITTED,**

**V.A. FIRE DEPARTMENT**

**MONTROSE, N.Y.**

December 06, 1996

MONROSE V.A. ADMINISTRATION  
BLD #1  
MONROSE N.Y.

RE-AMBULANCE SPEC AND PRICING.

TO WHOM IT MAY CONCERN,

AS PER YOUR REQUEST WE HAVE WORKED THE LAST FEW DAYS PUTING TOGETHER INFORMATION AND PRICING ON NEW AMBULANCES FOR THE NEW TRANSPORT PROGRAM YOU ARE WORKING ON. WE HAVE COME UP WITH THE FOLLOWING OUTLINE ON POSSIBLE OPTIONS THAT WOULD MEET OUR NEEDS.

- OPTION 1) GSA SPEC TYPE 1 WHEELED COUCH 4x4 ON A CHEVY K8500 CHASSIS 6.5L DIESEL ENGINE, AUTO, 12,000GVW, STRIPED DOWN GOV. UNIT.  
\$56,300.00 APPROX. COST  
4-5 MONTH (APRIL 96) DELIVERY
- OPTION 2) BID SPEC TYPE 1 WHEELED COUCH 4x4 ON A FORD F-350 CHASSIS 7.3L DIESEL ENGINE, AUTO, 11,000GVW, HIGHER QUALITY UNIT.  
\$71,600.00 APPROX. COST  
3 MONTH (FEBRUARY 96) DELIVERY
- OPTION 3) DEMO TYPE 1 WHEELED COUCH 4x2 ON A FORD F-350 CHASSIS 7.3L DIESEL ENGINE, AUTO, 11,000GVW, HIGHER QUALITY UNIT WITH EXTRA OPTIONS ALL READY ON UNIT.  
\$75,300.00 APPROX. COST  
IMMEDIATE DELIVERY
- OPTION 4) DEMO TYPE 3 WHEELED COUCH 4x2 ON A FORD E-350 VAN CUTAWAY CHASSIS 7.3L ENGINE, AUTO, 10,500GVW, HIGHER QUALITY UNIT.  
\$64,000.00 APPROX. COST  
IMMEDIATE DELIVERY

OPTIONS 2 THRU 4 ARE CIVILIAN SPEC. GRADE AMBULANCES WHICH ARE BUILT WITH HIGHER QUALITY MATERIALS AND STANDARDS. THESE UNITS WOULD NEED TO GO THRU THE BIDDING PROCESS IN OUR PURCHASING DEPARTMENT. OPTION 1 IS A FEDERAL GSA SPEC AMBULANCE IS A LOWER QUALITY UNIT WITH THE BEAR MINIMUM EQUIPMENT AND ALSO HAS THE LONGEST DELIVERY TIME DUE TO A CHASSIS



**FIREFIGHTER GS - 7****I. PRINCIPAL DUTIES AND RESPONSIBILITIES:**

This position involves shift work; fifty-six (56) hours per week on a rotating basis.

The incumbent serves as a driver-operator of motorized firefighting vehicles to combat fires in residences, hospital and office buildings, warehouse, fuel storage areas, shops, brush and wooded areas. He/she drives vehicle scene of fire, following predetermined route or selecting alternative He/she positions vehicle with respect to wind direction, water source, potential hazards. The incumbent operates pumps, foam generators, and equipment, determining and monitoring pressure needed for distance to be pumped and number of lines used. He/she monitors water levels in self-contained tanks and warns hosemen and rescuemen when water is low. He/she performs daily preventive maintenance inspections of vehicles and equipment, performing operator maintenance. He/she assists in training other firefighters in driving and operating equipment. He/she acts a rescueman when not operating vehicles and uses first aid skills to assist injured victims. In the absence of crew chiefs, may act as crew chief during appropriate shift, keeping log of activities and making incident reports on abnormal occurrences.

The incumbent performs advance fire protection inspection throughout the hospital for violations of fire regulations and for potential fire hazards. He/she inspects electrical systems and equipment, flammable materials, storage, oxygen and compressed gas storage. Checks fixed protected gas and equipment for proper placement. He/she participates in investigating causes of fires by inspecting damage. He/she conducts training for firefighters and other station employees in firefighting and fire protective methods.

The incumbent in addition to fire and fire safety related duties, may be assigned as a member of the water rescue crew (boat) or the Emergency medical response van (ambulance). In either case, he/she will function as a team member to accomplish the mission as necessary.

The Firefighter/Emergency Medical Technician will be a clinical member of the Emergency Response Team. His duties will consist of, but at a doctors direction not limited to, the following:

The EMT's employ all sources of information in order to determine the nature of the persons illness or the extent of his injury.

The EMT's survey the sick and injured person and establish priorities for emergency care.

The EMT's render emergency care. They establish and maintain an open airway; they ventilate

nonbreathing patients and administer Cardio Pulmonary Resuscitation when there is a full cardiac arrest; they control hemorrhage and dress and bandage wounds; they treat the patient for shock; they immobilize fractures; they care for medical and environmental emergencies; they assist in childbirth; they care for mentally disturbed patients. When properly qualified they defibrillate, <sup>and perform</sup> other advanced life support operations under the direction of a physician. (not to exceed his qualification level)

The EMTs reassure the patient, relatives and bystanders by working in a confident and efficient manner.

When accident victims must be extricated from entrapment, the EMTs use prescribed techniques and tools to remove victims quickly and safely. They perform basic rescue operations if other firefighters are not on the scene; if such firefighters are present they care for and protect the victims during the extrication operation. After extrication is accomplished, they continue emergency care measures.

The EMTs transfer the patient to a stretcher, secure and cover him and load the stretcher into the ambulance. When necessary, they employ special skills in transferring patients to the ambulance.

The EMT operates the ambulance in a manner such that the patients physical and emotional condition is not worsened, as by a rough, swerving ride and the sound of the siren.

The EMTs constantly observe the patient while enroute to the medical facility, administering additional care as indicated or at the direction of the physician.

The EMTs record changes in the patients vital signs during transportation to the medical facility; if under the direct care of the EMT this information will be presented to the emergency department physician upon arrival.

Upon arrival, the EMTs lift the stretcher-bound patient from the ambulance and transfer him to the emergency department.

The EMTs report verbally and in writing their observations and initial care of the patient at the emergency scene, to the physician, changes in the patient's vital signs during transportation and continuing care provided while enroute when under the direct care of the EMT.

The EMT transfers the patient's personal effects to an emergency department staff member.

Following completion of the call the EMTs will:

- Replace used linens and blankets
- Sanitize the ambulance and supplies
- Replace expendable supplies
- Check the ambulance inventory for completeness
- See that the vehicle is serviced
- Take personal Infection Control measures as required
- Complete required records and reports

-Critique the emergency run with peers

## II. COMPETENCIES:

Demonstrate the knowledge and ability to meet NFPA 1002, Driver Operator Professional Qualification Standards and to drive and operate a motorized fire apparatus.

Knowledge of/and ability to perform firematic duties that require the use of ropes, ladders, hose, water steam, foam, salvage and overall rescue, water supplies, sprinklers, extinguisher ventilation, haz-mat, forcible entry.

Knowledge of life savings apparatus and emergency equipment that assures maintenance and operations do not compromise the safety of patients staff, visitors, government property or the environment.

Knowledge of training requirements and regulations for all new and existing employees ensuring that the safety educational needs are successfully met.

Knowledge and ability to conduct training episodes.

Knowledge of Medical Center safety program.

Knowledge of/and ability to present and demonstrate fire prevention and education programs.

Knowledge of Fire Alarm and communications systems and the ability to identify problems with same.

Knowledge of F.C.C. and V.A. communications procedures, regulations, and proper radio protocol.

Knowledge of NFPA Fire Codes, OSHA Standards and VA regulations for implementation of program and inspections that ensure compliance.

Knowledge and ability to test and inspect smoke detectors, sprinkler, extinguisher.

Ability to read and interpret pre-fire plans and blueprints.

Knowledge and ability to prepare appropriate reports and documentation to ensure compliance with all codes, standards and inspections.

Demonstrate a basic knowledge of the equipment carried on the ambulance and the ability to operate & maintain the ambulance according to NYS Department Transportation E.M.S. standards.

Knowledge of Infection Control standards.

Demonstrate the ability to ensure that all firefighters use proper protective equipment and follow safe work practices at all times.

Knowledge to prepare a pre-plan for a given target hazard, using forms symbols, and maps/ blueprints prescribed by the authority having jurisdiction.

Ability to prepare an operational plan that identifies the required resources and safety considerations for the safe and successful control of an incident.

Knowledge of safety policies and infection control policies.

Demonstrate the ability to display tact and courtesy in all contacts with patients, employees, and the general public.

Demonstrate the ability to communicate orally and writing.

Knowledge of and the ability to communicate a working relationship with, local, county, state and other Federal Agencies as maybe required to facilitate inter-agency cooperations and coordination during both normal and emergency situations.

**III. SUPERVISORY CONTROLS:**

The incumbent is under immediate supervision of the shift crew chief/captain and general supervision of the Fire Chief. Routine duties receive only spot checks. Supervisor gives guidance on difficult problems regarding correction of fire safety hazards, methods of operation, etc. The incumbent while performing his emergency medical duties will be under the supervision of the doctor who writes the transfer order.

**IV. OTHER SIGNIFICANT FACTS:**

- a. The Firefighter works on a rotating shift. He/she is expected always be neat in appearance and must be courteous at all times.
- b. The incumbent works under severe conditions during actual fire situations, so he/she must meet DVA and OPM firefighter physical stan.
- c. The incumbent is responsible for all matters pertaining to the Department (Acting Crew Chief) when the Crew Chief and Fire Chief are not concurrently on duty.



**NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES**

AFFILIATED WITH THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

317 South Patrick Street  
Alexandria, VA 22314

Telephone 703/619-0300  
Fax 703/619-0311  
E-mail nage @ afeia.com

STATEMENT OF KENNETH T. LYONS  
NATIONAL PRESIDENT  
NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES  
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE  
HOUSE VETERANS' AFFAIRS COMMITTEE  
MAY 22, 1997

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PLACE THIS STATEMENT IN THE RECORD.

THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES (NAGE) IS AN AFFILIATE OF THE SERVICE EMPLOYEES INTERNATIONAL UNION, THE THIRD LARGEST UNION IN THE AFL-CIO. NAGE REPRESENTS OVER 120,000 EMPLOYEES NATIONWIDE INCLUDING OVER 10,000 IN THE VETERAN AFFAIRS DEPARTMENT.

IT IS MY UNDERSTANDING THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES (AFGE) WILL BE TESTIFYING REGARDING FIRE SAFETY ISSUES ON BEHALF OF THE FIVE LABOR ORGANIZATIONS WHO REPRESENT DEPARTMENT OF VETERANS AFFAIRS FIREFIGHTERS. BECAUSE OF TIME RESTRAINTS, I WILL FOCUS MY STATEMENT ON DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

RECENTLY, CONGRESSMAN BOB FILNER INTRODUCED H.R. 1215, A BILL TO PROVIDE LAW ENFORCEMENT STATUS TO INS AND CUSTOMS INSPECTORS. WHILE NAGE SUPPORTS THIS BILL WE BELIEVE THAT DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS, SERIES GS-063, SHOULD BE INCLUDED IN THIS BILL.

AS WE ALL KNOW, SAFETY AT VA FACILITIES IS AN EVER INCREASING PROBLEM. MANY ARE IN HIGH CRIME AREAS WHERE POLICE PROTECTION IS CRUCIAL. THE DEPARTMENT OF VETERANS AFFAIRS (DVA) POLICE OFFICERS, DO A REMARKABLE JOB SAFE GUARDING THE PATIENTS, VISITORS AND STAFF AT VA HOSPITALS AND MEDICAL CENTERS ACROSS THE COUNTRY. THESE POLICE OFFICERS ARE AUTHORIZED TO MAKE ARRESTS, POSSES DETENTION POWERS AND MOST ARE LICENSED TO CARRY A WEAPON. IN OTHER WORDS, THESE POLICE OFFICERS HAVE THE SAME RESPONSIBILITIES AS POLICE OFFICERS IN ANY CITY OR TOWN IN THE UNITED STATES.

CURRENTLY, DVA POLICE OFFICERS POSSESS THE SAME ELIGIBILITY REQUIREMENTS IN THE RETIREMENT SYSTEM AS MOST FEDERAL EMPLOYEES. THESE DEDICATED OFFICERS DESERVE TO BE DEFINED AS FEDERAL LAW ENFORCEMENT OFFICERS AND ARE ENTITLED TO ALL BENEFITS UNDER THIS DESCRIPTION. RECENTLY, I RECEIVED A LETTER FROM REPRESENTATIVE BOB

FILNER SUPPORTING THIS ISSUE. I WOULD LIKE TO SUBMIT THAT LETTER FOR THE RECORD. I AM ALSO PLEASED THAT AFGE AND THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES AGREE THAT DVA POLICE OFFICERS DESERVE TO BE DEFINED AS FEDERAL LAW ENFORCEMENT OFFICERS.

MR. CHAIRMAN, WHILE GIVING QUALITY HEALTH CARE TO VETERANS IS THE PRIORITY AT THE VA I BELIEVE THAT THE SAFETY OF THE FACILITY IS EQUALLY VITAL. WE MUST RECOGNIZE THE NEED TO ELEVATE THE STATUS OF THE DVA POLICE OFFICER SO WE CAN RETAIN AND RECRUIT THE BEST POSSIBLE OFFICER AVAILABLE.

# Hospital Shared Services

Personalized, Responsive Service  
...Our Commitment

May 19, 1997

Mr. Adam Sachs  
U.S. House of Representatives  
333 Cannon  
Washington, D.C. 20515

Dear Mr. Sachs:

It was a pleasure to talk with you today regarding the proposed arming of VA Police/Security personnel. Based upon the incident you related in Jackson, Mississippi, it is appropriate that this issue be reviewed.

As we discussed, I believe it is necessary to look at each facility on an as needed basis, verses a "blanket" of arming all facilities. This creates numerous problems including the selection, retention, training, retraining, competency, and effectiveness of the security personnel involved. Also, since the VA is part of the Federal Government, consideration would need to be given to consistent training with other comparable agencies.

In my opinion, the need to arm security personnel should be based on a site specific needs assessment. These assessments can be conducted by using a multi-disciplinary task force or by outside consultants. If outside consultants are used, healthcare specific expertise in various sizes and types of facilities should be mandatory. I personally utilize a wide variety of criteria in order to establish what constitutes a reasonable and appropriate security program for a specific health care facility. The following list denotes the standard areas of review. I then use my experience and expertise to develop recommendations.

- Security Program Organization Overview
- Security Vulnerabilities/Risks
- Security Functions and Activities
- Security Staffing and Deployment
- Security Crime Prevention Activities
- Communications/Physical and Electronic Security
- Security Personnel Training
- Security Staff Development
- Security Policies and Procedures
- Security Records and Reports
- JCAHO Environment of Care Security Related Issues
- OSHA #3148 Compliance
- Ancillary Areas as Necessary

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Mr. Adam Sachs  
U.S. House of Representatives

May 19, 1997  
Page 2

I am also sending you, via Federal Express, a hard copy of this correspondence, a copy of the ASHE Technical Document #055134, and a copy of Healthcare Security Management: Handbook for your edification. I hope this material allows your committee to ask appropriate questions during your hearing.

If I can be of further assistance, please contact me at (303) 722-5566.

Sincerely,



Fredrick Roll, CPP, CHPA  
Executive Vice President - Security

CREDENTIALS

FREDRICK G. ROLL

370-52-8070

CERTIFIED PROTECTION PROFESSIONAL # 2618CERTIFIED HEALTHCARE PROTECTION ADMINISTRATOR #N0055CERTIFIED SECURITY EXECUTIVE #00104CERTIFIED HEALTH CARE SECURITY EXECUTIVE #00104HC

<b>EDUCATION</b>	A.A. Degree	Mott Community College Criminal Justice
	B.S. Degree	Eastern Michigan University Education - Sociology
	Post Graduate Work	University of Detroit Security Administration
	M.A. Degree	Webster University (Denver) Security Administration
<b>EXPERIENCE</b>	<b>Current:</b>	
	Executive Vice President- Security Services Healthcare Security Services 1395 S Platte River Dr Denver, Colorado 80223 (303) 722-5566	Responsible for security services in over 100 hospitals nationwide.
	<b>Previous:</b>	
	Vice President, General Manager HealthCare Security USA Atlanta, Georgia	General management of HealthCare Security USA, providing high-quality security services exclusively to health care facilities, nationwide.
	<b>Past:</b>	
Police Officer	- Eastern Michigan University	
Deputy Sheriff	- Washtenaw County (Michigan)	
Security Supervisor	- University of Michigan, Ann Arbor	
Director, Campus Safety	- University of Michigan, Flint, Michigan	
Director, Public Safety	- Hurley Medical Center, Flint, Michigan	
Director, Safety and Security	- Baptist Medical Center, Jacksonville, Florida	
Director, Security	- Hospital Shared Services of Colorado - Responsible for 400 security officers in 50 facilities throughout Colorado and Wyoming.	
V.P. Consulting Services	- Healthcare Security Services, Denver, Colorado	

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<b>INSTRUCTOR</b>	<p>Basic and Supervisory Security Occupational Health and Safety Various areas of Security</p>	<ul style="list-style-type: none"> <li>- Mott Adult High School</li> <li>- Detroit College of Business</li> <li>- International Association for Healthcare Security and Management and Safety, International Association for Campus Law Enforcement, various colleges, American Society for Healthcare Engineers, and various healthcare organizations and departments.</li> </ul>
<b>CONSULTING SERVICES</b>	Former owner of Roll Enterprises Security Consulting and Training Company plus various independent projects. Nationally known security consultant.	
<b>PUBLIC SPEAKER</b>	Dale Carnegie Graduate Assistant. Guest speaker for numerous clubs and service organizations. Nationally known public speaker and lecturer.	
<b>AWARDS/HONORS</b>	<p>I.B. Hale Chapter of the Year recipient from the American Society for Industrial Security (Charter Chapter Chairperson) Who's Who in Security Certified Protection Professional - American Society for Industrial Security Certified Healthcare Protection Administrator - International Association for Healthcare Security and Safety Certified Healthcare Risk Manager - American Institute of Medical Law, Inc.</p>	
<b>PUBLICATIONS</b>	<p>Author: <i>Healthcare Security Management Handbook</i> Chapter Contributor "Security Management" <u>The AUPHA Manual of Health Services Management</u>. Publish date January 1994. Numerous articles in various professional security publications. Author: "OSHA 3148: Analysis of Workplace Violence Guidelines" <u>Healthcare Facilities Management Series</u>, American Society for Healthcare Engineering</p>	
<b>PROFESSIONAL ASSOCIATIONS AND ACTIVITIES</b>	<p><b>Current:</b></p> <p>Member International Association for Healthcare Security and Safety American Society for Industrial Security American Society for Hospital Engineering (AHA) Aspen Publishing Editorial Advisory Board of <u>Healthcare Facility Safety and Security Administration: Forms, Checklists &amp; Guidelines</u>.  Safety and Security Management Committee-American Society for Healthcare Engineers Board of Directors - Security Management Institute Advisory Board Member - Health Care Safety Institute</p> <p><b>Past:</b></p> <p>President International Association for Healthcare Security and Safety President Florida Society for Healthcare Professionals Treasurer International Healthcare Security and Safety Foundation State Chapter Chairperson International Association for Healthcare Security and Safety (Florida and Michigan) Chairperson American Society for Industrial Security, Flint Chapter Board Member International Association for Healthcare Security and Safety President Michigan Campus Law Enforcement Administrators</p>	

# HEALTHCARE FACILITIES MANAGEMENT SERIES

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of the American  
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AAHA

Facilities and Plant Engineering  
Chemical Engineering and  
Biomedical Technology  
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Safety and Security

*The Leader in Healthcare  
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## OSHA 3148: Analysis of Workplace Violence Guidelines

### SUMMARY

*OSHA has developed guidelines that are the agency's recommendations for reducing workplace violence, specifically in the health care and social services work environments. These guidelines are intended to be advisory in nature as well as informational in content to assist employers in establishing a safe workplace by creating effective violence prevention programs. These guidelines should be used and adapted to meet the specific needs and resources of each place of employment.*

**Subject File:**  
Safety and Security

**Healthcare Facility  
Number:** 055134

**Date:**  
October 1996

**Prepared by:**  
Fredrick G. Roll  
Vice President-General Manager  
HealthCare Security USA  
Littleton, CO

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## Healthcare Facilities Management Series

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The healthcare facilities management series is a collection of publications that are printed monthly. A product of the American Society for Healthcare Engineering, the documents cover single topics important in Clinical/Biomedical Engineering, Facilities Engineering, Design and Construction, and Safety and Security Management.

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## INTRODUCTION

The purpose of this document is to familiarize readers with the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) Document 3148 which became effective March, 1996. OSHA had been working on this document for some time and requested the assistance and input of various groups and organizations including the American Hospital Association. Members of the American Society for Healthcare Engineering's Safety and Security Committee were involved in the review and comment process. As a result of these efforts, the guidelines allow facilities, as stated in their commitment section, to use them as an advisory and educational resource to be "used by employers in providing a safe and healthful workplace through effective violence prevention programs, adapted to the needs and resources of each place of employment."

Due to the impact of the name "OSHA" on a document, many people believe that compliance is mandatory. The document does, however, stress that these guidelines are NOT a new standard or regulation. The rationale for this document is to make employers aware of the potential of violence in the health care and social services areas and help with the development of effective violence prevention programs. Also, for a number of years emphasis has been placed on the protection of patients with little or no effort being specifically directed toward the employees. OSHA has always emphasized the protection of employees, and through these guidelines, specified recommended action in the health care and social services areas.

OSHA will not cite employers for failure to comply with or utilize the guidelines. They will, however, rely on the General Duty Clause of the 1970 OSHA Act if there is a recognized hazard of workplace violence in an establishment and if the employer has failed to take action to either prevent or abate the hazard. Since employers have a general duty to provide an environment that is free of recognized hazards likely to cause death or serious harm, employers are placed on notice that an assessment should be conducted as a proactive method of providing a safe environment. This assessment will allow properly trained and educated individuals to identify potential risks and vulnerabilities and make reasonable and appropriate recommendations. This can be done on a local level, or if necessary, with the assistance of a certified health care security professional.

Health care facilities with effective security management programs under the Joint Commission's Environment of Care security-related standards, will find that they have already addressed a number of the areas cited in the OSHA guidelines. Facilities in California, for example, will also find that the OSHA guidelines parallel Cal-OSHA and Assembly Bill 508.

The guidelines are performance-based, and the recommendations will differ based upon a hazard analysis of each facility. The guidelines state, "Violence inflicted upon employees may come from many sources including patients, third parties such as robbers or muggers, and may include co-workers. These guidelines only address violence inflicted by patients or clients against the staff." The principles, however, create a blueprint and outline to develop a *reasonable and appropriate* violence prevention program to best serve each facility. The recommendations will be different based upon a hazard analysis of each facility. The policies, procedures and guidelines established should stress "zero tolerance for violence." OSHA realizes that not all incidents can be prevented. However, many can either be prevented or mitigated with appropriate assessments, by implementing reasonable processes and physical controls, training of staff and monitoring of incidents to continually improve the program.

According to the Bureau of Labor Statistics data for 1993, health care and social service workers have the highest incidence of assault injuries. Almost two-thirds of non-fatal assaults occurred in nursing homes, hospitals and establishments providing residential care and other social services. Studies conducted by the International Association for Healthcare Security and Safety, the Emergency Nurses Association and the Emergency Physicians Associations have all indicated violence as a significant issue. There is also concern about the under-reporting of these incidents which prompted California Legislation Assembly Bill 508 to mandate the reporting of assaultive behavior and the tracking of near misses.

Health care and social service workers face an increased risk of work-related assaults stemming from several factors:

- Prevalence of hand guns and other weapons in society
- Use of hospitals by police for criminal holds

- Care of acutely disturbed and violent individuals
- Care of mentally ill patients
- Availability of drugs, money and supplies in the hospital setting
- Presence of gang members
- Drug and alcohol abusers
- Trauma patients
- Distraught family members
- Domestic violence cases
- Frustration due to long waits in the emergency department
- Isolated work sites
- Lack of training to the staff
- Environmental security issues, i.e., poor lighting, potential hiding places, etc.

This technical document contains a copy of the guidelines, sample policies and forms and a self-assessment analysis tool. By reading and understanding the information contained herein and using the tool, employees will be able to assess their facilities and work environments, identify potential hazards, risks and vulnerabilities, and develop reasonable and appropriate recommendations for corrective actions. These recommendations should be examined by the employer for applicability based upon the needs and resources at each facility and work site.

#### HIGHLIGHTS OF THE OSHA GUIDELINES

The guidelines will be discussed covering the following five sections: Management commitment and employee involvement, work site analysis, hazard prevention and control, training and education, and record keeping and evaluation of the program.

#### SECTION I: THE NEED FOR MANAGEMENT'S COMMITMENT AND EMPLOYEE INVOLVEMENT

Management's commitment should include the endorsement and visible involvement of top management, provide for the motivation and resources to deal effectively with workplace violence, and should include the following:

- A demonstrated organizational concern for employees' emotional and physical safety and health.
  - An assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors and employees understand their obligations.
  - An appropriate allocation of authority and resources to all responsible parties.
  - A system of accountability for involved managers, supervisors and employees.
  - A comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
  - A commitment to support and implement appropriate recommendations from safety and health committees.
  - Employee involvement and feedback which enables workers to develop and express their own commitment to safety and health, and provide useful information to design, implement and evaluate the program.
- Employee involvement should include the following:
- An understanding and compliance with the workplace violence prevention program and other safety and security measures.
  - Participation in an employee complaint or suggestion procedure covering safety and security concerns.
  - The prompt and accurate reporting of violent incidents.
  - Participation on safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections and respond with recommendations for proposed corrective strategies.
  - Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discuss appropriate responses.

**Written Prevention Program for  
Job Safety and Security**

A written program for job safety and security needs to be incorporated into the organization's overall safety and health program with clear goals and objectives to prevent workplace violence. It needs to be suitable for the size and complexity of the workplace operation and be adaptable to specific situations in each establishment.

The prevention program and startup data must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:

- Create and disseminate a clear policy of zero-tolerance for workplace violence, verbal and nonverbal threats, and related actions.
- Ensure that no reprisals are taken against an employee who reports or experiences workplace violence.
- Encourage employees to promptly report incidents and to suggest ways to reduce or eliminate risks.
- Outline a comprehensive plan for maintaining security in the workplace, which includes establishing a liaison with law enforcement representatives.
- Assign responsibility and authority for the program to individuals or teams with appropriate training skills.
- Affirm management's commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.

**SECTION II: THE NEED FOR A WORKSITE  
ANALYSIS**

The following are suggestions as to how to perform, at a minimum, a worksite analysis:

- A review of specific procedures or operations that contribute to hazards and specific locations where hazards may develop.
- An assessment from individuals of the potential for

workplace violence and a determination of the appropriate preventive actions to be taken. The assessment team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal and the human resources staff.

- Injury and illness records and workers' compensation claims should be reviewed to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes or employee training.
- The team should analyze and track records, monitor trends, analyze incidents, screen surveys and analyze workplace security procedures.
- Screening surveys which provide employees with a questionnaire or survey to get their ideas on the potential for violent incidents should be developed to identify or confirm the need for improved security measures.
- Periodic surveys should be conducted at least annually or whenever operations change or incidents of workplace violence occur to help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures or controls.
- Safety and health professionals or security specialists and other qualified persons to offer advice to strengthen programs. These experts also can provide fresh perspectives to improve a violence prevention program.
- A workplace security analysis should be conducted to evaluate employee tasks to identify hazards, conditions, operations and situations that could lead to violence.
- An analysis of incidents should include the characteristics of assailants and victims, an account of what happened before and during the incident and the relevant details of the situation and its outcome.
- Jobs or locations with the greatest risk of violence should be identified.
- Attention to high-risk factors such as types of clients or patients (disoriented by drugs, alcohol or stress),

factors of the building, isolated locations/job activities, lighting problems, lack of phones and other communication devices, areas of easy, unsecured access, and areas with previous security problems should be noted.

- The effectiveness of existing security measures should be evaluated including engineering control measures.

**SECTION III: THE APPLICABILITY OF MEASURES THROUGH ENGINEERING OR ADMINISTRATIVE AND WORK PRACTICES TO PREVENT OR CONTROL HAZARDS**

(Note: These should be evaluated for specific applicability based upon the work site analysis and for the reasonableness and appropriateness at each individual site).

*Considerations for engineering controls and workplace adaptation include:*

- Removing the hazard from the workplace or creating a barrier between the worker and the hazard.
- Installing and regularly maintaining alarm systems and other security devices, panic buttons, hand-held radios where risk is apparent.
- Providing metal detectors (installed or hand-held) where appropriate, according to the recommendations of certified health care security consultants.
- Using a closed-circuit video recording for high-risk areas on a 24-hour basis.
- Enclosing nursing stations and installing deep service counters or bullet-resistant or shatter-proof glass in reception areas, triage, admitting or client service rooms.
- Providing employees with "safe rooms" for use during emergencies.
- Establishing "time-out" or seclusion areas.
- Providing client or patient waiting rooms designed to maximize comfort and minimize stress.
- Providing counseling or patient care rooms with two exits.

The following are *considerations* for administrative and work practice controls:

- Administrative and work practice controls should state clearly to patients, clients and employees that violence is not permitted or tolerated.
- Employees should be required to report all assaults or threats to a supervisor or manager.
- Management support should be provided during emergencies.
- There should be a trained response team to respond to emergencies.
- Properly trained security officers should be used when necessary to deal with aggressive behavior.
- Sensitive and timely information should be provided to persons waiting in line or in waiting rooms.
- Visiting hours and procedures should be enforced.
- Access control for the general facility and sensitive areas should be carefully evaluated.
- Employees should be prohibited from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable.
- The behavioral history of new and transferred patients should be evaluated to learn about any past violent or assaultive behaviors.
- Contingency plans should be developed to treat clients who are "acting out" or making verbal or physical attacks or threats.
- Staff members should be provided with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lit, and be safely accessible to the building.
- A post-incident response plan should be developed to provide for a comprehensive treatment for victimized

employees and employees who may be traumatized by witnessing a workplace violence incident.

- Home health care providers, social service workers and others should be encouraged to avoid threatening situations.
- Policies and procedures covering home health care providers such as contracts on how visits will be conducted, the presence of others in the home during the visits and the refusal to provide services in a clearly hazardous situation.
- A daily work plan for field staff should be established to keep a designated contact person informed about workers' whereabouts throughout the workday.
- The training should cover topics such as the facilities workplace violence prevention policy.
- Risk factors that cause or contribute to assaults should be covered.
- Early recognition of escalating behavior and recognition of warning signs or situations that may lead to assaults should be identified.
- Employees should understand how to prevent or diffuse volatile situations or aggressive behavior, manage anger and how to appropriately use medications as chemical restraints.
- Information on multi-cultural diversity to develop sensitivity to racial and ethnic issues and differences should be reviewed.

#### SECTION IV: THE IMPORTANCE OF TRAINING AND EDUCATION FOR ALL EMPLOYEES

The following are recommendations for staff training and education programs:

- All employees should understand the concept of "universal precautions for violence," which means that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available.
- Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility.
- The training program should involve all employees, including supervisors and managers. New and re-assigned employees should receive an initial orientation prior to being assigned their job duties in potentially hazardous areas.
- Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations and drills. The competency and performance of the employees should be demonstrated and documented.
- Refresher training should be provided to employees annually.
- A standard response action plan for violent situations, including availability of assistance, response to alarm systems and communication procedures should be explained.
- Employees should know how to deal with hostile persons other than patients and clients, such as relatives and visitors.
- Progressive behavior control methods and safe methods of restraint application or escape should be taught.
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures, need to be known and understood.
- Employees should also know ways to protect themselves and coworkers, including use of the "buddy system" and the policies and procedures for reporting and record keeping.
- Supervisors and managers should be taught that employees are not to be placed in assignments that compromise safety and should encourage employees to report incidents.
- Supervisors and managers should learn how to reduce security hazards and ensure that employees

receive appropriate training.

- Supervisors and managers should be able to recognize a potentially hazardous situation and be empowered to make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate the hazards.
- Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders and ways to handle aggression and defuse hostile situations.
- The training program should also include an evaluation. The content, methods and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

#### SECTION V: THE NEED FOR RECORD KEEPING AND EVALUATION OF THE PROGRAM

The following are recommendations for record keeping and program evaluation:

- Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patients' histories and training, among others, can help identify problems and solutions for an effective program.
- The OSHA Log of Injury and Illness (OSHA 200) can be used to track programming.
- Medical reports of work injury and supervisors' reports for each recorded assault should be kept.
- Incidents of abuse, verbal attacks or aggressive behavior should be recorded, perhaps as part of an assault's incident report.
- Information on patients with a history of past violence, drug abuse or criminal activity should be recorded on the patient's chart.
- Minutes of safety meetings, records of hazard

analyses, and corrective actions recommended and taken should also be documented.

- Records of all training programs, attendees and qualifications of trainers should be maintained for documentation purposes.
- Employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties should collectively reevaluate policies and procedures on a regular basis.
- A uniform violence reporting system should be established.
- Improvement based on lowering the frequency and severity of workplace violence should be measured.
- Employees should be surveyed before and after making job or worksite changes, or installing security measures or new systems to determine their effectiveness.
- Complying with OSHA and state requirements for recording and reporting deaths, injuries and illnesses is essential.
- Consideration should be given to using a qualified outside consultant to review the worksite for recommendations on improving employee safety.

#### THE OSHA SELF-ASSESSMENT ANALYSIS TOOL

Included as part of this technical document is a "self-assessment analysis tool" developed by HealthCare Security USA. This includes a synopsis of the various guidelines discussed in each section. The tool is designed to document a self-assessment of the health care facility and the steps taken to develop or strengthen a workplace violence prevention program. The following steps are suggested for optimal use of this tool:

- Individuals involved in the assessment process should familiarize themselves with OSHA 3148.
- Persons conducting the assessment should check whether the institution is in compliance by checking yes or no.

- The next box allows for comments and documentation including actions, persons responsible and time tables. The final area should be used to document the monitoring and evaluation of each guideline including methods and dates.
- Upon completion of this self-assessment analysis tool, facilities will have also established an outline which can be used to develop a sound workplace violence prevention program based upon the OSHA guidelines.

*Fredrick Roll is a certified protection professional, a certified health care protection administrator and a certified health care risk manager, and holds a master's degree in security management. He is also a past president of the International Association for Healthcare Security and Safety.*

**GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTH CARE AND SOCIAL SERVICE WORKERS: OSHA 3148-1996**

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These appendices can be obtained through OSHA at its Web site — [www.osha.gov/oshpubs/workplace](http://www.osha.gov/oshpubs/workplace). Or contact OSHA directly at (202) 219-6091 or OSHA, U.S. Department of Labor, 200 Constitution Drive, NW, Washington, DC 20210.

**INTRODUCTION**

For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase.

OSHA's new violence prevention guidelines provide the agency's recommendations for reducing workplace violence developed following a careful review of workplace violence studies, public and private violence prevention programs, and consultations with and input from stakeholders.

OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

**OSHA'S COMMITMENT**

The publication and distribution of these guidelines is OSHA's first step in assisting health care and social service employers and providers in preventing workplace violence. OSHA plans to conduct a coordinated effort consisting of research, information, training, cooperative programs, and appropriate enforcement to accomplish this goal.

The guidelines are not a new standard or regulation. They are advisory in nature, informational in content, and intended for use by employers in providing a safe and healthful workplace through effective violence prevention programs, adapted to the needs and resources of each place of employment.

**EXTENT OF PROBLEM**

Today, more assaults occur in the health care and social services industries than in any other. For example, Bureau of Labor Statistics (BLS) data for 1993 showed health care and social service workers having the highest incidence of assault injuries (BLS, 1993). Almost two-thirds of the nonfatal assaults occurred in nursing homes, hospitals, and establishments providing resi-

dental care and other social services (Toscano and Weber, 1995).

Assaults against workers in the health professions are not new. According to one study (Goodman et al., 1994), between 1980 and 1990, 106 occupational violence-related deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aides, and 18 health care workers in other occupational categories. Using the National Traumatic Occupational Fatality database, the study reported that between 1983 and 1989, there were 69 registered nurses killed at work. Homicide was the leading cause of traumatic occupational death among employees in nursing homes and personal care facilities.

A 1989 report (Carmel and Hunter) found that the nursing staff at a psychiatric hospital sustained 16 assaults per 100 employees per year. This rate, which includes any assault-related injuries, compares with 8.3 injuries of all types per 100 full-time workers in all industries and 14.2 per 100 full-time workers in the construction industry (BLS, 1991). Of 121 psychiatric hospital workers sustaining 134 injuries, 43 percent involved lost time from work with 13 percent of those injured missing more than 21 days from work.

Of greater concern is the likely underreporting of violence and a persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

#### RISK FACTORS

Health care and social service workers face an increased risk of work-related assaults stemming from several factors, including:

- The prevalence of handguns and other weapons as high as 25 percent among patients, their families, or friends. The increasing use of hospitals by police and the criminal justice systems for criminal holds and the care of acutely disturbed, violent individuals.
- The increasing number of acute and chronically mentally ill patients now being released from hospi-

tals without followup care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.

- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets.
- Situational and circumstantial factors such as unrestricted movement of the public in clinics and hospitals; the increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members; long waits in emergency or clinic are as, leading to client frustration over an inability to obtain needed services promptly.
- Low staffing levels during times of specific increased activity such as meal times, visiting times, and when staff are transporting patients.
- Isolated work with clients during examinations or treatment.
- Solo work, often in remote locations, particularly in high-crime settings, with no back-up or means of obtaining assistance such as communication devices or alarm systems.
- Lack of training of staff in recognizing and managing escalating hostile and assaultive behavior.
- Poorly lighted parking areas.

#### OVERVIEW OF GUIDELINES

In January 1989, OSHA published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include a workplace violence prevention program.<sup>6</sup> OSHA's violence prevention guidelines build on the 1989 generic guidelines by identifying common risk factors and describing some feasible solutions. Although not exhaustive, the new workplace violence guidelines include policy recommendations and practical corrective methods to help prevent and mitigate the effects of workplace violence.

The goal is to eliminate or reduce worker exposure to conditions that lead to death or injury from violence

by implementing effective security devices and administrative work practices, among other control measures.

The guidelines cover a broad spectrum of workers who provide health care and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community care facilities, and long-term care facilities. They include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home health care workers, social/welfare workers, and emergency medical care personnel. Further, the guidelines may be useful in reducing risks for ancillary personnel such as maintenance, dietary, clerical, and security staff employed in the health care and social services industries.

#### **VIOLENCE PREVENTION PROGRAM ELEMENTS**

There are four main components to any effective safety and health program that also apply to preventing workplace violence, (1) management commitment and employee involvement, (2) worksite analysis, (3) hazard prevention and control, and (4) safety and health training.

#### **MANAGEMENT COMMITMENT AND EMPLOYEE INVOLVEMENT**

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and front-line employees must work together, perhaps through a team or committee approach. If employers opt for this strategy, they must be careful to comply with the applicable provisions of the National Labor Relations Act.

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence, and should include the following:

- Demonstrated organizational concern for employee emotional and physical safety and health.
- Equal commitment to worker safety and health and patient/client safety.
- Assigned responsibility for the various aspects of

the workplace violence prevention program to ensure that all managers, supervisors, and employees understand their obligations. Appropriate allocation of authority and resources to all responsible parties.

- A system of accountability for involved managers, supervisors, and employees.
- A comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
- Commitment to support and implement appropriate recommendations from safety and health committees.
- Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement, and evaluate the program.

Employee involvement should include the following:

- Understanding and complying with the workplace violence prevention program and other safety and security measures.
- Participation in an employee complaint or suggestion procedure covering safety and security concerns.
- Prompt and accurate reporting of violent incidents.
- Participation on safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections, and respond with recommendations for corrective strategies.
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discusses appropriate responses.

#### **WRITTEN PROGRAM**

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program need not be written or heavily documented to be satisfac-

tory. What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment.

The prevention program and startup date must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:

- Create and disseminate a clear policy of zero-tolerance for workplace violence, verbal and non-verbal threats, and related actions. Managers, supervisors, co-workers, clients, patients, and visitors must be advised of this policy.
- Ensure that no reprisals are taken against an employee who reports or experiences workplace violence.
- Encourage employees to promptly report incidents and to suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and to measure progress.
- Outline a comprehensive plan for maintaining security in the workplace, which includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. The written plan should ensure that there are adequate resources available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address such issues as preserving safety, supporting affected employees, and facilitating recovery.

#### WORKSITE ANALYSIS

Worksite analysis involves a step-by-step, common-sense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop.

A "Threat Assessment Team," "Patient Assault Team," similar task force, or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. Implementing the workplace violence prevention program then may be assigned to this group. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal, and human resources staff.

The team or coordinator can review injury and illness records and workers' compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes, or employee training. As the team or coordinator identifies appropriate controls, these should be instituted.

The recommended program for worksite analysis includes, but is not limited to, analyzing and tracking records, monitoring trends and analyzing incidents, screening surveys, and analyzing workplace security.

#### RECORDS ANALYSIS AND TRACKING

This activity should include reviewing medical, safety, workers' compensation and insurance records including the OSHA 200 log, if required to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular departments, units, job titles, unit activities, work stations, and/or time of day. Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement.

#### Monitoring Trends and Analyzing Incidents

Contacting similar local businesses, trade associations, and community and civic groups is one way to learn about their experiences with workplace violence and help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

### Screening Surveys

One important screening tool is to give employees a questionnaire or survey to get their ideas on the potential for violent incidents and to identify or confirm the need for improved security measures.

Detailed baseline screening surveys can help pinpoint tasks that put employees at risk. Periodic surveys conducted at least annually or whenever operations change or incidents of workplace violence occur help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures, or controls. Also, the surveys help assess the effects of changes in the work processes. The periodic review process should also include feedback and followup.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists, insurance safety auditors, and other qualified persons may offer advice to strengthen programs. These experts also can provide fresh perspectives to improve a violence prevention program.

### WORKPLACE SECURITY ANALYSIS

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations, and situations that could lead to violence.

To find areas requiring further evaluation, the team or coordinator should do the following:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when. Note high-risk factors such as types of clients or patients (e.g., psychiatric conditions or patients disoriented by drugs, alcohol, or stress); physical risk factors of the building; isolated locations/job activities; lighting problems; lack of phones and other communication devices, areas of easy, unsecured access; and areas with previous security problems.
- Evaluate the effectiveness of existing security measures, including engineering control measures. Determine if risk factors have been reduced or eliminated, and take appropriate action.

### HAZARD PREVENTION AND CONTROL

After hazards of violence are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

### ENGINEERING CONTROL AND WORKPLACE ADAPTATION

Engineering controls, for example, remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those actions presented in the following paragraphs. The selection of any measure, of course, should be based upon the hazards identified in the workplace security analysis of each facility.

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated, and arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors installed or hand-held, where appropriate to identify guns, knives, or other weapons, according to the recommendations of security consultants.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations, and install deep service counters or bullet-resistant, shatter-proof glass in

- reception areas, triage, admitting, or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
  - Establish "time-out" or seclusion areas with high ceilings without grids for patients acting out and establish separate rooms for criminal patients.
  - Provide client or patient waiting rooms designed to maximize comfort and minimize stress.
  - Ensure that counseling or patient care rooms have two exits.
  - Limit access to staff counseling rooms and treatment rooms controlled by using locked doors.
  - Arrange furniture to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp corners or edges, and/or affixed to the floor. Limit the number of pictures, vases, ashtrays, or other items that can be used as weapons.
  - Provide lockable and secure bathrooms for staff members separate from patient-client, and visitor facilities.
  - Lock all unused doors to limit access, in accordance with local fire codes.
  - Install bright, effective lighting indoors and outdoors.
  - Replace burned-out lights, broken windows and locks.
  - Keep automobiles, if used in the field, well-maintained. Always lock automobiles.
- ADMINISTRATIVE AND WORK PRACTICE CONTROLS**
- Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.
- State clearly to patients, clients, and employees that violence is not permitted or tolerated.
  - Establish liaison with local police and state prosecutors. Report all incidents of violence.
  - Provide police with physical layouts of facilities to expedite investigations.
  - Require employees to report all assaults or threats to a supervisor or manager (e.g., can be confidential interview). Keep log books and reports of such incidents to help in determining any necessary actions to prevent further occurrences.
  - Advise and assist employees, if needed, of company procedures for requesting police assistance or filing charges when assaulted.
  - Provide management support during emergencies. Respond promptly to all complaints.
  - Set up a trained response team to respond to emergencies.
  - Use properly trained security officers, when necessary, to deal with aggressive behavior.
  - Follow written security procedures.
  - Ensure adequate and properly trained staff for restraining patients or clients.
  - Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
  - Ensure adequate and qualified staff coverage at all times. Times of greatest risk occur during patient transfers, emergency responses, meal times, and at night. Locales with the greatest risk include admission units and crisis or acute care units. Other risks include admission of patients with a history of violent behavior or gang activity.
  - Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
  - Establish a list of "restricted visitors" for patients with a history of violence. Copies should be available at security checkpoints, nurses' stations, and

- visitor sign-in areas. Review and revise visitor check systems, when necessary. Limit information given to outsiders on hospitalized victims of violence.
- Supervise the movement of psychiatric clients and patients throughout the facility.
  - Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
  - Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Employees should never enter seclusion rooms alone.
  - Establish policies and procedures for secured areas, and emergency evacuations, and for monitoring high-risk patients at night (e.g., open versus locked seclusion).
  - Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors. Establish a system such as chart tags, log books, or verbal census reports to identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.
  - Treat and/or interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).
  - Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent patients.
  - Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals (CEAPs) or in-house social service or occupational health service staff to help diffuse patient or client anger.
  - Transfer assaultive clients to "acute care units," "criminal units," or other more restrictive settings.
  - Make sure that nurses and/or physicians are not alone when performing intimate physical examinations of patients.
  - Discourage employees from wearing jewelry to help prevent possible strangulation in confrontational situations. Community workers should carry only required identification and money.
  - Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff which could be used inappropriately by patients.
  - Provide staff with identification badges, preferably without last names, to readily verify employment.
  - Discourage employees from carrying keys, pens, or other items that could be used as weapons.
  - Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.
  - Use the "buddy system," especially when personal safety may be threatened. Encourage home health care providers, social service workers, and others to avoid threatening situations. Staff should exercise extra care in elevators, stairwells and unfamiliar residences; immediately leave premises if there is a hazardous situation; or request police escort if needed.
  - Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits, and the refusal to provide services in a clearly hazardous situation.
  - Establish a daily work plan for field staff to keep a designated contact person informed about workers' whereabouts throughout the workday. If an employee does not report in, the contact person should followup.
  - Conduct a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior.

**POST-INCIDENT RESPONSE**

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for victimized employees and employees who may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity. Transportation of the injured to medical care should be provided if care is not available on-site.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These include short and long-term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness, and fear of criticism by supervisors or managers. Consequently, a strong followup program for these employees will not only help them to deal with these problems but also to help prepare them to confront or prevent future incidents of violence (Flannery, 1991, 1993; 1995).

There are several types of assistance that can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical incident stress debriefing, or employee assistance programs may be provided to assist victims. Certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists, or social workers could provide this counseling, or the employer can refer staff victims to an outside specialist. In addition, an employee counseling service, peer counseling, or support groups may be established.

In any case, counselors must be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, such counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

**TRAINING AND EDUCATION**

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

**All Employees**

Every employee should understand the concept of "Universal Precautions for Violence," i.e., that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available. Frequent training also can improve the likelihood of avoiding assault (Carmel and Hunter, 1990).

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards.

The training program should involve all employees, including supervisors and managers. New and re-assigned employees should receive an initial orientation prior to being assigned their job duties.

Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations, and drills.

Topics may include Management of Assaultive Behavior; Professional Assault Response Training; police assault avoidance programs, or personal safety training such as awareness, avoidance, and how to prevent assaults. A combination of training may be used depending on the severity of the risk.

Required training should be provided to employees annually. In large institutions, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees.

The training should cover topics such as the following:

- The workplace violence prevention policy.
- Risk factors that cause or contribute to assaults.
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
- Ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints.
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences.
- A standard response action plan for violent situations, including availability of assistance, response to alarm systems, and communication procedures.
- How to deal with hostile persons other than patients and clients, such as relatives and visitors.
- Progressive behavior control methods and safe methods of restraint application or escape.
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures.
- Ways to protect oneself and coworkers, including use of the "buddy system."
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury.

#### **Supervisors, Managers, and Security Personnel**

Supervisors and managers should ensure that employees are not placed in assignments that compromise safety and should encourage employees to report incidents. Employees and supervisors should be trained to behave compassionately towards coworkers when an incident occurs.

They should learn how to reduce security hazards and ensure that employees receive appropriate training.

Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate the hazards.

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders, and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. The content, methods, and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

#### **RECORDKEEPING AND EVALUATION OF THE PROGRAM**

Recordkeeping and evaluation of the violence prevention program are necessary to determine overall effectiveness and identify any deficiencies or changes that should be made.

#### **Recordkeeping**

Recordkeeping is essential to the success of a workplace violence prevention program. Good records help employers determine the severity of the problem, evaluate methods of hazard control, and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who "pool" data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories, and training, among others, can help identify problems and solutions for an effective program.

The following records are important:

- OSHA Log of Injury and Illness (OSHA 200). OSHA regulations require entry on the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness.<sup>9</sup> (This applies only to establishments required to keep OSHA logs.) Injuries caused by assaults, which are otherwise record-

able, also must be entered on the log. A fatality or catastrophe that results in the hospitalization of three or more employees must be reported to OSHA within eight hours. This includes those resulting from workplace violence and applies to all establishments.

- Medical reports of work injury and supervisors' reports for each recorded assault should be kept. These records should describe the type of assault, i.e., unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident.
- The records should include a description of the environment or location, potential or actual cost, lost time, and the nature of injuries sustained.
- Incidents of abuse, verbal attacks or aggressive behavior which may be threatening to the worker but do not result in injury, such as pushing or shouting and acts of aggression towards other clients should be recorded, perhaps as part of an assaultive incident report. These reports should be evaluated routinely by the affected department.
- Information on patients with a history of past violence, drug abuse, or criminal activity should be recorded on the patient's chart. All staff who care for a potentially aggressive, abusive, or violent client should be aware of their background and history. Admission of violent clients should be logged to help determine potential risks.
- Minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.
- Records of all training programs, attendees, and qualifications of trainers should be maintained.

#### Evaluation

As part of their overall program, employers should evaluate their safety and security measures.

Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties (managers, supervisors, and employees) should collectively reevaluate policies and

procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve the following:

- Establishing a uniform violence reporting system and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.
- Analyzing trends and rates in illness/injury or fatalities caused by violence relative to initial or "baseline" rates.
- Measuring improvement based on lowering the frequency and severity of workplace violence.
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness.
- Surveying employees before and after making job worksite changes or installing security measures or new systems to determine their effectiveness.
- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as these develop.
- Surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later.
- Complying with OSHA and state requirements for recording and reporting deaths, injuries, and illnesses.
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.
- Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives, or other employee groups.

#### SOURCES OF ASSISTANCE

Employers who would like assistance in implementing an appropriate workplace violence prevention program can turn to the OSHA Consultation service provided in their state. Primarily targeted at smaller companies, the consultation service is provided at no charge to the employer and is independent of OSHA's enforcement activity. OSHA's efforts to assist employers combat workplace violence are complemented by those of NIOSH (1-800-35-NIOSH) and public safety officials, trade associations, unions, insurers, human resource, and employee assistance professionals as well as other interested groups. Employers and employees may contact these groups for additional advice and information.

#### CONCLUSION

OSHA recognizes the importance of effective safety and health program management in providing safe and healthful workplaces. In fact, OSHA's consultation services help employers establish and maintain safe and healthful workplaces, and the agency's Voluntary Protection Programs were specifically established to recognize worksites with exemplary safety and health programs. Effective safety and health programs are known to improve both morale and productivity and reduce workers' compensation costs.

OSHA's violence prevention guidelines are an essential component to workplace safety and health programs. OSHA believes that the performance-oriented approach of the guidelines provides employers with flexibility in their efforts to maintain safe and healthful working conditions.

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**Self-Assessment Analysis Tool****HealthCare Security USA  
Guidelines for Preventing Workplace Violence  
for Health Care and Social Service Workers**

The following is a self-assessment analysis tool which is designed to address all or most of the information contained in the U.S. Department of Labor - Occupational Safety and Health Administration, OSHA #3148, 1996, publication entitled "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers." It is recommended that persons using this should familiarize themselves with the entire OSHA #3148 publication.

These guidelines are not new standards or regulations. They do however recommend a method of enhancing the security of employees in the health care and social services environments as it relates to the prevention of violence.

This analysis tool is designed to allow appropriate individuals to have a documented response to the various elements contained in the guidelines. This document can address compliance, establish and track compliance elements or document the rationale for non-compliance or non-applicability. This analysis should be conducted as soon as possible for documentation and appropriate action in *advance* of an adverse incident. This will establish and document the rationale for your workplace violence prevention program. Upon completion of the analysis, the information can be used to create your written policy, procedures and guidelines based on these national guidelines.

If you have any questions regarding the information in this self-assessment analysis tool, review the guidelines. Questions regarding the use or purpose of the self-assessment analysis tool may be directed to the author.

## HealthCare Security USA "Guidelines for Preventing Workplace Violence for Health Care and Social and Service Workers" Self Assessment Analysis Tool



Facility Name \_\_\_\_\_ Date(s) of Review \_\_\_\_\_

**Note:** This tool addresses all or most of the information combined in OSHA 48148 "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers." Refer to the guideline to answer specific questions. For questions regarding the use of the analysis tool contact Fredrick G. Rios, Vice President/General Manager of HealthCare Security USA at (800)899-8377.

Summary of Guidelines	Compliance		Marking/Evaluation including: Method/Date
	Yes	No	
<b>SECTION I</b> <b>Management Commitment and Employee Involvement</b> Management commitment, including the endorsement of the guidelines, is a key factor in preventing workplace violence, and should include the following: <ul style="list-style-type: none"> <li>• Demonstrated organization concern for employee emotional and physical safety and health.</li> <li>• Equal commitment to worker safety and health and jurisdiction safety.</li> <li>• Assigned responsibility for the various aspects of the workplace violence prevention program to various levels of management that obligates.</li> <li>• Appropriate allocation of authority and resources to all responsible parties.</li> <li>• A system of accountability for involved managers, supervisors and employees.</li> </ul>			

SECTION I Management Commitment and Employee Involvement (Cont'd)			
<ul style="list-style-type: none"> <li>A comprehensive program of medical and psychological counseling and debriefing for personnel and family members who are directly involved with other violent incidents.</li> </ul>			
<ul style="list-style-type: none"> <li>Commitment to support and implement appropriate accommodations from safety and health conditions.</li> </ul>			
<ul style="list-style-type: none"> <li>Employee involvement and feedback create avenues to identify and address the most serious safety and health conditions. Social Incentives to design, implement and evaluate the program.</li> </ul>			
<p>Employee involvement should include the following:</p> <ul style="list-style-type: none"> <li>Identifying and working with the workforce to design preventive programs and other safety and security measures.</li> <li>Participation in an employee committee or organization providing counseling safety and security measures.</li> <li>Accept and commit reporting of violent incidents.</li> <li>Participation in safety and health committees or other safety organizations, safety initiatives or security programs, make safety inspections, and report with recommendations for corrective strategies.</li> <li>Taking part in a working education program that includes information on identifying hazards, assessing hazards or control factors, and discussing appropriate responses.</li> </ul>			
<p>Written Program</p> <p>A written program for job safety and security is incorporated into the organization's overall safety and health program with clear goals and objectives to ensure that the program is fully understood and compliance of the workplace and be able to be applied to specific situations as they occur in each report, holding.</p>			

SECTION I Management Commitment and Employee Involvement (Cont'd)	
The prevention program and strategy ideas must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:	
• Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions.	
• Ensure that all employees are fully informed on workplace violence reports or experiences.	
• Encourage employees to promptly report workplace violence or verbal threats or related actions. Provide periodic refresher training to ensure staff and to maintain program.	
• Outline a comprehensive plan for establishing security in the workplace, which includes strategies to protect staff for emergency circumstances.	
• Assign responsibility and authority for the program to individuals or teams with appropriate training skills. Have adequate resources available to support the program. Assign the appropriate individuals with training to workplace violence prevention in health care and related services.	
• Affirm management commitment to a visible, ongoing program to improve workplace safety and health on working the patient or client.	
• Set up a company funding as part of the budget plan to address such issues as providing and upgrading workplace employee staff training programs.	
ADDITIONAL COMMENTS FOR SECTION I	

Summary of Guidelines		Compliance		Comments/Documentation Including: Action/Persons Responsible/Time Tables	Monitoring/Evaluation Including: Methods/Notes
SECTION II Workable Analysis	Yes	No			
<ul style="list-style-type: none"> <li>Review specific procedures to guarantee that the correct laboratory tests are ordered and that the correct specimens are collected which include tests and devices.</li> </ul>					
<ul style="list-style-type: none"> <li>Assess the responsibility for activities and determine the appropriate persons and determine the appropriate procedures to be followed in the laboratory. This should include the responsibility for the collection of specimens, the handling of specimens in the lab, the time that specimens are available, the quality of specimens, the accuracy of results, the safety of patients, staff, and the environment.</li> </ul>					
<ul style="list-style-type: none"> <li>Review policy and these records and procedures to ensure that the safety of patients and staff is maintained by specimen collection, handling, and storage.</li> </ul>					
<ul style="list-style-type: none"> <li>Analyzing and tracking records, including the use of computer systems, to ensure that the safety of patients and staff is maintained by specimen collection, handling, and storage.</li> </ul>					
<p><b>Records Analysis and Tracking</b></p> <ul style="list-style-type: none"> <li>Review the accuracy, quality, and quantity of records, including the OSHA 300 log.</li> </ul>					
<ul style="list-style-type: none"> <li>Review the log and employee and patient records to ensure that the records are accurate and complete. This should include the OSHA 300 log, employee and patient records, work orders, and other records. The records should be reviewed to ensure that the records are accurate and complete.</li> </ul>					

SECTION II Worksite Analysis (Cont'd)						
<b>Monitoring Trends and Analyzing Incidents</b>						
<ul style="list-style-type: none"> <li>Conducting safety tool inventories, team observations, and other methods of data gathering are more ways to learn about safety experiences with workplace violence than the traditional methods of incident reports or OSHA forms. It is possible to have trends of injuries and incidents of actual or potential workplace violence.</li> </ul>						
<b>Screening Surveys</b>						
<ul style="list-style-type: none"> <li>Give employees a questionnaire to survey to get their views on the potential for workplace violence and to identify or outline the need for improved safety practices.</li> </ul>						
<ul style="list-style-type: none"> <li>Provide a survey consisting of the following questions:                             <ul style="list-style-type: none"> <li>Have you ever been the victim of workplace violence or witnessed workplace violence occur? (Specify date or period.)</li> <li>Have you ever been physically injured, harassed, threatened, intimidated, or coerced?</li> <li>Do you and your coworkers, security guards and other qualified persons feel safe in your workplace?</li> <li>What do you think are the most significant workplace safety concerns?</li> <li>These surveys also can provide fresh perspectives to improve a workplace prevention program.</li> </ul> </li> </ul>						
<b>Workplace Security Analysis</b>						
<ul style="list-style-type: none"> <li>Evaluate employee roles to identify hazards, conditions, operations and situations that could lead to violence.</li> </ul>						
<ul style="list-style-type: none"> <li>Analyze incidents, including the circumstances and potential safety concerns of related suspended tasks and during the incident, and the relevant Work at the location and its context. When at the scene, gather reports and recommendations.</li> </ul>						
<ul style="list-style-type: none"> <li>Identify jobs or incidents with the greatest risk of violence.</li> </ul>						

SECTION II Wastewater Analysis (Cont'd)			
<p>• Note High-Dist factors such as types of plants or patients (nursing home), design, location, topography, climate, water quality, industrial wastewater, safety problems, lack of permits and other environmental issues, and other pertinent facility problems.</p>			<p>ADDITIONAL COMMENTS FOR SECTION II</p>
<p>• Evaluate the effectiveness of existing control measures, including engineering controls, and other pertinent factors.</p>			

Summary of Guidelines	Compliance Y/N/NA	Comments/Documentation Including: Action/Person(s) Responsible/Time/Tables	Monitoring/Evaluation Including: Methods/Dates
<b>SECTION III</b>			
<b>General Ergonomics and Controls</b>			
<ul style="list-style-type: none"> <li>Design measures through engineering or administrative means to prevent or control human factors.</li> </ul>			
<b>Engineering Controls and Workplace Adaptation</b>			
<ul style="list-style-type: none"> <li>Remove the hazard from the workplace or isolate the hazard between the worker and the hazard.</li> </ul>			
<ul style="list-style-type: none"> <li>Install stop pins for safe configuration or physical changes to the facility or equipment to address or reduce safety hazards.</li> </ul>			
<ul style="list-style-type: none"> <li>Install and regularly maintain safety devices such as safety interlocks, safety-related radios and other safety devices where risk is apparent.</li> </ul>			
<ul style="list-style-type: none"> <li>Provide control devices—handheld or hand-held, where appropriate—according to the requirements of safety standards.</li> </ul>			
<ul style="list-style-type: none"> <li>Use a fixed-height table providing for high-side access on a 24-hour basis.</li> </ul>			
<ul style="list-style-type: none"> <li>Provide control devices—handheld, hand-held, or extended arm.</li> </ul>			
<ul style="list-style-type: none"> <li>Establish control devices and hand-held stop service access in public restrooms, shower-prayer areas, reception areas, triage, waiting or client service rooms.</li> </ul>			
<ul style="list-style-type: none"> <li>Provide employee "safe zones" for use during emergencies.</li> </ul>			
<ul style="list-style-type: none"> <li>Establish "safe-zone" or shelter areas in high-rise buildings and public or shelter work areas and other appropriate rooms for critical patients.</li> </ul>			
<ul style="list-style-type: none"> <li>Provide direct or indirect safety access designed to maintain patient(s) and ambulatory status.</li> </ul>			

<ul style="list-style-type: none"> <li>• Review best community or patient care records have been made.</li> </ul>									
<b>SECTION III</b> <b>Hazard Prevention and Control (Cont'd)</b>									
<ul style="list-style-type: none"> <li>• Limit access to staff emergency areas and fire exits to those using hospital floors.</li> </ul>									
<ul style="list-style-type: none"> <li>• Assign lockers to prevent compartment of fire.</li> </ul>									
<ul style="list-style-type: none"> <li>• Provide lockers and access lockers for staff lockers and other fire exits.</li> </ul>									
<ul style="list-style-type: none"> <li>• Lock all unused doors to both exterior, to communicate with local fire units.</li> </ul>									
<ul style="list-style-type: none"> <li>• Install light, electric lighting systems and switches.</li> </ul>									
<ul style="list-style-type: none"> <li>• Provide hand-out signs, buttons, wireless and lock.</li> </ul>									
<ul style="list-style-type: none"> <li>• Keep accessible, stored in the lock, well-maintained. Always lock.</li> </ul>									
<b>Administrative and Work Practice Controls</b>									
<ul style="list-style-type: none"> <li>• Be alert to patients, clients and employees for release to car, ambulance or hospital.</li> </ul>									
<ul style="list-style-type: none"> <li>• Establish lines with local police and fire departments. Report all incidents of accidents.</li> </ul>									
<ul style="list-style-type: none"> <li>• Prepare employees to report all accidents or incidents to supervisor or manager.</li> </ul>									
<ul style="list-style-type: none"> <li>• Advise and assist employees, if needed, police departments or other agencies when needed.</li> </ul>									
<ul style="list-style-type: none"> <li>• Provide management support during emergencies.</li> </ul>									
<ul style="list-style-type: none"> <li>• Set up a hazard response team to respond to emergencies.</li> </ul>									
<ul style="list-style-type: none"> <li>• Use properly trained security officers, when necessary, to deal with aggressive patients.</li> </ul>									



SECTION III Hazard Prevention and Control (Cont'd)			
<ul style="list-style-type: none"> <li>• Provide educational aids to "warn" new patients of the "normal" side effects of their drugs and other procedures.</li> </ul>			
<ul style="list-style-type: none"> <li>• Make sure that nurses and other physicians are not alone when performing highly physical manipulations of patients.</li> </ul>			
<ul style="list-style-type: none"> <li>• Encourage employees from receiving injury to fully present possible complications to management officials.</li> </ul>			
<ul style="list-style-type: none"> <li>• Periodically survey the facility to ensure that all personnel are aware of the most common and most serious safety hazards and their responsibility for patients.</li> </ul>			
<ul style="list-style-type: none"> <li>• Provide staff with identification badges, preferably without last names, to readily identify employees.</li> </ul>			
<ul style="list-style-type: none"> <li>• Encourage employees from carrying any weapons.</li> </ul>			
<ul style="list-style-type: none"> <li>• Provide staff members with security access to parking areas in evening or late hours. Parking areas should be highly visible and well lit and easily accessible to the building.</li> </ul>			
<ul style="list-style-type: none"> <li>• Use the "buddy system," especially when personal safety may be involved. Encourage team health care providers, especially nurses, to have others to assist in emergency situations.</li> </ul>			
<ul style="list-style-type: none"> <li>• Clearly define and delineate emergency health care procedures, such as maintenance of vital signs, monitoring the pulse, and the method by which services in a clearly hazardous situation.</li> </ul>			
<ul style="list-style-type: none"> <li>• Establish a daily work plan for staff and to have a designated contact person for each of the emergency interventions throughout the facility.</li> </ul>			

SECTION III Hazard Prevention and Control (Cont'd)			
<ul style="list-style-type: none"> <li>Conduct a comprehensive post-incident investigation to determine the cause of the incident and the extent of the injury, and to identify the employees who have been subjected to similar incidents.</li> </ul>			
<ul style="list-style-type: none"> <li>Post-incident Response</li> </ul>			
<ul style="list-style-type: none"> <li>All workplace violence programs should provide comprehensive treatment for employees who have been subjected to workplace violence incidents. Treatment should be provided by referring a victim to a qualified professional counselor or psychologist to provide treatment and support. The program should also provide for the safety of the victim and the safety of the workplace.</li> </ul>			
ADDITIONAL COMMENTS FOR SECTION III			



SECTION IV Thinking and Education (Cont'd)					
•	A selected response scale rate for violent situations, handling availability of resources, response to radio systems and communication procedures.				
•	How to deal with health issues after working shift, such as:				
•	Prevents behavior control methods and safe methods of removal techniques or concepts.				
•	The location and operation of safety devices such as alarm systems, along with the maintenance activities and procedures.				
•	How to provide counsel and consultation, handling use of the "Ready system."				
•	Polite and courteous in reporting and reworking.				
•	Polite and courteous in obtaining needed items, materials, supplies, cooperation, or help (colleagues after a team spirit is kept).				
<b>Supervisors, Managers and Security Personnel</b>					
•	Supervisors and managers should insure that employees are not placed in dangerous situations and that they should encourage employees to report incidents.				
•	They should learn how to reduce security hazards and ensure that employees receive appropriate training.				
•	Supervisors and managers should be able to read and interpret the information available to make any necessary changes in the physical plant, policies and procedures and the policy and procedures to reduce or prevent the hazards.				

<p><b>SECTION IV</b> <b>Training and Education (Cont'd)</b></p>	<p>The testing program should also include a review of the program's frequency of testing against the evidence and evaluated annually by the team or representative of the program's implementation. Program evaluation may include supervisor and employee feedback, self-evaluation, other methods such as surveys, and methods to remediate deficiencies.</p>	<p><b>ADDITIONAL COMMENTS FOR SECTION IV</b></p>
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Summary of Guidelines	Compliance		Comments/Documentation Including: Action/Person Responsible/Time Taken	Monitoring/Evaluation Including: Methods/Issues
	Yes	No		
<b>SECTION V</b> <b>Recordkeeping and Evaluation of the Program</b>				
<b>Recordkeeping</b>				
Records of injuries, illnesses, workdays lost, medical, workers' compensation, disability, and other costs, should be maintained in a central location and accessible for an effective program.				
OSHA Log of Injury and Illness (OSHA 300) should be maintained.				
Medical reports of work injury and supervisor reports for each recorded injury should be kept.				
Records of cases, verbal reviews or written reports should be maintained as part of an effective program.				
Information on a patient with a history of job violence, drug abuse, or criminal activity should be recorded on the patient's chart.				
Records of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.				
Records of safety program, standards and guidelines of workers should be maintained.				
<b>Evaluation</b>				
Employers should evaluate their safety program annually. The safety program manager should review the program regularly, and with each incident, to determine if the program is effective. The program should undergo periodic audits and procedures on a regular basis.				
Establishing a written violence reporting system and regular review of reports.				

SECTION V Recordkeeping and Evaluation of the Program (Cont'd)				
• Review records and indicate how/when recording activity and monthly losses.				
• Identify and indicate in records the number of health care workers relative to total or "available" staff.				
• Measure improvement based on recording the frequency and severity of reported infections.				
• Identify in records when and after handling activity commences or ceases to determine their effectiveness.				
• Record treatment of new arrivals and to other staff members in the health care unit relative to the health care unit received from other sources.				
• Develop agreements with appropriate health care facilities about the transfer of patients from one facility to another, including recording activity from several months later.				
• Comply with OSHA and state requirements for recording and reporting deaths, injuries and illnesses.				
• Recording records how achievement or failure consider content of the records for use in reporting on employee safety.				
ADDITIONAL COMMENTS FOR SECTION V				

NAME:	
TITLE:	
CREDENTIALS:	
NAME	TITLE
DATE COMPLETED	



**FOREWARD**

This handbook is designed for the person ultimately responsible for the security program in a healthcare facility. The format will allow for overhead projection of the various charts and graphs allowing for educational programs and presentations if desired.

The intent of this handbook is to define the role of security in the healthcare environment by giving a brief historical prospective depicting the responsibilities and authorities currently utilized. Various functions will be addressed along with staffing and equipment methodologies necessary to attain a viable security program. Also covered will be how to develop a risk assessment process as well as a sound quality management program.

Finally, this handbook will address the current trends and anticipate how future developments will evolve including the interrelationships with other healthcare departments and organizations.

**ABOUT THE AUTHOR**

FREDRICK G. ROLL IS A CERTIFIED PROTECTION PROFESSIONAL, CERTIFIED HEALTHCARE PROTECTION ADMINISTRATOR, A CERTIFIED HEALTHCARE RISK MANAGER, AND HOLDS A MASTERS DEGREE IN SECURITY MANAGEMENT FROM WEBSTER UNIVERSITY-DENVER GRADUATE CENTER. AT THE PRESENT TIME HE IS THE VICE PRESIDENT-GENERAL MANAGER FOR HEALTHCARE SECURITY-USA. PRIOR TO THIS POSITION HE WAS THE VICE PRESIDENT FOR CONSULTING SERVICES AND THE DIRECTOR OF SECURITY FOR THE ROCKY MOUNTAIN REGION WITH HOSPITAL SHARED SERVICES OF COLORADO AND WAS RESPONSIBLE FOR OVER 50 FACILITIES WITH OVER 400 SECURITY PERSONNEL. HE IS A PAST PRESIDENT OF THE INTERNATIONAL ASSOCIATION OF HEALTHCARE SECURITY AND SAFETY AS WELL AS A NATIONALLY KNOWN EXPERT, LECTURER, AND CONSULTANT ON HEALTH CARE SECURITY.

FREDRICK G. ROLL CPP, CHPA  
VICE PRESIDENT-GENERAL MANAGER  
HEALTHCARE SECURITY-USA  
P.O. Box 3721  
LITTLETON, CO 80161-3721  
(303) 794-9577  
FAX (303) 794-9578

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**HEALTHCARE SECURITY MANAGEMENT  
HANDBOOK**

by  
*Fredrick G. Roll, CPP, CHPA*

**PURPOSE OF HEALTHCARE SECURITY MANAGEMENT:** To provide a secure and safe environment that allows everyone using the healthcare facility to deliver or receive quality services with minimal threats against their personal well-being and security of their property. Security management, especially in the healthcare environment, must be very concerned with providing appropriate service for people who often require special attention.

**I. OVERVIEW**

The term "security" has numerous meanings. Traditional security definitions vary, however, Richard S. Post and Arthur A. Kingsbury defined security in their book Security Administration: An Introduction, as "Related translations (definitions of security) encompassed the terms protect, shield from, guard against, render safe, and take effective precautions against."<sup>1</sup> In most definitions "safety" is closely tied to security. Healthcare safety specifically deals with such areas as slips and falls, hazardous and infectious wastes, as well as numerous environmental issues. Although in some organizations security and safety are managed together, the current trend is toward separation, as healthcare safety becomes more specialized with the advent of various laws and specific regulatory requirements. This handbook specifically addresses the healthcare security rather than safety issues.

Healthcare security is also becoming a more specialized field as medicine and patient care become more complex. The need for professional, flexible, and business-oriented security managers is becoming more evident.

Healthcare security continues to become better defined. This handbook will address the current trends and predictions on how future developments will evolve including the interrelationships with other healthcare departments and organizations.

**A. Functions of the Security Program**

Most security operations concentrate on the prevention of crime by taking a proactive approach versus the reactive approach usually associated with law enforcement. Law enforcement, by its very nature, provides a totally different function - the overall protection of the public. Healthcare security, however, specializes in protecting the assets and persons utilizing the healthcare facilities. In most instances, 90 to 95 percent of the time of a security officer and security manager deal with non-law enforcement activities. Managers must understand what authorities they do have in relation to the enforcement of rules, regulations, and applicable laws.

In order to explain the appropriate relationship of security management in a healthcare environment, there are several basic functions that need to be understood.

1. Security Assessment - Vulnerabilities must be identified by conducting a security audit or security risk identification review. This will allow for development of action plans to reduce the threats and develop monitoring mechanisms.
2. Crime Prevention - Crime prevention activities must be developed and instituted to reduce security-related incidents from occurring.
3. Personal Protection - Protection systems must be developed to safeguard patients, physicians, staff, visitors, and others.
4. Property Protection - Protection systems must be developed to protect property.
5. Service-related Activities - Service-related activities must be identified and implemented to meet the goals, mission, and philosophy of the institution served (i.e. parking services, information, escorts, etc.)

6. **Enforcement** - Enforcement criteria must be developed and authorized by administration to meet the philosophy of the institution (i.e. arrests, discipline, investigations, etc.)

Managers of security operations must realize that in almost all instances their department is an ancillary, non-revenue-producing department. Although very important to the well-being of the medical facility, it is often viewed as a necessary expense by many other departments that would prefer to use funds for direct patient care. This is particularly important as healthcare dollars become even more difficult to attain. Astute security managers must clearly identify how their department interfaces with the organization, what services must be provided, and what is the most cost-effective method to provide an environment that protects people and assets. Security managers must understand the level of administrative commitment for the program. They must clearly know their responsibilities and authority and be prepared to meet the overall mission of the healthcare facility.

B. **Management Principles**

Security managers must understand there is a security-related thread that runs through each and every department and operation within a healthcare facility. Therefore, it is necessary to work with the administration of the hospital to establish a firm commitment of support. Once established, the security manager can work with the various departments and individuals to identify specific risks and take preventative steps to avoid losses. The competent security manager can be a valuable resource to the institution in overall loss prevention. This includes accountability for equipment, protection of high-risk patients, proper screening and selection of employees, adequate orientation, and training of all employees. All employees need to understand their involvement and responsibility for the security of the facility, the specifics of security rules and regulations.

The specific security management principles involved include:

1. Management must provide leadership in encouraging and supporting security awareness and constructive preventive measures, among all those who work in and utilize the facility.
2. Management must solicit administrative support and commitment and demonstrate the need for a strong security program.
3. Management must provide a secure working environment which allows workers to perform their services with minimal concern about threats to their person or property.
4. Management must assess the organization, especially property and financial resources that are vulnerable to misappropriation, and provide reasonable preventive measures.
5. Management has a special obligation to protect patients and others who may be especially vulnerable to breaches of security because of their medical condition, infirmity, age, sex, or other factors.

To integrate a security program into a healthcare facility successfully, basic management principles must be utilized. Risk Management and Security Management have similar goals and workable principles. They share in name and philosophy the word "management." In traditional planning, organizing, staffing, directing and controlling associated with management, it is implied that this will be done in a cost-effective manner. Although there are numerous definitions for "risk management", one of the foremost experts in the field, George L. Head, Vice President for Insurance Institute of America, stated the following definition of risk management in his book Essentials of the Risk Management Process. "Risk management may be defined as the process of planning, organizing, leading and

controlling the activities of an organization in order to minimize the adverse effects of accidental losses on that organization at reasonable costs."<sup>2</sup>

These two managerial philosophies are discussed in an article which was published in the Fall, 1988 issue of the Journal of Healthcare Protection Management entitled, "Safety and Security = Risk Management." See Figure #1 page 6. The management process is described as a six step procedure.

Step 1--Identify potential for loss and problems.

Step 2--Analyze potential loss or significance of problem.

Step 3--Examine all potential alternatives for viability.

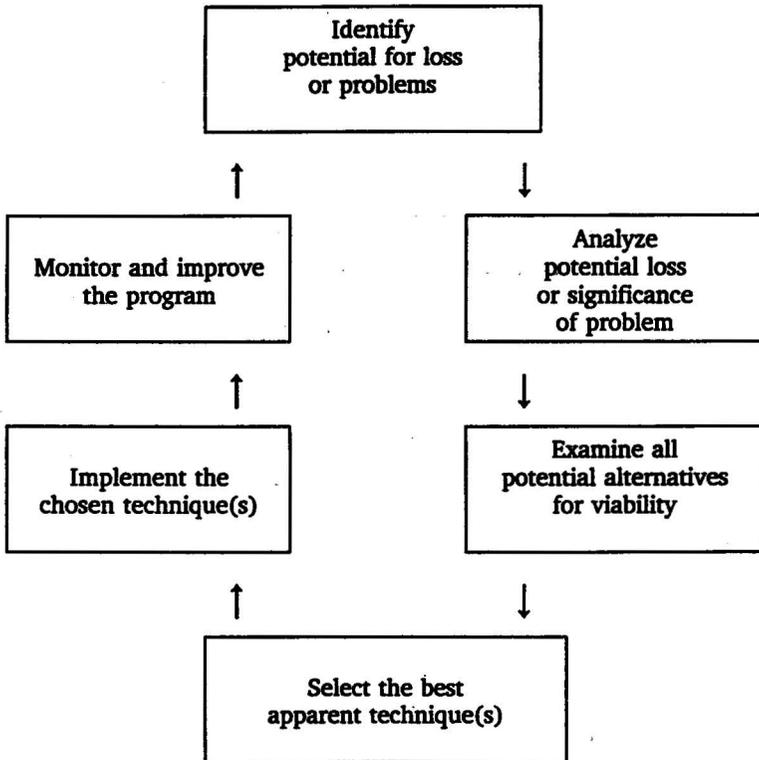
Step 4--Select the best apparent technique(s).

Step 5--Implement the chosen technique.

Step 6--Monitor and improve the program.<sup>3</sup>

The article encouraged persons responsible for the security management program to think like their risk management counterparts, as well as the new breed of healthcare administrators.

FIGURE #1



Source:

Journal of Healthcare Protection Management, Vol. 5, No. 1, Fall 1988. Safety & Security + Risk Management = Loss Prevention by Fredrick G. Roll. (Publication of the International Association for Hospital Security and Safety).

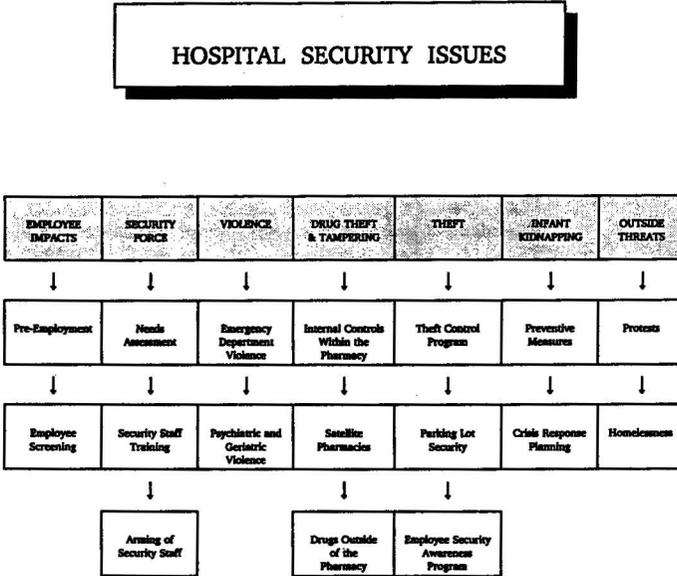
## II. ORGANIZATIONAL ROLE AND FUNCTION

Although there are numerous issues facing healthcare today, security of the patients and persons using the facilities, as well as the property of both are of utmost importance. The American Hospital Association created an Ad Hoc Committee on Hospital Security Issues. This committee generated a report in 1991 which briefly addresses the following areas of concern: Employee Impacts, Security Force, Violence, Drug Theft and Tampering, Theft, Infant Kidnapping and Outside Threats, see Figure #2 on page 8. These areas certainly affect the role and function of a healthcare security operation and must be addressed by the person responsible for the program.

The history of hospital security is well outlined in Hospital Security, 3rd Edition by Russell L. Colling.<sup>4</sup> Mr. Colling traces the organization of hospitals back to England in A.D. 1123. The first designated security reference was known as "Office of the Porter." This was the security manager and the "Beadles" provided the function of stationary guards. The modern era in the United States is summarized as follows:

- 1900-1950 - Protective aspects (i.e. watch rounds and fire watch) were performed by maintenance personnel. There was little mention of specified security personnel.
- 1950-1960 - Shift from fire watch to law enforcement, with police officers working in or out of hospitals in larger communities.
- 1960-1975 - The beginning of the security management era. The protective aspects began to expand beyond dealing with only illegal activities.
- 1975-1980 - Security and safety aspects began to join together. Managers became more recognized.
- 1980s - Security began to take a more expanded role in the hospital environment. More emphasis on the protection of assets. Greater demand for flexibility and the interface with other team players.

FIGURE #2



Source: The American Hospital Association, Ad Hoc Committee on Security Issues. 1991

As we travel the 1990s, the trend toward the application of professional management concepts and team interventions increases. Persons responsible for healthcare security management must become business minded and approach their responsibilities in a cost-effective, yet quality manner.

The overall role of healthcare security is to provide a proactive approach to providing a secure and safe environment. Public law enforcement is deemed responsible for the enforcement of laws enacted to protect the general population. Because this is a very broad responsibility, this usually relates to the response to criminal activities that have already occurred. Security, on the other hand, is usually involved in providing a specific service to a more defined organization or group and its primary function is to prevent incidents from occurring on that particular property. These go beyond laws since security also deals with the prevention of breaches in rules, regulations, and policies associated with the operation of a business. Laws may also be enforced; however, this is usually within the same authority vested with a private citizen. Law enforcement will most likely be called upon to deal with a violation of public law. It is essential that these two entities work closely together to provide adequate protection to the citizenry of a community.

Figure #3 on page 10 defines some of the differences often used to differentiate between security and law enforcement.

Another interesting comparison between security and law enforcement is the total number of personnel and dollars expended annually. The chart on page 11 (Figure #4) from the Hallcrest Report II, by Cunningham, Strauchs, and Van Meter identifies the number of employees and the financial expenditures in each field in 1980, 1990 and makes projections into the year 2000.

FIGURE #3

SECURITY/LAW ENFORCEMENT COMPARISON

<u>Security's Role</u>	<u>Law Enforcement's Role</u>
Loss Prevention .....	Loss Recovery
Protect Specific Clients .....	Protect General Public
Enforcement of Rules/Regulation .....	Enforcement of Laws
Prevention of Crimes .....	Apprehension of Criminals
Proactive .....	Reactive

SOURCE: Fredrick G. Roll

FIGURE #4

**TABLE 7.1  
HALLCREST ESTIMATES AND PROJECTIONS 1980 - 2000  
SUMMARY OF PRIVATE SECURITY AND LAW ENFORCEMENT  
EMPLOYMENT AND EXPENDITURES**

Year	Private Security Employment (Millions)	Law Enforcement Employment (Millions)	Total Protective Services Employment (Millions)	Private Security Expenditures (Billions)	Law Enforcement Expenditures (Billions)	Total Expenditures (Billions)
1980	1.0	0.6	1.6	\$ 20	\$14	\$ 34
1990	1.5	0.6	2.1	\$ 52	\$30	\$ 82
2000	1.9	0.7	2.6	\$103	\$44	\$147

Source: Hallcrest Report II

Figure #4 also indicates a trend toward the need for the private sector to support the efforts of security programs and recognizes that the public resources will continue to remain somewhat constant through the 1990s. As discussed earlier in the evolution of healthcare security, law enforcement personnel are relying on institutions such as hospitals to provide adequate levels of protection. As law enforcement resources remain static and their responsibilities expand with population growth, organizations such as hospitals must assume even more responsibility for their own protection.

Hospital security must first focus on the protection of persons and secondly on property. This includes patients, physicians, staff, visitors, and others, as well as their personal property and the assets of the hospital. In some larger and more sophisticated hospital security operations, members of the security department may also be involved in in-depth investigations involving computer fraud or loss of financial assets. For the most part, however, hospital security operations involve loss prevention including identification of potential problems that would have an adverse financial impact upon the hospital.

#### PREVENTIVE PATROLS AND CRIME PREVENTION

Security loss prevention is usually accomplished through a concept called "preventive patrol." High security visibility will act as a deterrent for most rational persons contemplating a criminal act. Not only does this patrol provide a uniformed security officer that is highly visible, it also verifies that conditions are as they should be. For example, a patrolling officer may observe a door stuck open allowing unauthorized access or find a cracked water pipe that can be reported for repair before damage occurs.

Persons responsible for healthcare security must also realize that our society includes a number of persons who are not rational and/or predictable. These afflictions may be psychological, physiological, or neurological. People may be affected by drugs and alcohol or be part of a group actively involved in protests such as animal rights or anti-abortion. Since some hospitals do animal research

and/or abortions, healthcare security professionals must design an effective method of dealing with all of these groups.

The International Association for Healthcare Security and Safety has been conducting crime surveys for the past several years on hospital-related crimes. Hospitals are not the sanctuaries they once were. People and property both are vulnerable. Hospitals have large supplies of items used by the general public including food, clothing, computers, and drugs. There has also been a rising trend in infant kidnapping up until 1992. The number of female employees working various hours has also created an increased opportunity for sexual assault.

The surveys clearly indicate that all phases of crime do, in fact, occur in hospitals. These crimes include homicide, rape, arson, infant kidnapping, armed robbery, assault, and theft. In one highly publicized homicide, a female physician working in her research laboratory at Bellevue Hospital in New York was brutally raped and murdered by a homeless vagrant in 1989. The offender was found to have lived in a machinery area of the hospital for over a month prior to the murder.

Although the numbers and percentages of these crimes vary, hospitals in all geographical settings from inner city to rural environments reported crime occurrences. Persons found to be the perpetrators of these crimes included employees, patients, and persons off the street. As a result, surveys should indicate to security management and administrative personnel the necessity to analyze the security risk at their facilities and take appropriate corrective action.

It is difficult to identify specific dollar amounts attributed to theft in hospitals since much is unreported. Hospital owned property loss is estimated to be between \$2,000 and \$3,000 per bed per year on an average. Using an average of \$2,500 per year, a 300 bed hospital could lose \$750,000 annually. The theft of patient property, in addition to the dollar loss, has a tremendous impact on customer/patient relations. Theft of employee property also negatively affects employee moral and productivity. All of these emphasize the need to develop extensive loss-prevention, security-related programs.

Assaults, thefts, kidnappings, and other criminal incidents have led to an epidemic of legal actions against hospitals charging inadequate security. Charges include lack of security, too few security personnel, untrained security personnel, improper hiring and retention, poor security management practices, not meeting perceived national or community standards, and failing to foresee and negate criminal activity. Hospitals by their very nature must meet the public's expectation to provide a caring and protective environment. This is complicated by the fact that healthcare dollars are becoming increasingly tighter, and security, a non-revenue producing department, is becoming more costly to maintain.

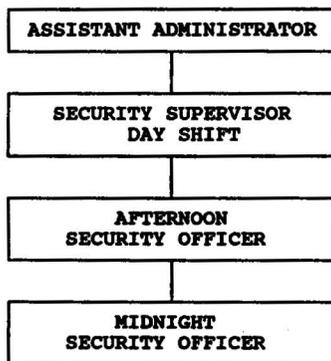
### SECURITY PROGRAMS

Healthcare security programs vary in size and complexity. The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) recommends that hospitals shall provide a security program that meets the specific needs of that facility. In a small rural hospital, the program could consist of maintenance personnel locking and unlocking doors at certain hours staff members handling small problems, and the local law enforcement department called in for larger problems. An adequate security program exists as long as the program meets the needs of the facility and there is documentation that the program has been reviewed and is viable in that hospital. Some small hospitals may supplement the above program with on-site security personnel for after-hour coverage to round out their program. Figures #5,#6, & #7 on the following pages demonstrate potential organizational security models in different sized organizations.

When hospitals have a formal security program, the organizational reporting level will also vary. In some large organizations, a Vice President for Security Operations heads the program from a corporate perspective with individual managers at each facility. In most medium to large hospitals, there is a Director or Manager of Security who usually reports to an assistant administrator responsible for several ancillary departments. In many cases, the Manager of Security would be considered a staff member at the level of department head. Managers might also have other areas of responsibility such as parking, safety,

FIGURE #5

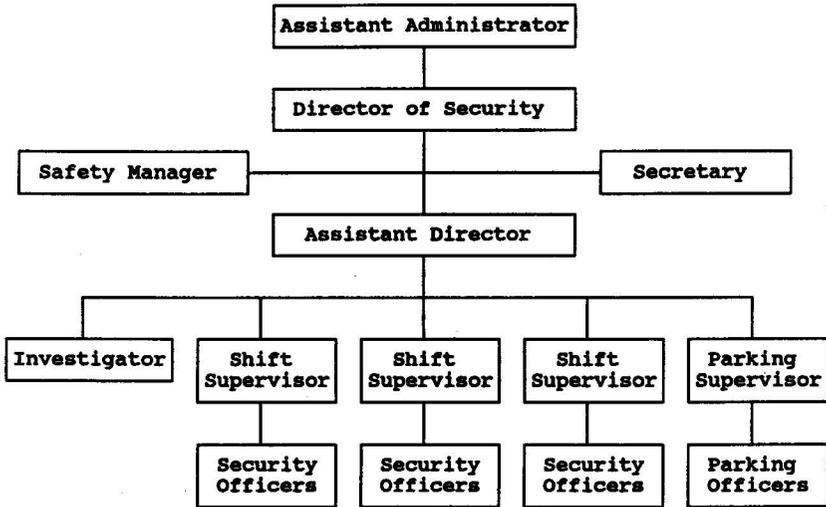
SMALL SECURITY DEPARTMENT



Source: Hospital Shared Services of Colorado

FIGURE #6

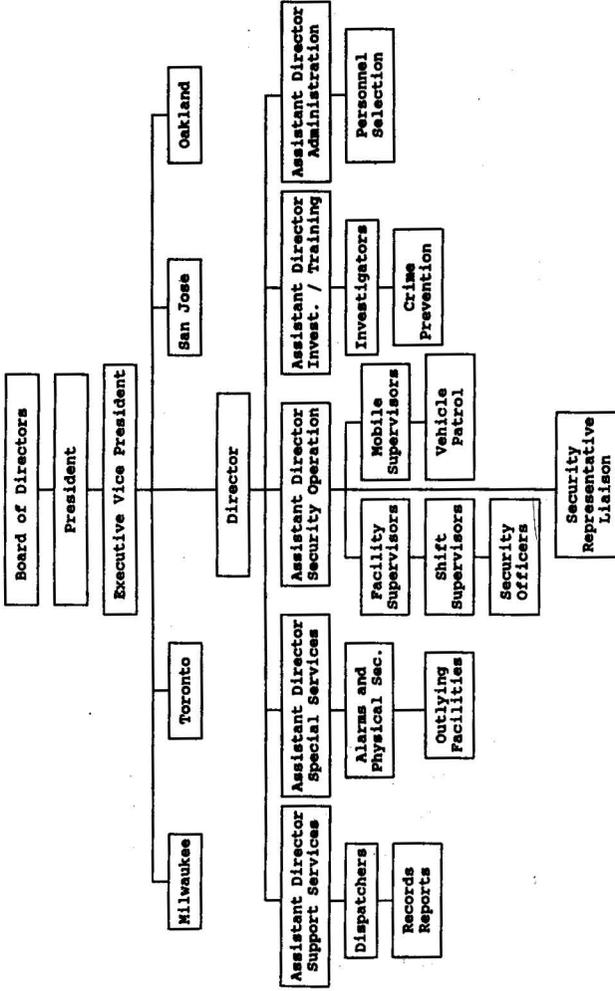
Medium to Large Security Department



Source: Hospital Shared Services of Colorado

FIGURE #7

Hospital Shared Services of Colorado Organization Chart



Source: Hospital Shared Services of Colorado

and transportation. In large hospitals which are often located in urban or inner city areas, security is a major responsibility that would encompass the Director's full attention.

At one time, security was thought of as an off-shoot of the physical plant department, with security reporting to the plant manager. This occurred when the security operation was primarily a watch-clock or fire-watch service. As the problems in security have become more complex and the responsibilities have become greater, for the most part this concept has changed except in relatively small facilities. Recently however, there has been a financially-related trend to revert back to the plant facilities model and either eliminate or reduce the security manager's position. This is a result of organizational "flattening." This may mean that managerial responsibility for security is transferred to another manager within the facility with numerous other departments to manage.

Security managers should remember that security usually entails, among other responsibilities, the enforcement of rules, regulations, policies, and applicable laws that safeguard the institution from financial loss. These are primarily the functions of administration, and the security department acts as its agent. The security program should, therefore, report to someone in the administrative hierarchy who understands the importance of this function and can take appropriate administrative actions as needed. The lower the reporting level of the security operation within the organizational structure, the greater potential for more bureaucratic and self-servicing elements.

#### INTER-DEPARTMENTAL RELATIONSHIPS

The inter-departmental relationships of the security program are extremely important. As previously mentioned, security must be part of every unit within a healthcare facility. Staff members must take an active role in protecting persons and property within their work area. At a minimum, this might be to contact security when they see a suspicious person. Departments must also be responsible for protecting personal and hospital property to avoid theft.

In-depth relationships must exist between specific departments including safety, risk management, and quality management. These departments are all involved in the loss prevention aspects of a hospital. In some departments, security is directly involved with the general liability issues; whereas risk management focuses on the insurance area, and in conjunction with quality assurance, on medical malpractice issues. Security departments may also work closely with human resources and employee health departments on such issues as background screening, employee assistance, and substance abuse programs.

Although a few security departments have sworn law enforcement personnel providing their enforcement function, most have individuals with the same authorities as a private citizen. The latter allows for greater flexibility when dealing with inter-departmental issues since they can be handled administratively and not necessarily legally.

Persons have high expectations when utilizing hospitals, including a very high expectation of security and safety. When incidents occur such as physical and sexual assault, theft of valuables, infant kidnappings or even the loss of eyeglasses or dentures. Patients and the community are disappointed and disillusioned. The high financial awards issued in medical malpractice and inadequate security cases reflect the public's expectation and view on this matter.

Staff members and physicians also expect a crime-free environment in which they can concentrate on their primary function, patient care. The effect of criminal activity or the sense of a lack of security has a major impact on the productivity and morale of staff members.

Security officers are often called upon to perform security-related functions that might offend some staff members. These might include package or locker inspections, parking enforcement, and the enforcement of specific rules, regulations and policies. This makes the security officer's job very difficult since on one hand, the officer is expected to be a helpful public relations representative and on the other, the hospital's private policeman.

Enforcement actions need to be thought out in advance, coincide with the mission and philosophy of the institution and have administrative backing. This is true whether you are enforcing parking, policy or criminal violations. In addition, the person responsible for the security function should also be familiar with the legal authorities associated with enforcement. Are licenses required for security personnel? Do they have authorities greater than a private citizen? When can they legally take action and in what circumstances? Are there specific training requirements for security personnel? What, if any, weapons may they use? Do they understand the laws of arrest, search and seizure? All of these questions should be considered when developing and managing a security department. Finding that you did not address these issues effectively, in advance of an incident, can have a devastating legal and financial impact.

### III. RESOURCES

In the area of human resources, exceptional character, and flexibility are probably the greatest attributes either a security officer or security manager can possess. Patients, visitors and persons within the facility have high expectation from persons in a security uniform. This expectation needs to be fulfilled by demonstrating a good example of physical and moral character. Hospitals are also extremely complex institutions performing functions ranging from high-tech procedures to giving a helping hand. Security personnel must provide a good public relations image while performing enforcement functions. Many persons entering this field have former security and or law enforcement experience, while others use this as an opportunity to gain experience to move into law enforcement positions. The key is the ability to move from one situation to another and to handle each equally well. In other words, an officer might be on an exterior patrol at 3:00 AM without seeing anything but parked vehicles and locked doors for a substantial period of time and then be called to the emergency room to confront a patient who is "acting out." Each situation is demanding in a substantially different way.

Whether security officers are male or female, young or old, they must convey an image that they can, in fact, fulfill a security function. Persons in a healthcare setting must feel secure. This will not be the case if the security officer does not create this perception. This perception is often demonstrated through the ability to communicate and the visual image the individual projects. An officer's uniform, be it a blazer or traditional uniform, is an outward and visible sign of authority. This means the officer will frequently be asked for information and directions as well as for help. The ability to communicate successfully and demonstrate a concern for people goes a long way toward projecting the desired confidence.

The security manager must also be flexible. Security managers will usually be asked to participate on a number of committees that will test their ability to effectively and tactfully communicate. Basic management and effective human relations skills, in conjunction with the ability to enforce policies effectively, must be blended together for this position to be accepted in a healthcare environment.

The most effective way for persons involved in the management of the security program to succeed is to actively pursue and participate via a team concept. In other words, since a number of people may be leery of the authoritative figure in charge of security, it is essential to have other people in the facility work with you to develop policies and procedures.

In a paper written for an Emergency Planning class as part of the Webster University Graduate program in Security Management, Fredrick G. Roll cited the development of a Severe Weather Plan while being the new Director of Security at Baptist Medical Center in Jacksonville, Florida. In this particular application, he utilized the resources of the Safety Committee to develop a philosophy that would allow the various departments to "buy into" the overall plan. By demonstrating a commitment to the team concept this negated being cast as the "top cop" and build a long term rapport with peers and administration.

The person in charge of the security operation must remember that confidence must be maintained when emergency situations do occur and there is not enough time for the team approach, that the established protocols, policies and procedures can and will be effectively implemented. In a separate paper for that same class entitled "Walk Softly/Carry a Big Stick", he outlined this philosophy as follows:

Respect and confidence must be earned. Aggressive and/or arrogant people are most often rejected, not trusted and are disliked. The competence of a manager can best be displayed by interacting with the various components within an organization and seeking their input in how an emergency plan can best meet the needs of their areas. These individual needs can then be integrated into the master plan for overall effectiveness.

Confidence from the organization can most easily be gained when the manager demonstrates the reasonableness of the planning process. In other words, is the plan related to the overall mission of the organization while taking into account the various needs of each component and meeting them whenever possible? When done properly this interactive and participatory management style will allow the manager assigned the task of planning to develop and administer an effective response to various emergency and crisis situations.

Although there are numerous managerial styles I have found that being a participating and interactive manager provides the best opportunity to gain the respect and confidence of those responsible for affecting a successful emergency response. This is particularly important since most true emergencies are rare and the emergency manager needs to be successful before, during, and after the incident.<sup>5</sup>

The International Association for Healthcare Security and Safety (IAHSS) has developed training guidelines and certification programs to assist security officers, supervisors and managers in understanding healthcare security issues. At the present time, these are the only recognized standards in the healthcare security field. Figure #8 on page 24 contains the course description for the 40-hour officer's training program. Figure #9 on page 25 outlines the supervisory program, and Figure #10 on page 26 describes the criteria necessary for a manager or director to achieve the designation of Certified Healthcare Protection Administration (CHPA).

FIGURE #8

**INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY  
& SAFETY BASIC TRAINING PROGRAM RECORD**

	NO. HOURS
Note: Courses marked with an asterisk are elective. Mandatory training of 34 hours must be completed with an additional 6 elective hours to complete the 40 hour program.	
<b>INTRODUCTION TO HOSPITAL SECURITY</b>	
Hospital Organization .....	1
Security as a Service Organization .....	1
Public and Community Relations .....	1
Labor Relations .....	1
<b>DEVELOPING COMMUNICATION AND INVESTIGATIVE SKILLS</b>	
Investigations and Interviews .....	2+1
Report Writing .....	3+2
Patrol Procedures/Techniques .....	3
Handling the Disturbed Patient, Visitor, Employee .....	1
Courtroom Procedures .....	1
<b>SECURITY'S ROLE IN HOSPITAL OPERATIONS</b>	
Nursing Units .....	1
Business Office .....	1
Pharmacy .....	1
Dietary Service .....	1
Ancillary Services .....	1
<b>PROTECTIVE MEASURES</b>	
Hospital Vulnerabilities .....	1
Lock and Key Systems/Access Control .....	1
Physical Security Controls .....	1
Alarms .....	1
Equipment Usage/Maintenance .....	1
<b>HOSPITAL SAFETY AND EMERGENCY PREPAREDNESS</b>	
Functional Safety .....	2
Fire Prevention .....	2
Fire Control .....	2
Bomb Threats .....	1
Disaster Control .....	2
Civil Disturbance .....	1
<b>SECURITY AND THE LAW</b>	
Laws of Arrest/Search/Seizure .....	2
Narcotics and Dangerous Drugs .....	2
Law Enforcement Liaison .....	1
<b>SPECIALIZED SKILLS</b>	
Career and Professional Development .....	1
Self-Defense .....	2
Weapons: Use and Handling .....	2
Emergency First Aid/Life Saving Techniques .....	1

**MUST TOTAL 40 HOURS \_\_\_\_\_ (34 MANDATORY PLUS 6 ADDITIONAL)**

SOURCE: Training Committee, International Association for Healthcare Security & Safety, P.O. Box 637, Lombard, IL 60148. (708) 953-0990

FIGURE #9

**INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY  
& SAFETY SUPERVISORY TRAINING PROGRAM RECORD**

SUBJECT	HOURS
Introduction to Supervision	1
Contemporary Issues in Healthcare	1
Supervisory Responsibilities	2
Employee Relations & Employees Appraisals	2
Authority and Control	1
Leadership	2
Handling Complaints and Grievances	2
Effective Communications/Management Skills	2
Self Improvement	1
Civil Liability and the Supervisor	1
Safety	2
Budgeting/Cost Control	1
Principles of Customer Relations	1
Professionalism and Ethics	1
<b>TOTAL</b>	<b>20</b>

SOURCE: Training Committee, International Association for Healthcare Security & Safety, P.O. Box 637, Lombard, IL 60148. (708) 953-0990

**FIGURE #10**

**INTERNATIONAL ASSOCIATION FOR HEALTHCARE  
SECURITY AND SAFETY  
PROFESSIONAL CERTIFICATION**

**Description & Purpose**

This credentialing program is intended to encourage and assist healthcare security, safety and risk management administrators to continue their professional development through a structured and recognized certification process.

The IAHSF credentialing program, administered by the International Healthcare Security & Safety Foundation, consists of progressive credentialing levels. Qualified candidates are accepted into the credentialing program at the nominee level. Nominees progress to the graduate level to become a Certified Healthcare Protection Administrator (C.H.P.A.) by successfully passing the examination. The third level (fellow) is yet to be developed.

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**NOMINEE LEVEL**

The IHSSF will issue a certificate conferring nominee status on an applicant meeting the qualifying criteria.

**Eligibility**

Applicant must be, have been or qualified to be a member of the security/safety risk management administration of a healthcare facility.

**Requirements**

Applicant must submit a completed application clearly documenting the accumulation of the required (10) Credits among the four categories listed below.

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**GRADUATE LEVEL**

The IHSSF will confer the title of Certified Healthcare Protection Administrator (C.H.P.A.) on applicants successfully completing the graduate examination. Persons receiving this certification are authorized to use the designation C.H.P.A. with their name to attest to this professional credentialing.

**Eligibility**

Candidates for the graduate level exam must first have attained nominee status.

**Requirement**

Nominees must successfully pass a written examination covering four (4) bodies of knowledge (management, security, safety/life safety, and risk management). Preparation for the examination is achieved by utilizing the study guide provided and the references listed therein.

**Graduate Examinations**

Examinations will be administered at the winter seminar and annual membership meeting of the IAHSF. To arrange other examination times contact the IHSSF.

Each CHPA is required to re-certify every three years.

**SOURCE:** International Association for Healthcare Security and Safety

Another prominent general security organization, the American Society for Industrial Security (ASIS) maintains a management certification program that would also reflect the competency of a security manager. This designation is called Certified Protection Professional (CPP). Administration should encourage and reward hospital security managers who attain these certifications. Each indicates a level of professional accomplishment. Since the CHPA and CPP require initial testing and periodic re-certification, they also demonstrate continued commitment to the field.

Private companies have developed training programs aimed specifically at healthcare security. Communicorp, based out of Chicago, Illinois, has produced a number of videotapes that assist the patrol officers, supervisors and managers with their duties. The Private Security Television Network (PSTN), based out of Carrollton, Texas, has recently created a unique training program designated as their Healthcare Edition. The monthly programs are "viewer driven" as quoted by William Jackson, President of PSTN. Subscribers to PSTN receive two videos each month. The first video, ProForce, is a continuing education program broken into 1/2 hour segments. This video section also has a corresponding student test to verify the proficiency of the student, as well as serving as documentation of the training. The second video, Security Works, contains timely information for supervisory and management personnel on legal issues, technology advances and current issues associated with healthcare and relevant security activities.

#### STAFFING METHODOLOGIES

The number of security personnel necessary to provide adequate security is often discussed in courtrooms hearing litigation for "inadequate security." Numerous people have attempted to quantify this issue based upon bed size, square footage, acreage, number of employees, number of patient days, location of the hospital, and other parameters. Because of the unique relationship Hospital Shared Services of Colorado has with the shareholder hospitals it services, it is possible to compare various data as it relates to staffing. Even with the ability to compare this

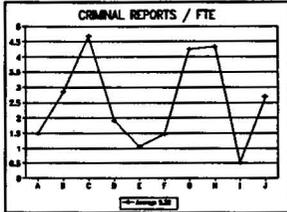
data, no significant conclusions can be determined; however, this information is useful for discussion purposes at each particular hospital at budget preparation time. See Figure #11 page 29.

Realistically, the proper number of security personnel should be based on the results of a risk assessment and a review of services rendered. The assessment should include such factors as the type and location of the hospital, the crime rate of the surrounding area, the frequency and severity of past incidents in or near the hospital, local and community standards, the function and responsibilities assigned to the department, as well as the size and complexity of the healthcare services rendered. The development of a security program necessitates a full review of these factors and a periodic review to see if there have been changes that affect the number of personnel required to perform the assigned tasks. However, more is not necessarily better. Staffing levels can be adjusted upward with the expansion of a new facility or downward if electronic devices are installed to handle some specific tasks. In some cases, security personnel have been assigned numerous ancillary service duties due to the lack of serious security incidents. This may mean that the original security functions are no longer being performed completely. A periodic review will allow for analysis of the continuing adequacy of security staffing.

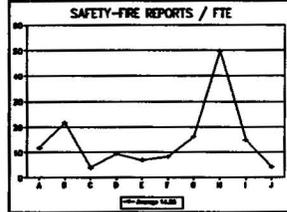
The size and complexity of a hospital obviously has a bearing on the number of personnel and scope of the security operation. The times of coverage and the number of personnel assigned can only be determined after a thorough review is performed. Administrators may want to consider an outside consultant for this purpose. Many of these consultants would be the same persons reviewing the security program if litigation were to occur. This objective, outside view can help determine the risk potential under the current staffing plan and make appropriate recommendations in advance of a major incident and/or litigation.

FIGURE #11

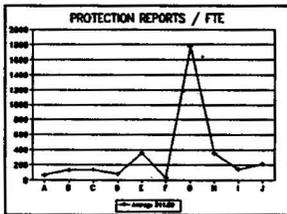
**CRIMINAL REPORTS  
COMPARED TO  
STAFFING LEVELS**



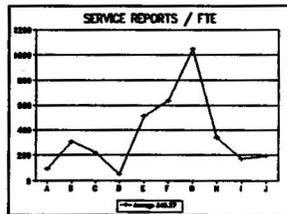
**SAFETY REPORTS  
COMPARED TO  
STAFFING LEVELS**



**PROTECTION REPORTS  
COMPARED TO  
STAFFING LEVELS**



**SERVICE REPORTS  
COMPARED TO  
STAFFING LEVELS**



Source: Hospital Shared Services of Colorado

In most proprietary security programs, the security personnel earn wages somewhat above entry-level employees. Many contract security agencies often pay their security officers at or slightly above minimum wage. In some institutions, this may be appropriate, and in others unacceptable, based upon the scope of the security operation responsibility.

### SECURITY MODELS

Hospital security is being performed in a number of different ways throughout the United States. These include proprietary, contractual, off-duty law enforcement, and shared services security operations. Figure #12 page 31 offers some potential advantages and disadvantages often associated with proprietary, contract and law enforcement models.

Proprietary programs give the hospital direct selection and supervision of the employees. This usually results in adequate training, supervision, quality control, and direct participation in hospital activities. On the negative side, this often results in high and escalating costs for wages and benefits. In addition to these obvious costs, in-house programs lose sight of the hidden costs such as extra insurance costs, recruiting, and training which are paid through other cost centers. An examination of the total costs for a proprietary program range from 40-100 percent over the actual wage, see Figure #13 on page 32. In some cases, it may also be difficult to terminate sub-standard officers. The cost effectiveness of a high paid security management staff may also be questioned at small to medium sized facilities.

Contract security programs are usually less expensive than an in-house program since the contractor is responsible for all wages, benefits, insurance, and overhead. In many cases the wages and benefits are not based on a hospital scale and are substantially less. The hospital can calculate a fixed annual budget for the program. Also the personnel burden remains with the contractor, meaning the hospital can demand a replacement for marginal or inadequate officers without liability.

FIGURE #12

COMPARING HOSPITAL SECURITY MODELS		
<p><b>IN-HOUSE PROGRAM</b></p> <p><i>ADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Control Policies</li> <li>• Good Training</li> <li>• Good Supervision</li> <li>• Good Quality</li> <li>• Higher Wage Rates</li> <li>• Better Selection of Personnel</li> <li>• Integration of Specific Hospital Culture</li> </ul> <p><i>DISADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Cost-Budget Creep / Expensive</li> <li>• Overhead Costs High</li> <li>• Fringe Benefit Cost High</li> <li>• Training Cost High</li> <li>• Limited Growth Opportunities</li> <li>• Communications to Other Hospitals Inadequate</li> <li>• Difficult to Terminate Marginal Officers Employees</li> <li>• Tend to Seek Unionization</li> </ul>	<p><b>CONTRACT PROGRAM</b></p> <p><i>ADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Lower Cost, Pay, Benefits</li> <li>• Control Cost - Fixed Yearly Budget</li> <li>• Relieve Administration Burden</li> <li>• Quick Replacement of Marginal Employees</li> <li>• Security Focused Management</li> </ul> <p><i>DISADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Poor Training Program</li> <li>• Low Wages; Poor Quality</li> <li>• Inadequate Supervision</li> <li>• Low Morale</li> <li>• Not Hospital-Oriented</li> <li>• Breakdown of Communications</li> <li>• Limited Healthcare Expertise</li> </ul>	<p><b>OFF-DUTY POLICE</b></p> <p><i>ADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Trained in Law Enforcement</li> <li>• Known Cost - Fixed Yearly Budget</li> <li>• Law Enforcement Agency Liaison</li> </ul> <p><i>DISADVANTAGES</i></p> <ul style="list-style-type: none"> <li>• Inadequate Communications</li> <li>• Low Level of Supervision</li> <li>• Potential of Personnel Exclamation</li> <li>• Lack of Continuity</li> <li>• High Wage Rates</li> <li>• Limited Security Knowledge or Services</li> <li>• Secondary Job Interest</li> <li>• Aggressive Reaction - Higher Liability</li> <li>• Limited Healthcare Expertise</li> <li>• Potential Union Problems</li> </ul>

Source: Hospital Shared Services of Colorado

FIGURE #13

The Total Costs for In-House Security Programs

<u>Payroll</u>	<u>Benefits</u>
Wages	FICA
Shift Differential	Pension
Training	Health
Holiday Leave	Workmen's Compensation
Paid Time Off	Unemployment Insurance
Extended Illness	Life Insurance
Funeral Leave	Dental Insurance
Jury Duty	Vision Insurance
Overtime	
On-call	
<u>Non-Payroll</u>	<u>Related Expenses</u>
Reports, Forms, Crime Prevention Materials	Investigations
Uniforms	Crime Prevention Programs
Licensing	Liability Insurance
Printing	Recruiting Expense
Training Materials	Cost of Payroll Expense Checks
Depreciation of Equipment	Supervisory Support
Postage	Possible Over-Staffing to Avoid Overtime
Office Supplies	Liability Exposure of Short Staff to Avoid Overtime
Office Space	Interview and Selection Time
Utilities	Possible Unionization
Telephones	

Source: Fredrick G. Roll

On the downside, contract agencies often pay low wages and benefits which may attract low-quality personnel. There is often inadequate supervision, and the officers may suffer from low morale and confusion over knowing their actual employer. There is often high turnover which can result in a lack of proper training. These officers may rotate from hospitals to industrial contracts and have less of a commitment or desire to work in the hospital environment. Most contract agencies lack hospital specific expertise.

The Hallcrest Report II addresses proprietary versus contract employment in the security field. It states, "The Hallcrest research staff predicts that employment in proprietary security will experience as substantial reduction over the next 10 years; annual growth will average out to be negative by the end of the decade. Employment in the contract service...will continue to be robust, averaging three times the rate of growth of the total national work force 1.2 percent".<sup>6</sup>

Some organizations have found that a combination of proprietary supervisors and key personnel supplemented with contract personnel to be cost effective in providing security for a healthcare facility. This can, however, still have some of the difficulties outlined in the contractual area since the actual loyalty of the security officers may be questionable.

The number of off-duty police officers providing hospital security functions continues to decline, except in some specific applications. The presence of a law enforcement officer was once considered a plus by many hospital administrators. These officers have law enforcement training and present a strong sense of security to most of the public. They are also vested with the authority to make certain arrests when a security officer could not.

Using off-duty police officers, however, has several negative components. In some cases, law enforcement officers are not willing to perform the vast number and assortment of security functions necessary to provide a full-service security operation. Secondly, off-duty law enforcement personnel have an obligation to their

oath of office to act in their sworn capacity when they observe violations of the law. The actions they take may not always be in the best interest of the hospital. In some instances, however, it may be necessary to use these sworn personnel for specific functions such as directing traffic on a city street which can not be done by non-law-enforcement personnel. This is often very expensive and it is not uncommon for one police officer to cost twice as much as a security officer. When used in conjunction with security personnel, this can also create a significant morale issue once the differences in wages and responsibilities are identified.

Another security staffing concept gaining popularity is the shared service, co-op or hybrid model. Under this plan, more than one hospital or groups of hospitals share the various components of a hospital security program that they could not afford independently. The costs of a quality hospital security administrator, managers, supervisors, investigators, communication center, and equipment are funded based upon the size, scope, and usage of each member hospital. Since this is a specific hospital security program, the enhanced expertise in the hospital field can be realized. Because the hospitals govern the program, usually through representatives or board members, they have a direct method of control and develop quality similar to an in-house program, but without the higher costs since the wages and benefits are outside of the direct hospital scale.

On the down side of this concept, each hospital must give up a certain amount of autonomy for the overall good of the program. If developed properly, this program operates in the same manner as shared purchasing, linen or other shared programs.

In any of the models, strong consideration should be given to the use of part-time personnel. By developing a mix of both full-time and part-time personnel, adequate and flexible coverage can be maintained while minimizing the use of overtime. Also, part-time employees are usually on a different, less expensive benefit package. Since many programs are on a restricted or limited overtime basis, this also lends itself to maintaining minimum staffing levels at all times. This is

extremely important in inadequate security litigation cases. In other words, if an incident occurs when short staffed, the excuse of not being able to use overtime can be devastating when a judgment is awarded. The mix would, of course, vary based on the size and complexity of the security program at the particular facility.

In some hospitals, the security personnel have become commissioned law enforcement officers or special police officers. The officers have the capability of enforcing parking regulations under a municipal ordinance but do not have full police powers. Some hospitals, however, do have full police authority which would allow the security personnel to enforce laws with the same authority as the local law enforcement officers on their property. This can, in some instances, create complications in determining what is an administrative action versus a legal action. There may also be a question as to who holds the final authority in a situation: the chief of police or agency granting the authority or the chief executive of the hospital.

Although some administrators believe commissioned authority is advantageous, officers immediately become bound by the Fourth, Fifth, Sixth and Fourteenth Amendment of the Constitution which contain a substantial amount of guidelines and bureaucratic complexities. Since most security operations act under the same authority as a private citizen their responsibilities vary dramatically. In Private Security and the Law Charles P. Nemeth states, "In simple terms, private security (which includes non-commission proprietary departments) can arrest with the same rights, reservations, liabilities, and obligations that a private citizen may. Secondly, private security practitioners are not governed or restricted by the language and interpretations of the Fourth, Fifth, Sixth and Fourteenth Amendments of the United States Constitution. This has given rise to greater flexibility and freedom in surveillance, search, apprehension and detection of evidence and its eventual admissibility."<sup>7</sup> (The Fourth Amendment deals with unreasonable search and seizure. The Fifth Amendment deals with a person's rights against self incrimination. The Sixth Amendment deals with a person's rights to a speedy trial, right to counsel and to confront accusers. The Fourteenth Amendment incorporates the equal protection clauses of the Constitution into state actions.)

This is in no way intended to infer that private/proprietary security personnel should not at all times be cognizant of an individual's rights. It does, however, allow for more flexible perimeters and more administrative intervention from the healthcare facility as to the control of incidents that occur within their scope. Law enforcement personnel can always be summoned as necessary.

#### SECURITY EQUIPMENT

In the area of equipment, numerous systems and components are available to enhance a hospital security program. It is important to remember to correctly balance between security devices and personnel. This is discussed in detail in the integrated security section.

A two-way radio is often referred to as the most valuable piece of equipment a security officer can have. A two-way radio allows officers to maintain continuous communication while moving about their patrol areas. They can be directly summoned to situations as well as seek assistance themselves, as necessary. Communication systems vary tremendously including paging, alarm and telephone interface, multiple frequency radios, various sized radio units, cellular phones and mobil or hand-held radio units. Once the specific purpose and function is defined, manufacturer representatives can submit proposals to meet the needs of the healthcare facility.

Uniforms allow the security personnel to project an appropriate image to the public. Traditional police style uniforms continue to be the most popular, with some facilities adopting blazers. Many of the larger institutions use a combination of the two, with outside personnel using the full uniform to provide a strong, highly visible deterrent effect, while inside officers wear blazers to provide a "soft image." The best uniform for a specific hospital is one that meets the overall mission of the department and the facility.

The type of protective equipment issued to security personnel should be based on the hospital's philosophy. Equipment could include a nightstick or baton, handcuffs, chemical gases, electronic stunning devices, or firearms.

The administration of the hospital must evaluate the security risk and decide if, and what type of, weapons should be utilized by security personnel. The institution must decide if it is more or less of a risk for the security officers to carry weapons. In some institutions, the security personnel have been unarmed until there was a significant problem. Some have remained armed until there was a problem involving the weapon, then disarmed.

There appears to be a broad national trend toward disarming security personnel, including those in healthcare settings. The current overall sense seems to be that the carrying of a firearm can be a greater liability than not carrying one. However, in some facilities, weapons may be essential.

The Hallcrest Report II suggests, "With few exceptions, the 1989-1990 field and focus group interviews with security practitioners revealed agreement that the trend toward unarmed security personnel will continue in the future. By the year 2000, the Hallcrest staff projects that not more than 5 percent of private security operational personnel will be armed (firearms)."<sup>8</sup>

At Hospital Shared Services of Colorado, which provides security coverage for over 40 healthcare-related facilities, the percentage of armed personnel continues to decline. As an example, in some multiple officer facilities where all of the security personnel at a facility were once armed, the revised model calls for only one officer to carry a firearm. This allows for better control, yet quick response if an armed officer is required.

In any event, the use of firearms, electric stunning devices, chemical gases, batons, and other devices, require complete and documented initial and continued training by competent personnel. The improper use of any weapon will immediately

result in potential litigation. The training course, instructor, and proficiency of the user will be under close scrutiny. Proper records and documentation of all training is essential.

Training is also an extremely important element in other areas of the security officer's responsibilities such as human relations, dealing with combative patients, intoxicated visitors, and illegal parking by staff and visitors. Security specific training in conjunction with the hospital's specific training needs will allow the security officer to understand the overall aspects of their position in the unique healthcare setting. Training requirements for weapons, especially firearms, require specific in-depth training programs. These may also be governed by rules, regulations and laws established by local or state ordinances.

#### SECURITY DEVICES

Some basic security devices require constant consideration in the healthcare system. These include proper lighting, fences and barriers, and locking devices. These components must be assessed regularly to assure they are providing the basis of a sound physical security program. Failure to maintain these items properly can in some case result in greater litigation damages since improper equipment demonstrates that the facility had knowledge of the need for these devices.

Crime Prevention Through Environmental Design (CPTED) is another component of an overall security program. CPTED is a means of reducing crime and the fear of crime through a positive interaction of human behavior and the physical environment. This concept allows for the integration of a number of physical, psychological and manpower components to aid in the overall security effort.

Electronic security systems are becoming an integral part of the overall healthcare security program. These include closed-circuit television (CCTV), video recorders, electric locks, card control access systems, alarms identification systems, computer systems and robotics. These systems can be utilized independently or be integrated into security packages. The greatest advantage of these electronic

security systems is to augment the overall security program. This program consists of sound physical security (i.e. locks, fences, lighting) and adequate security personnel both in number and quality. When properly blended, electronic security can allow a single security officer at a stationary position to monitor and control a number of access points and vulnerable areas of a facility. Combined with alarm monitoring, telephone and radio communications can facilitate a cost-effective position in the security program.

Some caution, however, needs to be considered in the area of electronic security. Dummy or simulation CCTV cameras have led to successful litigation against hospitals because victims have construed that there was a higher security level than was actually present. Litigation has also been successful when live cameras were not monitored or had become inoperative. The use of electronic security devices mandates careful initial financial consideration, a regular review of the intent and purpose for the installation, and a sound maintenance program.

Healthcare facilities should consider developing a statement that indicates that these systems are an augmentation and be prepared to prove that if they fail or are out of order that there is still an adequate security program.

#### IV. INTEGRATED APPROACH TO HEALTHCARE SECURITY

Astute healthcare security managers must clearly identify how their department interfaces with the organization, what services must be provided and what is the most cost-effective method to maintain a safe and secure environment. Security managers must develop and understand the level of administrative commitment for the security program. They must clearly know their responsibilities and authority and be prepared to meet the overall mission of the healthcare facility.

Since healthcare facilities are unique to many businesses, the security manager or person responsible for security must identify and assess the threat levels to the facility. This is especially important in light of the increased national trend in criminal activity and the epidemic level of increases in litigation for inadequate security. There is also a competitive nature among facilities to provide a safe environment to market their programs effectively to the patients as well as for recruitment of staff.

Healthcare facilities have numerous potential property loss vulnerabilities such as food supplies, drugs and narcotics, office equipment, and computers. Hospitals have thousands of items, either on-hand or in storage, that can be used in other businesses or at home. Because most facilities operate 24 hours per day, there are also unique vulnerabilities present for the patients, staff and visitors unless appropriate safeguards are established and implemented.

Persons responsible for healthcare security must work with the administration and each and every department of the healthcare facility to establish a firm commitment of support. Once established, the security manager can work with the various departments and individuals to identify specific risks and take appropriate preventive steps to avoid losses and injuries. These would include accountability of equipment, protection of high-risk patients, proper screening and selection of employees, adequate orientation and training of all employees regarding their involvement and responsibility for the security of the facility, the specifics of security rules and regulations as well as a guide for disciplinary action and enforcement.

Each healthcare facility must identify how the security function will operate. Very small facilities may not have specific security personnel, but must identify and develop a security program. In other words, they must develop mechanisms using available resources to address security issues. Very large organizations may have a director or administrative personnel running their security programs with over a hundred security officers. The majority, however, fall somewhere in between.

In order to maximize the overall effectiveness of the security effort, many departments are utilizing physical and electronic measures. These measures, when integrated with security officers, can provide a more comprehensive security program.

In too many instances the security aspects of a project under construction or a facility being renovated are reviewed after the work is complete or after security problems have developed. Security considerations must play an active role in planning all projects. Often security is viewed as being on the opposite end of the spectrum from convenience. In other words, a well fortified campus with fences, gates, locks and multiple barriers may be great security devices, however, create a great deal of inconvenience for the users.

Healthcare facilities are usually marketed as remaining open 24 hours per day, available to the public and friendly places for people to come. "Open visitation" can become a security manager's nightmare. The ability to design and implement adequate security measures with minimal inconvenience starts during the planning stage of construction and renovation. Persons responsible for security management or security consultants should be asked for their input at the planning and design stage. Installation of systems at the time of construction is less costly than change orders or retrofit. In many cases, it may be possible to at least pull extra wire which will allow for the installation of future security devices in a more cost-effective manner.

Comprehensive protection can best be provided by developing a series of multi-barrier protective devices. The overall protective system is usually defined as a series of protective rings. These rings consist of a perimeter ring which is at the outer most portion of the property, the secondary ring is usually the perimeter of the building, and the inner ring which is usually the interior or the area immediately in proximity of the object to be protected. Given today's technology for sources of protection, it is now possible through physical, electronic and computer enhancements to aid security personnel with the assigned task of providing protection to persons as well as assets.

#### OUTER PERIMETER RING (GROUNDS)

The perimeter of a facility can be protected in a number of methods. These typically include barriers which can be either natural or man-made. Natural barriers include lakes, rivers, mountains, heavy thick bushes. Man-made barriers usually deal with fencing. Fencing at a minimum will usually put people on notice that the occupants have clearly delineated that this property is off limits. This may or may not also include signage which is considered as a passive device to clarify this position.

To augment perimeter protection there are a number of alarm techniques available. These include fence vibration alarms, fence disturbance alarms, electronic capacitance sensors, pressure sensitive sensors, motion detectors, photoelectric beams, microwave sensors, heat sensors, all of which can be the sensing device for an alarm system. Alarm systems traditionally consist of a sensor, a transmission device and an annunciator. The sensor detects a change, the transmission device is the medium that communicates to the annunciator which reads and assimilates the information received.

#### MIDDLE PERIMETER RING (BUILDING)

In order to protect a building's perimeter effectively security personnel must remember all sides of a building have a certain vulnerability to attack: Doors, windows, and openings are always vulnerable, but in addition walls, ceilings, floors and roofs need to be considered as possible means of access.

A number of alarm devices are available to address these various vulnerabilities of an attack. These devices include contacts on doors and windows, foil and glass break sensors for windows, and vibration alarms.

#### INNER PERIMETER RING (OBJECT)

Once inside pressure sensitive devices, photoelectric, motion detection, heat sensors, sound detection, wall vibration, microwave, capacitance sensors, and other devices can be used to detect intruders. Many of these devices can be utilized in dual capacity that work together as a check and balance to negate false alarms. They also work together to identify intrusion if one of the two systems are defeated.

All three areas can be monitored by various types of standard alarm systems. Standard enhancements to the protection of these areas can be accomplished by providing adequate lighting, locks and keys, environmental security design features, duress buttons, security patrols, closed circuit television systems, fastening locking devices to articles, electronic locking devices.

#### ALARM DEVICES

As technology continues to develop many alarm devices are taking on computer enhancements which have the capability of polling the various sensing devices on a regular basis and immediately registering either an alarm, if activated, or registering a trouble alarm if no response is received. Computers or microprocessors have the ability to measure both the existing conditions and changes. Through programming, perimeters or tolerances can be established for the sensing devices to measure. This can help reduce the number of false alarms which continues to be one of the greatest problems in the alarm industry.

Current computerized alarm software packages can stand alone or be a component of a card-control access system. Computerized software packages allow for the monitoring of thousands of alarm points, automatic display capabilities, automatic arming and disarming of systems, time control windows, alarm review of priority, systems reports, automatic telephone notification as programmed. One of

the greatest advantages to the computerized alarm enhancement is that numerous manual tasks that formerly required operator action and intervention can now be handled by the computer.

#### ACCESS CONTROL (CARDS)

Card-control access evolved from a card and manual punch technology in the 1950s, to the current status of computer and software enhanced systems with various methods of validating and authorizing access. Whether the system is what we consider today a simple card system or a more sophisticated biometrics device, the heart of the system is computer based. Card access systems require an encoding device, a reader, a locking mechanism, and a processor. The sensor extracts the information from the card and the reader translates the information via a code. The information is transmitted to the computer for comparison against the programmed data authorized and stored. Based upon the programming, access is either granted or denied. There are also numerous variations of the actions taken by different systems but virtually all record the transactions for documentation purposes. Most systems also have alarming capability from unauthorized card usage to standard alarm monitoring.

Card technology consists of magnetic cards (magnetic coding), Weigand cards (coded magnetic wires), magnetic dot cards (coded magnetic dots), optical cards (coded light patterns), and proximity cards (coded radio frequencies). These cards are designed to interface with specific card readers.

Smart cards contain a micro processor and coded memory. This allows the card to have personal identification codes. These systems operate from either random access memory (RAM) or read only memory (ROM). Also they work only in conjunction with smart readers thus raising the cost of these advanced systems.

#### ACCESS CONTROL (BIOMETRICS)

Comparisons of physical characteristics is the basis for biometric access control. This is defined in James Arlin Cooper's book Computer and

Communications Security as follows; "There are currently seven relatively successful biometrics techniques in use. These are:

1. Signature recognition...
2. Fingerprint recognition...
3. Palmprint recognition...
4. Hand-geometry recognition...
5. Voice print recognition...
6. Eye retina pattern recognition...
7. Typing rhythm recognition..."<sup>9</sup>

The basis for these biometrics systems is the comparison of the data being read with the data stored in the computer data bank. The software package after comparison either allows or denies access.

#### CLOSED-CIRCUIT TELEVISION (CCTV)

Closed-circuit television has been a basic security device for a number of years. A basic CCTV system consists of a lens, camera, transmission medium, and a monitor. Variations to the basic system include, housings, pan tilt and zoom mechanisms, switchers, quad screens, digital screens, scanning devices, loping - bridging devices, motion detectors, time lapse video recorders.

Computer enhanced CCTV systems are now in use on a fairly widespread basis. Some systems utilize MS-DOS operating software to integrate the various systems and components found in complex CCTV systems. Via programming the operator can pre-set the sequencing of the various monitors, by pass when desired and manage multiple cameras and associated devices. In one system a camera is focused on a specific heavily-used exit. The adjacent stairway however, is protected via a motion detector which, when activated, allows the computer to direct the camera to pan, tilt and refocus the camera to view the exit, record as well as alert the dispatcher, via an alarm.

Compressed video imaging continues to become refined. These systems allow for transmission via telephone lines thus eliminating the costly requirement of coaxial cable, fiber optics and the heavy expense of installation. Radio Frequency (RF) or wireless systems are also available to negate installation costs, however, are they initially expensive. These do have tremendous applications in covert situations.

#### OTHER COMPUTERIZED SECURITY SYSTEMS

In addition to the above mentioned systems, computers can also be used to lock and unlock doors on pre-program schedules electronically without a physical response from security personnel. Computerized guard patrol or watch patrol systems can specify the exact tour a guard should take. The tour can be tracked and verified. If the proper rounds are not met, the computer can notify the operator with an alarm that the perimeters of the checks are not being met or that the guard may be in need of assistance. Event messages can also be sent to the stations to provide the security officer with specific guard directions.

Electronic mail can be used as a security device in certain circumstances. Breaches in security, suspicious person descriptions and security incident notification can be sent over the "E-mail" system to the "need to know" people without unnecessarily notifying or alerting others or the public.

Photo identification systems are now becoming computerized using digital imaging devices. With these systems it is possible to capture and store images, signatures and vital data on employees and have instant recall. These systems are valuable for comparative recognition and allow for the creation of a replacement card without the employee being present.

#### INTEGRATED COMPUTER SYSTEMS

Various security devices can be computer enhanced so that their individual capabilities can be more effective. The greatest benefit to computer enhancement is the ability to integrate and interface the various security components to maximize the overall security program. This allows for more than one component to work in concert with other devices and provide a more comprehensive system.

The possibility exists to integrate a number of independent systems in a facility including security, safety, and maintenance. From a security-related perspective alarms, CCTV, access control, guard tour, and photo imaging are capable of being interfaced with the appropriate central processing unit and software programs. Some security professionals are not totally comfortable with a total integration and feel this is "putting all of your eggs in one basket." Many prefer partial integration and partial separation. However, as the reliability and comfort level increases more integration and consolidation will develop. The capabilities of a single person (or more in large operations) at one central control point are greatly enhanced when he or she can monitor alarms, CCTV, guard tours, intercoms, identification systems. As these responsibilities become greater and more complex, computer enhancement is essential.

Artificial intelligence is also now available which allows, through computer based software, options and directions for the operator to take in the event that various circumstances occur to assist in assuring a successful outcome to the incident. The computer can also be programmed so that more normal types of activities can automatically be handled by the computer without operator intervention.

In any case, the healthcare facility that utilizes electronic components to enhance its security program should consider developing a statement of purpose defining the scope of the system(s). In other words, it should be clear that the system(s) augment the overall security program in advance of an adverse incident in which it could be construed that these system(s) provided a foolproof or guaranteed security program.

It is also extremely important to develop a preventative maintenance plan and service agreement to insure that the system is functioning at all times. Electronic and computer systems that do not function as designed or are not properly maintained, may from a litigation sense, be potentially more damaging than no system.

Security can be enhanced in a healthcare facility in a number of ways but must be aware of existing vulnerabilities and explore how they can be addressed. The security program can include a number of physical and electronic components, however, a predetermined appropriate response by persons responsible for security is necessary to provide for a comprehensive, integrated security system.

**V. RISK ASSESSMENT**

For healthcare security managers to assess their unique security needs, they must first define what they are attempting to protect. The patient, staff, visitors, physical assets, the institution's name, are usually vital areas of concern. Although each facility may list their priorities differently, most will probably agree with the patient being first.

Once the overall assets and other areas of concern are identified, the next step is to determine the potential threats that may exist which can create an adverse effect on the organization. As previously discussed, the International Association for Healthcare Security and Safety has conducted surveys of member healthcare facilities to determine what crimes and to what extent, occur throughout the United States and Canada. All reporting hospitals have indicated that they had various levels of crime occur on their property regardless of whether they were inner-city, urban or rural. This along with the fact that healthcare facilities do not operate in a vacuum, as crime continues to exist throughout society, should place healthcare security managers and administrators on notice that security threats and incidents do exist and occur.

Next an identification of the vulnerabilities must be conducted. This will allow the appropriate persons at the healthcare facility to make the appropriate action plans to address these vulnerabilities or, if they so choose, consider what risks they are willing to take in lieu of the changes.

After the assessment of what is to be protected, addressing what the threats exist and either how to develop action plans to address the vulnerabilities or what risk they are willing to take, a monitoring process needs to take place. This process should be conducted on a regular basis possibly every six months or at least once a year to assure a safe and secure environment. In the event of significant changes either to the types of patients seen (possibly adding a psychiatric unit), or major additions to the facility, you may choose to conduct another total assessment to determine how these changes may impact the overall security program.

Assessments or risk analysis should be conducted for a variety of reasons. In his book Effective Security Management, Second Edition, Charles Sennewald states, "The eventual goal of risk analysis is to strike an economic balance between the impact of risk on the enterprise and the cost of protective measures. A properly performed risk analysis has many benefits, a few of which are:

- The analysis will show the current security posture (profile) of the organization.
- It will highlight areas where greater (or lesser) security is needed.
- It will help to assemble some of the facts needed for the development and justification of cost effective countermeasures (safeguards).
- It will serve to increase security awareness by assessing the strengths and weaknesses of the security to all organizational levels from management to operations."<sup>10</sup>

When it is determined that a risk analysis or a security survey should be conducted Richard Post and Arthur Kingsbury suggest in their book, Security Administration, "An understanding of the planning process prior to and during a survey is essential for success. Consequently, general management planning processes should be considered in preparing a workable survey instrument. The traditional steps in planning include:

- 1) Recognizing a need
- 2) Stating objectives
- 3) Gathering significant/relevant data
- 4) Developing alternatives
- 5) Preparing a course of action
- 6) Analyzing the plan
- 7) Reviewing the plan
- 8) Implementing the plan"<sup>11</sup>

Note: This writer would add a ninth step: Monitor the plan for improvement.

At this point a security manager or administrator might question whether such a process is worth the time and effort. In Avoiding Liability In Premises Security, a case called Thomas C. Roettger and Diane D. Roettger v. United Hospitals of St. Paul, Inc. is discussed. This case deals with an assault on Diane Roettger while she was hospitalized by an individual named Charles Brown. Brown was a trespasser and had been loitering in the hospital on at least three other occasions. Diane Roettger was awarded \$300,000 and her husband, Thomas \$22,500 in the case. The important significance to this case can be summarized in the commentary:

This case once again illustrates the need for continuing assessment and reassessment of the security needs of a particular business or enterprise. When one or more individuals has been found to breach the existing security measures, then that in and of itself should give rise to a reevaluation of the effectiveness of the security measures being utilized. Repeated breaches should alert security personnel (or persons responsible for security) that the measures being employed are insufficient and immediate steps should be taken in order to prevent future breaches of security...<sup>12</sup>

#### JOINT COMMISSION FOR ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Another reason for healthcare facilities to conduct security risk assessments is to maintain accreditation. The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) is an accreditation body that allows for voluntary inspections of healthcare facilities to review standards/guidelines compliance. In the past ten years there has been a variety of changes in the way security has been reviewed as part of this process. These changes have evolved to the current level, which many feel is inadequate in terms of security specific standards, however, interpretations can be made of the existing standards/guidelines to develop effective healthcare security programs.

The history of JCAHO is described by Russell L. Colling in his third edition of Hospital Security. Mr. Colling stated that the beginning of the organization can be traced to the American College of Surgeons in 1917 with the formal beginning of the Commission in 1951. The current structure was formulated in 1979. At that time the organization was known as the Joint Commission on Accreditation of Hospitals (JCAH).

Although there has been numerous changes in the Joint Commission over the years, two recent changes are notably significant. In August of 1987 the name of the organization was changed to the Joint Commission for Accreditation of Healthcare Organizations to demonstrate the expanded role of healthcare organizations over hospitals. A second major change which became effective in 1988 was the development of the KIPS scoring process. KIPS stands for key items, probes and scoring and is described in the 1991 Accreditation Manual, under the Plant Technology and Safety Management (PTSM) section, as:

The key items, probes and scoring (KIPS) document outlines the process that the Joint Commission will use to evaluate compliance with the safety management standard. It is important to note that the process is interactive. It is designed to involve any appropriate staff member in the survey process to evaluate how well information has been transmitted and retained. Such an approach assumes that the development and transmission of information about the environment is a key function of management. Transmission of information, coupled with astute analysis and measurement of change, is assumed to stimulate the continuous improvement of the management of the care environment.<sup>13</sup>

KIPS utilizes the key items as the key factors in the accreditation process. The probes then become the questions that are asked to identify if the key items are in fact addressed and the scoring is just that, a method of judging the level of compliance.

In the area of security there have also been a number of significant changes. For example, ten years ago the 1982 Accreditation Manual for Hospitals listed specific guidelines regarding security. Although brief they did list some basic components that hospitals should consider. At the time these guidelines were a component of the Functional Safety and Sanitation section of the Accreditation Manual for Hospitals:

Security Measures shall be taken to provide security for patients, personnel, and the public, consistent with the conditions and risks inherent in the hospital's location. When used, these measures shall be uniformly applied. Based on administrative decision, these measures may include, but are not necessarily limited to, the following:

- Effective screening and observation of new employees.
- Identification badges for all hospital personnel.
- Exit/entry control, including good lighting.
- Internal traffic control, including the use of visitor passes.
- A written plan for managing bomb threats or civil disturbances. This plan should be coordinated with, and may be a part of, the hospital's internal disaster and evacuation plan.
- Use of security guards.
- Package control, to deter theft and to prevent introduction of unauthorized items.
- Well-lighted walkways and employee and visitor parking areas.
- Use of surveillance equipment such as visual monitors (mirrors and closed-circuit television) and alarm systems.
- Management of prisoner-patients as required.<sup>14</sup>

Under this format you will note that this particular approach allows for a great deal of latitude and interpretation in evaluating the security programs in hospitals.

In the mid 1980's the Commission dropped the specific guidelines for security as the manual began to be used more for self assessment purposes. The material began to address security as part of safety management as the PTSM section became a stronger component of this overall survey process. In 1986, for example, the guidelines were reduced to "PL.3.1.7 a program that is designed to protect human and capital resources and that is consistent with the conditions and risks inherent in the facility."<sup>15</sup>

Members of the International Association for Hospital Security (IAHS) [note the name was change to the International Association for Healthcare Security and Safety (IAHSS) in 1989] made an attempt to have the Joint Commission adopt specific security standards in 1987. Unfortunately the expectations of IAHS fell short of being adopted. This was described in the September 1988 issue of Hospital Security and Safety Management:

The IAHS submitted guidelines, only to have them deleted by a committee of the Joint Commission, which considered the material "too prescriptive," says Ode Keil, Director of Plant and Technology Management. Even the one statement on security that had existed in the Joint Commission's accreditation manual is no longer there.

PL.19.11, no longer included, read: "There are security measures for patients, personnel and the public consistent with the conditions and risks inherent in the location of the hospital." But the updated PL.1.3.2 calls only for "a risk-assessment program," which Keil says includes security.

"It doesn't say security program. That's implied," says David Bushelle, Assistant Director of Corporate Relations for JCAHO. "It's just common sense for people charged with safety responsibilities to be aware of individual security needs of their organizations."<sup>16</sup>

Another reason for conducting security assessments is outlined in the 1992 Joint Commission of Healthcare Organizations, Accreditation Manual for Hospitals Volume II Scoring Guidelines:

(PL.1.2.2 a risk-assessment program that evaluates the impact on patient care and safety of the buildings, grounds, equipment, occupants, and internal physical systems;

PROBES is there a risk-assessment program that includes:

- a. a security program that addresses concerns regarding patients, visitors, personnel, and property?
- b. reporting to the safety committee, at least quarterly, security incidents involving employees/patients? and,
- c. reporting to appropriate individuals, at least quarterly, the safety committee's conclusions, recommendations, actions taken, and monitored effectiveness of actions taken?

**NOTE:** The security program also includes policies and procedures for appropriately identifying all patients, hospital staff, and visitors.<sup>17</sup>

In April of 1992 the JCAHO's Standards and Survey Procedures Committee endorsed the revised standards. In the August 1992 issue of Health Facilities Management, V. James McLarney states that:

Although Standard PL.1.2.2 requires healthcare facilities to set up risk assessment programs, requirements for security programs are addressed only in the JCAHO's survey scoring guidelines. JCAHO staff thus recommended that security and risk-assessment requirements be separated into two distinct standards - PL.1.2.2.1 and PL.1.2.2.2 respectively - each with its own set of scoring guidelines.

**Security:**

**PL.1.2.** The safety-management program is based on monitoring and evaluation of organizational experience, applicable law and regulation, and accepted practice and includes:

**PL.1.2.1** policies and procedure for safety in all departments/services;

**PL.1.2.2.1** a risk assessment program that **PL.1.2.2.1** evaluates the impact on patient care and safety of the buildings, grounds, equipment, occupants and internal physical systems;

**PL.1.2.2.2** includes policies and procedures for a security-management program.<sup>18</sup>

Numerous methodologies are available to conduct risk or security assessments. In some cases a facility may need to bring in a professional hospital security consultant to provide an objective outside review. Another possibility however may be to develop a multidisciplinary team for the purpose of conducting this review. A multidisciplinary team that is familiar with the facility should also be familiar with the mission of the organization and be able to view the security-related issues in a non-bias manner. This should also reduce the possibility of specific security related requests by the security manager or administrator responsible for security, as self-serving.

The Appendix contains a sample format. The intent of this process is to allow for Annual Risk Identification/Security Analysis, Risk Action Plans and a Security Abatement/Monitoring Review. This three step process will also provide adequate documentation demonstrating your efforts to take assertive steps to identify and reduce the likelihood of security-related incidents. This format has also helped some hospitals identify specific security-related issues that require professional outside security consultant assistance or other methods of corrective action.

Each healthcare facility must understand that the potential for adverse security-related incidents does exist. A proactive approach which consists of the identification, abatement measures and a review process needs to be conducted and documented. Although there is no guarantee that these actions will negate incidents or litigation, your defense posture should be strengthened.

The following is the 1994 JCAHO Security Standard:

*PL 1.2.2.2 [The safety management program is based on monitoring and evaluation of organizational experience, applicable law and regulation, and accepted practice and includes a risk assessment program that] includes policies and procedures for a security management program.*

**PROBES** Do policies and procedures include

- a. a security management program addressing concerns regarding patients, visitors, personnel, and property?
- b. information regarding security incidents involving patients, visitors, staff and hospital property shall be reported to the Safety Committee every other month.
- c. information regarding security incidents involving patients, visitors, staff or hospital property having been reported to the Safety Committee, the recommendations, action plans and outcomes of the efforts of the Safety Committee should be reported to the appropriate management personnel on a Quarterly basis.
- d. provisions for identifying, as appropriate, all patients, hospital staff, and visitors?
- e. provisions for access control to sensitive areas defined by the security management program?
- f. a directive from the chief executive officer or designee designating the specific personnel responsible for security? and
- g. provisions for orientation for all personnel and at least annual continuing education of personnel in those areas determined to be sensitive by the security management program?

Notes; For probe e. sensitive areas may include, but are not limited to, emergency care areas, newborn nurseries, and pharmacies.

**SCORING**

Score 1	a-g
Score 2	any 6
Score 3	any 4 or 5
Score 4	any 2 or 3
Score 5	none or any 1

Notes; To receive credit for probes b. and c. the minimum number of required reports must be available.

Revised 6-94

**HealthCare Security USA****1996 JCAHO SECURITY PERFORMANCE  
EVALUATION  
OVERVIEW AND ASSESSMENT TOOL**

Attached is a synopsis of security and related information contained in the Joint Commission on Accreditation for Healthcare Organizations 1996 Comprehensive Accreditation Manual. The intent of the document is to provide an overview of the 1996 JCAHO Standards as they apply to the individual responsible for security services. In most facilities the individual responsible for security will follow whatever institutional design is formulated to address the global issues which effect all departments. This synopsis will provide a basic understanding of the JCAHO philosophy regarding the performance focused evaluation process. There are also specific references made to the areas directly addressing health care security issues. The final portion of this document is an assessment tool outlining standards effecting the security-related issues and select areas that will require action by the individual responsible for security services. It is recommended that the entire 1995 Comprehensive Accreditation Manual be reviewed and that this synopsis be used as reference.

The assessment tool is designed as a way to alert persons responsible for security services to be aware of specific components and mandates in the 1996 Standards and provide a method to document compliance. Areas of non-compliance should be discussed with appropriate security professionals, risk managers, legal council, and administrators. Relevant countermeasures or reasons for non-compliance should be documented in advance of an incident or inspection, not afterwards.

If you have any questions regarding the information contained in this synopsis, review the 1996 Comprehensive Accreditation Manual. Questions concerning the use of the synopsis or the self-assessment tool may be directed to Fredrick G. Roll, Vice President-General Manager, HealthCare Security USA, at (800)-866-9577 or (303)-794-9577. Fax (303)-794-9578.

***1996 ICAHO SECURITY PERFORMANCE  
EVALUATION OVERVIEW***

**PHILOSOPHICAL OVERVIEW**

The 1996 standards and evaluation methodology are very similar to the 1995 process. In other words, institutions with a sound 1995 Security Management Program will have only minor adjustments to comply with the 1996 format. Many of the philosophical processes have remained in place and an over view of the 1996 security related material is listed below:

- \* Stable standards form a framework that describes the eventual basic foundation for providing quality care and continuously improving that care over a period of time.
- \* Standards are performance- based and functionally organized.
- \* Ongoing performance-improvement activities should be developed.
- \* Ongoing performance-efforts across the organization is the key to enhancing the quality and value of the health care service.
- \* The survey process focuses on the performance of patient-focused and organizational functions that support quality patient care. Emphasis is placed on observation of performance and interviews with staff and patients.
- \* The framework for improving performance will be evaluated.
- \* The organization's relationship with its external environment is important.
- \* The organization's internal characteristic and functions are important.
- \* A method for systematically assessing and improving important functions and work processes and their outcomes need to be in place.
- \* Self evaluation should continue to be viewed as a major opportunity for continuous improvement.
- \* Standards should continue to emphasize actual performance, not simply the capacity to perform.
- \* The performance expectations reflected in the standards should be set forth in a quality improvement context. That goal is excellent care that continues to improve over time.
- \* The survey process continues to focus on assessing, across an organization, performance

of important patient-focused and organizational functions that support quality patient care, rather than evaluating activities that may have been conducted primarily to pass the survey.

- \* Utilize a methodology for systematically assessing and improving important functions and work processes and their outcomes. The improvement cycle is applicable at all levels of the organization. The improvement cycle flows in the following manner:

**DESIGN** refers to the rational, deliberate process of creating a quality service as viewed by those who receive it and provides opportunities to build into the service or product the demonstration of performance described as follows:

**MEASUREMENT** involves both routine, ongoing data collection for processes or functions performed by individuals or multi-disciplinary teams or groups, as well as time specific, focused data collection.

**ASSESSMENT** of the data to draw conclusions about current performance and decide whether to pursue an opportunity for improvement or resolution of a problem. Statistical analysis and other quality improvement tools are often useful including comparative data.

**Performance IMPROVEMENT** activities should be developed and prioritized. These may include a process to test a new approach, collecting data about its effects, and take action to standardize the improvement or repeat the process if results are not satisfactory.

**REDESIGN** of the existing function or process or an innovation based on the design of a new approach aimed at meeting or exceeding needs or expectations.

- \* Site examples of implementation, outline strategies, activities, and/or processes that you may use to meet the intent of the standards. You are encouraged to be innovative in your approach to meeting the intent of the standards.
- \* Examples of evidence of performance provide insight into what sources a surveyor may seek evidence from or that you may present to a surveyor to show that your organization complies with the intent of the standard(s).

### **Patient Rights and Organizational Ethics (overview)**

The goal of this function is to help improve patient outcomes. Respect each patient's personal dignity, provide considerate, respectful care focused on the patient's individual needs. Security personnel must understand and be prepared to verbalize that patients have a right to reasonable security while in the health care facility.

**RI.1** The hospital addressed ethical issues in providing patient care.

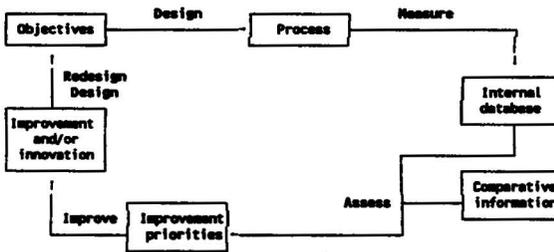
#### **Intent of RI.1**

The patient's right to security and personal privacy and confidentiality of information.

**RI. 1.3.3** The hospital demonstrates respect for the following patient needs; security (not scored).

### **Improving Organizational Performance (overview)**

#### **Improving Organizational Performance Function**



This flow chart illustrates the process for improving performance and outcomes in a health care organization. The components of the performance-improvement cycle are connected by the actions of organizational leaders, managers, physicians and other clinicians, trustees, and support staff who design, measure, assess, and improve their work processes.

The performance-improvement cycle depicted in this flow chart has no beginning and no end. An organization may start its improvement effort at any point: by designing a new service; by flow charting an existing clinical process; by measuring patient outcomes; by comparing its performance to that of other organizations; by selecting specific areas for priority attention; or even by experimenting with new ways of carrying out current functions.

**PLAN**

**PL.1** The organization has a planned, systematic, hospitalwide approach to process design, and performance measurement, assessment and improvement.

**DESIGN**

**PL.2** New processes are designed well.

**MEASURE**

**PL.3** Data is systematically collected.

**ASSESS**

**PL.4** The hospital has a systematic process to assess collected data.

**IMPROVE**

**PL.5** The hospital systematically improves its performance.

When designing a new process, redesigning an existing process, or deciding to act on an opportunity for incremental improvement in an existing process, the organization has a systematic approach. A systematic approach is one that includes identifying a potential improvement, testing the strategy for change, assessing data from the test to determine if the change produced improved performance, and implementing the improvement strategy system-wide.

**Management of the Environment of Care (overview)**

The goal of the management of the environment of care function is to provide safe, functional, and effective environment for patients, staff members, and other individuals in the hospital which is critical to providing patient care and achieving good outcomes. Achieving this goal depends on performing the following processes:

- \* Planning by hospital leaders for the space, equipment, and resources needed to safely and effectively support the services provided. Planning and designing is consistent with the hospital's mission and vision.
- \* Educating staff about the role of the environment in safely and effectively supporting patient care.

- \* Developing standards to measure staff and hospital performance in managing and
- \* Implementing plans to create and manage the hospital's environment of care.
- \* Reduce and control environmental hazards and risks.
- \* Prevent accidents and risks.
- \* Maintain safe conditions for patient, visitors and staff.

The performance-improvement framework is used to design, measure, assess, and improve the organization's performance of the management of the environment of care function. The management process for design, implement, monitor, assess, and improve components are applied to the standards.

## **DESIGN**

**EC.1** The organization designs a safe, accessible, effective, and efficient environment of care consistent with its mission and services, and law and regulation.

**EC.1.3** A management plan addresses safety.

### **Intent of EC.1.3**

To conduct risk assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety.

**EC.1.4** A management plan addresses security.

### **Intent of EC.1.4**

A security management plan describes how the organization will establish and maintain a security management program to protect staff, patients and visitors from harm. The plan provides processes for

- a. Leadership's designation of personnel responsible for developing, implementing and monitoring the security management plan;
- b. Addressing security issues concerning patients, visitors, personnel and property;
- c. Reporting and investigating all security incidents involving patients, visitors and staff;
- d. Controlling access to sensitive areas, as determined by the organization; and
- f. Providing vehicular access to urgent care areas

In addition, the plan establishes

- g. A security orientation and education program that addresses:
  - 1. Processes for minimizing security risks for personnel in security-sensitive areas,
  - 2. Emergency procedures followed during security incidents, and
  - 3. Processes for reporting security incidents involving patients, visitors, personnel and property;
- h. Performance standards for
  - 1. Staff security management knowledge and skill,
  - 2. The level of staff participation in security management activities,
  - 3. Monitoring and inspection activities,
  - 4. Emergency and incident reporting procedures that specify when and to whom reports are communicated, and
  - 5. Inspection, preventative maintenance, and testing of security equipment
- i. Emergency security procedures that address
  - 1. Actions taken in the event of a security incident or failure
  - 2. Handling of civil disturbances,
  - 3. Handling of situations involving VIP's or the media, and
  - 4. The provision of additional staff to control human and vehicle traffic in and around the environment of care during disasters.

The objectives, scope, performance, and effectiveness of the security management plan are evaluated annually.

Examples of Evidence of Performance for EC.1.4

- \* Management plans for the issue(s) addressed in the standard
- \* Performance standards for the issue(s) addressed in the standard
- \* Emergency procedures for the issue(s) addressed in the standard
- \* Staff interviews

## **IMPLEMENT**

**EC.2** The organization provides a safe, accessible, effective and efficient environment of care consistent with its mission and services, and law and regulation.

**EC.2.1** Staff members have been oriented and educated about the environment of care, and

possess the knowledge and skills to perform their responsibilities under the environment of care management plans.

**Intent of EC.2.1**

- \* Personnel can describe or demonstrate
- \* Personnel in security sensitive areas of the environment of care can describe or demonstrate
  - l. Processes for minimizing security risks;
  - m. Emergency procedures for security incidents; and
  - n. Reporting procedures for security incidents involving patients, visitors, personnel, and property.

**EC.2.3** The organization implements the security management plan and performance standards, including all features described in EC.1.4

Examples of evidence:

- \* Building and grounds tour
- \* Observation of visitor security procedures
- \* Staff interviews

**MEASURE OUTCOMES OF IMPLEMENTATION**

**EC.3** An organizationwide Information Collection Evaluation System (ICES) is developed and used to evaluate conditions in the environment of care.

**EC.3.1** The organization appoints an individual to direct an ongoing organizationwide process to collect information about deficiencies and opportunities for improvement in environment of care programs.

**Intent of EC.3.1**

- \* b. Reviews summaries of deficiencies, problems, failures, and user errors relate to managing
  2. Security

**EC. 3.2** The organization analyses identified environment of care safety management issues and develops or approves recommendations for resolving them.

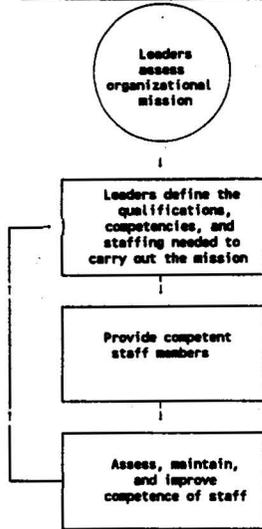
**Management of Human Resources(overview)**

A hospital needs an appropriate number of qualified people to fulfill its mission and meet the needs of the patients it serves. The goal of this function is to identify and provide the right

number of competent staff to meet the needs of patients served by the hospital.

- \* **Planning.** The leaders' planning process defines the qualifications, competencies, and staffing necessary to fulfill the hospital's mission.
- \* **Provide competent staff.** The leaders provide competent staff either through traditional employer-employee arrangements or contractual arrangements with other entities.
- \* **Assessing, maintaining, and improving staff competence**  
Ongoing , periodic competence assessment evaluates staff members' continuing ability to perform throughout their association with the hospital.
- \* **Promoting self-development and learning**

Measurement of Human Resources Function



**HR.1** The hospital's leaders define the qualifications and performance expectations for all staff positions.

Examples of Evidence of Performance - HR.1

- |  |   |
|--|---|
| ✓ Department-specific staffing plans                         | ✓ Hospital or departmental policies and procedures  |
| ✓ Policy   | ✓ Staffing plans  |
| ✓ Staff interviews   | ✓ Staff development plans   |
| ✓ Senior and departmental leadership interviews              | ✓ In-service and continuing education records   |
| ✓ Performance evaluations or competency-assessment mechanism | ✓ Orientation curriculum  |
| ✓ Contracts  | ✓ Reports and meeting minutes   |
| ✓ Employee personnel files                                   | ✓ Employee brochures or handbook  |
| ✓ Job descriptions   | ✓ Description of licensure, certificates, privileges, and credential verification process |

**HR.2** The hospital provides an adequate number of staff members whose, qualifications are consistent with job responsibilities.

**HR.3** The leaders ensure that the competence of all staff members is assessed, maintained, demonstrated, and improved continually.

(For personnel provided through a contractual arrangement, the hospital maintains a written job description and a completed competence assessment, evaluation, or appraisal tool for each individual).

**HR.4** An orientation process provides initial job training and information and assesses the staff's ability to fulfill specific responsibilities.

Intent of HR.4

The orientation process assesses each staff member's ability to fulfill specific responsibilities. The process familiarizes staff members with their job and with the work environment before the staff begins patient care or other activities.

**HR.4.2** Ongoing in-service and other education and training maintain improve staff competency.

Intent of HR.4.2

The hospital ensures that each staff member participates in ongoing in-serve education and other training to increase his or her knowledge of work related issues.

**CONCLUSION:**

Many of the security-related objectives remain in place from the 1995 JCAHO standards. There are however some minor changes and additions that need to be adapted into the 1996 JCAHO Security Management Program. Surveyors will continue to spend a great deal of their time looking for demonstrative performance of knowledge, competency and actions from staff members to validate their ability to manage the environment of care. By Understanding the information contained in this security related overview of the 1996 Comprehensive Accreditation Manual and complying with the appropriate standards, a facility should be able to functionally document and perform in a manner to successfully complete a JCAHO survey.



Reference	Summary	Yes	No	Comments/Documentation
IMPROVE PL.3	The hospital/department systematically improves its performance			

Reference	Summary	Yes	No	Comments/Documentation
DESIGN BC.1	<p style="text-align: center;"><b>MANAGEMENT OF ENVIRONMENTAL CARE</b></p> <p>The organization designs a safe, accessible, effective, efficient environment of care consistent with its mission and services, law and regulation.</p>			
BC.1.4	<p>A management plan addresses security</p> <p>Leadership's designation of personnel responsible for developing, implementing and monitoring the security management plan.</p> <ul style="list-style-type: none"> <li>- Addressing security concerns regarding patients, visitors, personnel, and property</li> <li>- Reporting and investigating all security incidents involving patients, visitors and staff.</li> <li>- Controlling access to sensitive areas, as determined by the organization.</li> <li>- Providing vehicular access to urgent care areas</li> <li>- Providing traffic control for emergency service areas</li> <li>- A security orientation an education program that addresses               <ul style="list-style-type: none"> <li>Processes for minimizing security risks for personnel in security sensitive areas.</li> <li>Emergency procedures followed during security incidents</li> <li>Processes for reporting security incidents involving patients, visitors, personnel and property.</li> </ul> </li> </ul> <p>Policies and procedures in the emergency room address the following risk factors associated with assaultive behavior:</p> <ul style="list-style-type: none"> <li>- History of assaultive behavior</li> <li>- Diagnosis of dementia</li> <li>- Drug or alcohol intoxication—history of abuse</li> <li>- Inflexible treatment or milieu routines</li> </ul>			

Reference	Summary	Yes	No	Comments/Documentation
EC.1.2.4	Emergency preparedness-security personnel provide security management and alternative roles as appropriate.			
EC.1.3.2	Security orientation and education components address: - The processes for minimizing security risks for personnel in sensitive areas as defined by the organization - Proper emergency procedures are followed during security incidents - For all personnel, the organization's processes for reporting security incidents			
EC.1.4.1	Emergency procedures for security address: - Specific procedures for security incidents or failures - Specific procedures for civil disturbances - Specific procedures for handling VIP or media situations - Specific procedures to staff and control human/vehicular traffic in and around the environment of care during disasters			
EC.1.5.2	Security Management Program establishes performance standards to protect employees, staff, visitors, and patients from harm: - Staff knowledge and skill requirements regarding their role and expected level of participation - Monitoring and inspection activities - Routine emergency/incident reporting procedures (i.e., when and to whom to communicate reports) - Inspection, preventative maintenance, and testing of security equipment			

Reference	Summary	Yes	No	Comments/Documentation
EC.2.1.2	<p>Personnel in security sensitive areas, as determined by the organization can describe and/or demonstrate:</p> <ul style="list-style-type: none"> <li>- Proper processes for minimizing security risks</li> <li>- Proper emergency procedures during a security incident</li> </ul>			
EC.2.2	<p>Organization's processes for reporting security incidents that involve patients, visitors, personnel, and property</p>			
EC.2.3.2	<p>The organization conducts emergency drills on a regular basis to test the responsiveness to emergency situations. Example might be hostage situation, ED or psychiatric disturbances, alarm response, etc...</p>			
EC.3.1	<p>Security implements, as designed, the documented management plan(s) and performance standards as required by ED.1.1.2 and EC.1.4.2. The organization also provides, as appropriate, access control provisions and inspections, as appropriate, ID procedures.</p> <p>Security provides the safety officer/safety committee with information identifying deficiencies and opportunities for improvement in the environment of care management program:</p> <ul style="list-style-type: none"> <li>- Summaries of program deficiencies or problems, failures, user errors and relevant reports of hazard or recalls associated with the program.</li> </ul>			
EC.3.4	<p>Security provides the safety committee with environment of care management issues and data according to the measurement guidelines established by the safety committee. Reports should follow the performance improvement cycle.</p>			

Reference	Summary	Yes	No	Comments/Documentation
Management of Human Resources	<p>Improvement of the management of human resources function focuses on essential processes, the understanding of these processes, and the revision of the processes based on relevant data. The essential processes include:</p> <ul style="list-style-type: none"> <li>- Organization leaders define qualifications, competencies, and staffing needed to carry out the organization's/department's mission</li> <li>- Provide competent staff members either through traditional employer-employee arrangements or the negotiation of contractual arrangements</li> <li>- Develop and implement processes designed to ensure that the competence of all staff members is assessed, maintained, improved and demonstrated throughout their association with the organization</li> <li>- Provide a work environment that promotes self-development and learning</li> </ul>			
HR. 1	<p>The performance - improvement framework is used to design, measure, assess, and improve the organization's performance of human resources.</p> <p>Leaders define in respective areas the qualifications and job expectations of staff, and a system to evaluate how well the expectations are met.</p>			
HR. 2	<p>The organization/department provides an adequate number of staff whose qualifications are commensurate with defined job responsibilities and applicable licensure, laws, regulations, and/or certificates. Should include: verification of education and training, appropriate licensure, certification, or registration and appropriate knowledge and experience.</p>			

References	Summary	Yes	No	Comments/Documentation
HR.3	<p>Processes are designed to ensure that the competence of all staff members is assessed, maintained, demonstrated and improved on an ongoing basis:</p> <ul style="list-style-type: none"> <li>- Staff development is conducted on the organizational, departmental, and individual levels, and such needs are used for continuing staff education purposes.</li> <li>- Leaders provide support and encourage staff to act with appropriate authority and work processes to give staff a sense of ownership/ accountability</li> <li>- Supervisory staff provides an environment/culture in which value is placed on the employee's human needs for self-respect and growth. Staff should be encouraged to participate in appropriate professional associations and continuing education activities inside/outside the organization whenever possible/feasible</li> <li>- The organization/ department assess staff competency with mechanisms to at least maintain competency through a combination of ongoing assessment and educational activities and an objective, measurable system periodically used to evaluate job performance, current competencies, and skills.</li> </ul>			
HR.3.1	<p>The organization/department has established methods and practices that encourage self development and learning for all staff. The organization/department is responsible for creating a work environment that helps staff discover what they need to learn and assist them, as appropriate, in acquiring new knowledge and skills.</p>			

Reference	Summary	Yes	No	Comments/Documentation
HR.3.2	Staff orientation process provides initial job training and information, including an assessment of an individual's capabilities to perform specified responsibilities. Orientation process is designed to promote the safe/effective performance of staff members' responsibilities and familiarize them with their responsibilities and/or work environment before initiating activities.			
HR.3.3	Ongoing, in-service and/or other education and training maintain and improve staff competence by ensuring that staff members participate in ongoing in-service education sessions and other work-related issues.			
HR.3.4	The organization/department collects aggregate data on an ongoing basis regarding self-competency patterns and trends to identify and respond to staff learning needs. Data is analyzed for patterns and trends to identify staff learning needs and offer appropriate in-service education, training, etc.....			
HR.4	The organization/department assesses an individual's ability to achieve job expectations as rated in his or her job description. Competence assessment activities should exist and be documented for each staff member.			

ASSESSMENT CONDUCTED BY:	
NAME:	
TITLE:	
CREDENTIALS:	
DATE:	
LIST PERSONS CONTACTED AS PART OF THE ASSESSMENT:	
NAME	TITLE
NAME	TITLE
NAME	TITLE

## **VI. QUALITY MANAGEMENT**

Security quality management deals with a quantifiable method of determining the effectiveness of the security program. Various institutions have different methodologies; most develop specific aspects of services with indicators identifying how measurement is achieved. These indicators would usually be expected to fall within certain thresholds for evaluations.

In order to identify and analyze aspects of service, security managers should follow this six-step process.

- 1) Identify areas of concern or problem of which the security department is held accountable.
- 2) Analyze the concern or problem as it relates to the service delivery and expectation of the security department.
- 3) Examine all potential alternatives to the concern or problem.
- 4) Select the best possible method to address the concern or problem.
- 5) Implement the chosen method of correction.
- 6) Monitor the action and improve as needed.

By following this format the security manager will be able to qualify and quantify the actions of the security department. The aspects of care or service will state what the manager is attempting to accomplish. A statement of an objective or rationale will address why the aspect of service was developed. The indicators will then outline the specifics of the evaluation. The thresholds for evaluation will set the acceptable parameters in which action should be accomplished. These should be established as realistic yet achievable goals. The methodology will establish how the evaluation is determined. In the event thresholds are not met, the security manager can investigate, identify, document and take corrective actions to assure future compliance. Finally, the data source will address the documents or sources of the information.

Figure #14 on page 60 is a sample format used as part of the quality management program for security services at Baptist Medical Center in Jacksonville, Florida.

The format described in Figure #14 was used by all departments to identify areas of concern. These reports were given to and addressed by the Medical Center Quality Assurance Committee. Each major department was required to submit report on a quarterly basis. A consolidated report was then constructed and shared with administration.

Quality management should be use to track and monitor on-going activities within the security department. This will allow the manager and administration to determine the effectiveness of the department as well as pertinent trends. These trends can then be used, through the evaluation process, to take corrective actions and strengthen the security program. For example, when security personnel are regularly unable to respond to stat/emergency calls within the appropriate time and within the thresholds for evaluation, this might suggest to management that procedures need to be improved, that additional personnel may be required, or other corrective action is needed.

Graphs and charts can also be an effective way of visually measuring the changes in activity levels. These changes may act as indications that certain areas need specific corrective actions. See Figure #15 on page 61 and Figure #16 on page 62.

In the 1992 Accreditation Manual for Hospitals quality continues to be stressed starting with a name change in the chapter formerly known as Quality Assurance to Quality Assessment and Improvement.

FIGURE #14

**MONITORING AND EVALUATION  
SUMMARY**

**DEPARTMENT:** Safety, Security, & Parking

**DATE:** August  
September  
October

**ASPECT OF CARE/SERVICE:**

The Safety, Security and Parking Department will provide a 2-minute response to various emergency situations.

**OBJECTIVE OR RATIONALE:**

To insure a prompt response to emergency situations.

**INDICATOR(S):**

	<u>Thresholds for Evaluation</u>
1. Fire Response	95%
2. Intrusion/Robbery Alarms Responses	95%
3. STAT/Emergency Responses	95%
4. Patient Restraints Assistance Responses	95%

**METHODOLOGY (TIME FRAME, SAMPLE SIZE, STAFF, HOW?):**

Because of the new computerized reporting system, 100% of the incident reports and fire reports are being reviewed on a monthly basis by the Security Supervisor.

**DATA SOURCE:**

1. Daily Activity Reports
2. Incident Reports

**Source:** Baptist Medical Center, Quality Management Department

FIGURE #15

CATEGORY	1987	1988	%	1989	%	1990	%	1991	%
Alarm/False-Fire	3	4	33%	6	50%	10	67%	5	-50%
Alarm/False-Security	16	41	156%	9	-78%	13	44%	18	38%
Assault	0	0	0%	1	N/A	0	-100%	0	0%
Auto Accident	0	1	N/A	1	0%	0	-100%	0	0%
Break. & Enter.-Building	0	0	0%	0	0%	1	N/A	1	0%
Break. & Enter.-Vehicle	1	0	-100%	0	0%	0	0%	0	0%
Disturbance-Visitor	0	2	N/A	1	-50%	2	100%	0	-100%
Fire	0	0	0%	2	N/A	1	-50%	0	-100%
Found Property	0	0	0%	0	0%	3	N/A	1	-67%
Information Only	16	21	31%	17	-19%	18	6%	41	128%
Missing Property-Facility	1	0	-100%	1	N/A	3	200%	4	33%
Missing Property-Personal	1	1	0%	0	-100%	0	0%	2	N/A
Patient Assistance-Mon ER	6	1	-83%	2	100%	36	1700%	28	-22%
Sex. Incident-Obscene Call	0	0	0%	1	N/A	0	-100%	0	0%
Susp. Person-Contacted	1	0	-100%	2	N/A	5	150%	2	-60%
Susp. Person-No Contact	0	1	N/A	0	-100%	5	N/A	1	-80%
Threat-Bomb	1	0	-100%	0	0%	1	N/A	0	-100%
Vandalism-Facility	1	0	-100%	1	N/A	4	300%	5	25%
Vandalism-Vehicle	1	0	-100%	0	0%	1	N/A	0	-100%
TOTAL	48	72	50%	44	-39%	103	134%	108	5%

Note: "N/A" appears when a mathematical calculation is invalid (caused when dividing by zero).

SOURCE: Hospital Shared Services of Colorado

FIGURE #16

Each Incident/Fire category may not contain enough activity to accurately analyze the frequency or seriousness of events at Saint Barnabas Medical Center. Combining similar categories, may expose patterns that would otherwise be unrecognizable. Each Incident/Fire category was combined as follows:

**Service Incidents**

- Alarm/False-Security
- Found Property
- Information Only
- Patient Assist-ER
- Patient Assist-Non ER
- Sexual Incident-Obscene Call
- Suspicious Person-Contacted
- Suspicious Person-No Contact
- Threat-Bomb

**Regulatory Incidents**

- Alarm/False-Fire
- Fire

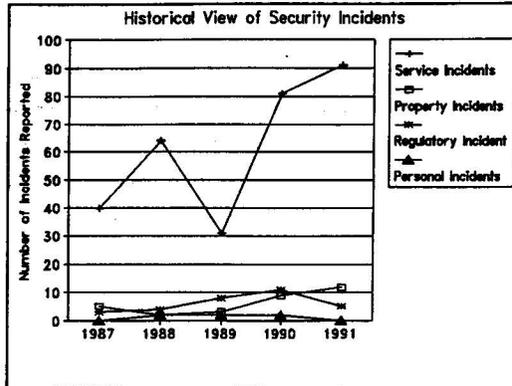
**Property Incidents**

- Auto Accident
- Breaking & Entering-Building
- Breaking & Entering-Vehicle
- Missing Property-Facility
- Missing Property-Personal
- Missing Property-Vehicle
- Vandalism-Facility
- Vandalism-Personal
- Vandalism-Vehicle

**Personal Incidents**

- Assault
- Disturbance-Employee
- Disturbance-Visitor
- Drug Abuse
- Robbery-Armed
- Robbery-Unarmed
- Sexual Incident-Assault
- Sexual Incident-Other
- Threat-Other

A graph of each summarized Incident/Fire category is displayed below:



SOURCE: Hospital Shared Services of Colorado

Some highlights of continuous quality improvement. The Joint Commission's transition to continuous quality improvement standards will draw upon the insights of the originators and major developers of continuous quality improvement, such as W. Edwards Deming, Joseph Juran, and Philip Crosby. Principles of continuous quality improvement incorporate the strengths of quality assurance as it is currently practiced, while broadening its scope, refining its approach to assessing and improving care, and dispensing with the negative connotations sometimes associated with it. In moving toward continuous quality improvement, the Joint Commission wants healthcare organizations to build on the strengths of their present quality assurance mechanisms. These mechanisms and the persons who have established them constitute a substantial foundation from which to launch the transition to continuous quality improvement.<sup>19</sup>

With this focus and emphasis from JCAHO all areas of health care, including security, can expect to become more involved in total quality management (TQM) or continuous quality improvement (CQI) efforts from their organization. More and more activities will become part of a "process" thus requiring greater intervention with other components of the organization and better team efforts.

**VII. THE FUTURE OF HEALTHCARE SECURITY MANAGEMENT**

Many security managers are striving to fortify and develop their expertise specifically in security. Although this is very important, many security directors are losing their jobs or their jobs are being eliminated or down graded.

The reason for this in most cases is simply financial. Many healthcare facilities in America are in a state of fiscal crisis. As money becomes tighter, administrators and chief financial officers are determining where dollars can be saved. These cuts are not taking place in the areas of nursing or premium positions where salaries and benefits continue to grow. As a matter of fact these salaries are at all time highs. Benefit and perk packages are very competitive among healthcare providers for these positions.

What does this mean for persons involved in the healthcare security field? Our job is to work harder, think smarter, and be business minded. In other words, search your budget and look for areas to make your operations as efficient as possible. The old days of spend it or lose it before the end of the next year's budget are long gone. The astute healthcare security manager will trim his or her operation before someone trims it for them. This is especially important since in some cases the trimming has been the director or manager's position.

In one case in Florida a hospital hired an independent management consulting firm to reduce the overall hospital expenditures by 10 percent. When the consulting group reviewed the security department which had an annualized budget of approximately \$500,000, the security director was well qualified and had a great deal of experience and had an annual salary of approximately \$50,000 per year. Since there was an assistant director and a minimum amount of working security personnel (in the consultant's opinion), the director's position was eliminated and the assistant director's title was changed to manager. The end result: a 10 percent savings and one more security director on the street.

Each security director must be aware of the economic climate within their facility. In general the national trend including healthcare is to reduce middle managers. Even if the institutional budget appears sound, don't become known as a big spender. Become known as a business-minded, cost-effective manager. Explore various alternatives to make all of the operations you manage as cost-effective as possible. Examine every area and function as if you are operating from a zero-based budget system. Be prepared at any time to justify each and every financial request and budgetary line item.

As defined in Managerial Accounting, Second Edition by Calvin Engler, "Zero based budgeting is a method of budgeting that starts with a base of zero and ranks each program and its cost, starting with the one most vital to the organization. In a manner, managers can choose to fund programs on the basis of merit, without preconceived notions about what must be included."<sup>20</sup>

Give things up in advance and if you don't need it, don't ask for it. At the same time be sure to take credit for this philosophy. Let the appropriate people know that you are attempting to improve your efficiency and cost effectiveness to the organization. Usually you don't have to look far to see which of your fellow directors or managers are moving ahead and obtaining greater responsibilities. They are usually the ones that are already cost effective and efficient.

Being creative is essential. Look at your staffing which is your greatest line item. Through attrition, can you hire part-time staff instead of full-time? This not only saves benefit costs to the institution but also should defray overtime since you have a manpower reserve to call upon that are normally scheduled at less than 40 hours per week. Have some of employees been with the organization too long? Certain jobs are worth only so much per hour and some security employees actually make too much for what they do. Can the institution afford to pay for this? Can these people move to other departments within the organization? Remember turnover can be good or bad depending on how you manage it. Are there any other staffing options that may be viable? These are questions that the astute business-minded security manager should ask and answer before an administrator does.

Healthcare security managers need to continue their professional development in the field of security. However, in addition to this, it is of the utmost importance that they explore a business-minded approach to management. Cost effectiveness and efficiency are key items on which they will be judged by their superiors. Administrators are usually insistent that management personnel explore all potential alternatives and have a sound rationale behind their recommendations and methods of operations. Survival means being creative in advance of being told what and how you will trim your organization.

This proactive approach should help you not only survive the budget tightening process that is expected to continue in the healthcare arena, but also excel by proving your effectiveness and worth to the organization. This in turn might result in added responsibilities where you can continue to demonstrate your management abilities.

#### MANAGEMENT IN THE NINETIES

As healthcare continues to become more sophisticated, each department must keep pace, including security. The education and integration of the various departments and employees of the hospitals with regard to security issues will become even more essential.

The administration of a hospital security department will require professional managers to develop and maintain successful budgets with limited resources. The use of electronic security devices in conjunction with manpower will need to be regularly and carefully reviewed to provide an adequate overall security program.

As the litigation trend continues, security incidents that occur at hospitals will be closely examined. The competency of security managers and officers will be reviewed by expert witnesses. The education, experience, training, and certifications of both will come under close scrutiny.

Hospital security has been elevated to a more significant role in our nation's health care delivery system over the past ten years. This role has been stimulated by greater violence in hospitals, increased awareness of the extent of property losses and the litigation epidemic alleging inadequate hospital security. Far too many cases have resulted in multimillion dollar awards or settlements.

The security role should be viewed in two separate and distinct categories. First, personal safety: approximately 90 percent of the security effort is directed to the protection of staff, patients, and visitors. Second, property losses: hospital property losses alone, are estimated to run in the area of \$2,000 to \$3,000 per bed per year.

Although security is generally referred to in terms of physical safeguards, it must be understood that security is also a perception. Even when there is a lack of serious incidents, or few obvious vulnerability, if the staff, patient or visitor feels apprehensive or uncomfortable, the security program must react to the perception and implement plans to create a positive image.

Figure #17 on page 68 describes trends (derived from professional literature, national and regional seminars, and Hospital Shared Services consulting projects) that forecast of events for the future of healthcare security through 2000.

In the December 1991 issue of Security, Figure #18 on page 69 contains a chart which projects a comparison between yesterday, today, and tomorrow in how security in general is evolving.

Because healthcare is an advanced field, I believe that many of the various components outlined in this chart will come to fruition in the healthcare security field as well.

FIGURE #17

### HEALTHCARE SECURITY TRENDS - 2000?

- Increased training for all levels of hospital security personnel.
- Increasing involvement of hospital employees, including non-security supervisory personnel, in contributing to the maintenance of safe and secure premises.
- Epidemic levels of litigation concerning security programs.
- More security personnel working in an unarmed capacity.
- A shift from security by providing non-security related services to a greater emphasis on the basis of "pro-active protection activities."
- A trend toward separating security and safety management as the safety function becomes better defined. Security personnel to continue as being ancillary to the safety function.
- A decrease in the overall use of centralized closed circuit television and a shift to departmental systems.
- Increased use of alarms, computerized card access controls and integrated security systems.
- A greater awareness by the hospital administrative staff of the need for more loss prevention safeguards to enhance the bottom line.
- Violence in emergency rooms remaining at the high level experienced during the past several years.
- Increasing security budgets despite attempts to supplement security manpower with physical security systems.
- Greater organizational demands on security as law enforcement services continue to diminish.
- A greater number of facilities utilizing contract or alternative security services to reduce costs.
- A continued trend to consolidate management positions including the restructuring of security departments to be managed by other areas within the organization.
- A greater need to conduct security risk assessments to identify and provide countermeasures to potential adverse incidents.
- A greater involvement by security personnel to provide geriatric and Alzheimer's patients with specific security protection as that group increases in number.

FIGURE #18

## THE SECURITY EVOLUTION

	Yesterday	Today	Tomorrow
<b>Function</b>	Security	• Asset Protection	• Resource Management
<b>Concept</b>	Stand-alone	• Interfacing	• Integration
<b>Staffing</b>	Proprietary	• Hybrid - Proprietary and Contract	• In-house Consultant; • Facilities Management Services
<b>Technology</b>	• Mechanicals; • Analog; • Electronics	• Electronics; • Mechanicals; • Networks; • Digital	• Digital; • Networks; • Software; • Electronics; • Mechanicals

Source: Security Magazine, December 1991.

A specific responsibility of the security manager needs to be a regular and documented risk assessment of their facility. It will become more popular for institutions to utilize outside consultants to give an objective view of the security risks and make recommendations to be considered by the security manager and hospital administration. Litigation will increasingly be a problem because of reductions of security personnel, improper or inadequate training, lack of documentation, not addressing foreseeable crimes/incidents either on the hospital premises or surrounding area, not attaining local or national standards for security services, lack of or malfunctioning security equipment, lack of security policies, and lack of administrative support for the security program.

In the years ahead, a continued emphasis will be placed upon security managers and departments to provide a high profile and enhanced public relations image for the facility. Uniformed security personnel are administrative agents of the hospital as perceived by the public. It will be necessary for the administration of a hospital and the various departments to realize and accept this elevated role within the organization.

Liaison with law enforcement agencies will become critical. As demonstrated earlier in a reference from the Hallcrest Report II, as the number of law enforcement personnel become fewer per capita, security organizations will take on a greater responsibility in providing protective services within their respective organizations.

Increased security emphasis will be placed on high-risk areas in healthcare facilities such as emergency rooms, nurseries, psychiatric units, drug and alcohol units, and pharmacies. This will require the security personnel to have a greater understanding of how to deal with people under stress or displaying aggressive and assaultive behavior.

A continued and greater emphasis will be placed on crime prevention efforts. This includes crime prevention materials, handouts, flyers, and posters. Security fairs will become more popular and allow the security staff to interface with other hospital personnel to gain understanding and support for the security program.

Quality management will continue to be a driving force in assuring that proper documentation is maintained which facilitates trend analysis and corrective action in problem areas. Along the same line, risk management will assure that the forecasting of incidents is maintained to avoid unnecessary losses.

With the continued financial strain in healthcare, loss prevention will continue to become even a more important issue in the 1990s. Security, safety, risk management, and quality assurance must strive together to identify, prevent and deal with incidents that might result in financial loss, either through frequency or severity of the situation, at the least possible cost to the institution.

## APPENDIX

### SECURITY ASSESSMENT

#### General Instructions

- 1) Multi-disciplinary groups or people can be helpful in conducting a security risk assessment of a facility and particularly in individual departments.
  - a) When possible solicit the assistance of the safety officer, risk manager, and the department head of each specific area reviewed.
  - b) In each area, check generic security-related matters such as functional locks, lighting, unsecured items, etc.
  - c) Look for unit specific vulnerabilities (i.e., unsecured narcotics in ICU).
  
- 2) Consider concepts such as rings of protection (outer and inner areas such as outside protection, perimeter doors and individual units), operational vs. non-operational time frames, etc.
  
- 3) Review the various sources identifying possible risk assessment vulnerabilities.
  - Past Security Incident Reports, Investigative Follow-up Reports.
  - Police Reports - statistics.
  - Organization feedback/perceptions/concerns.
  - Industry standards.
  - Local/National healthcare security standards.
  
- 4) Assigning risk threat levels (3=high, 1=low, and 0=N/A)
  - a) High, either through frequency or severity, of the likelihood of a specific incident occurring at that location. High ratings MUST have action plans.
  - b) Medium, would indicate the possibility of a specific incident occurring at the location. Medium ratings SHOULD have action plans.
  - c) Low, would indicate that a specific incident would most likely not occur at that location. Low rating MAY have action plans.
  - d) Not applicable, self explanatory.

- 5) **Annual Security Risk Identification/Analysis Form**
  - a) **Date the review was conducted.**
  - b) **Reviewer, person in charge.**
  - c) **List the various departments or areas reviewed in left hand column. (see sample form)**
  - d) **List the risks reviewed across the top using attached list. (see sample form)**
  - e) **Rate each department/area with the appropriate risk threat level (high, medium, low, not applicable).**
  
- 6) **Security Risk Action Plan**
  - a) **Date the review was conducted.**
  - b) **Reviewer, person in charge.**
  - c) **List the various departments or areas reviewed in left hand column.**
  - d) **Briefly explain the action plan used to abate the potential risks identified from the Risk Identification/Analysis Form. Use specific time tables.**
  
- 7) **Security Abatement/Monitoring Review**
  - a) **Date the review was conducted.**
  - b) **Reviewer, person in charge.**
  - c) **List the various departments or areas reviewed in left hand column.**
  - d) **Three to six months after the initial review, a follow-up is essential. Document the results to date and make changes when and if necessary.**
  
- 8) **Annually (unless specific changes warrant more frequent reviews) conduct another survey/assessment.**

**SECURITY RISK/VULNERABILITY CHECKLIST**

ASSAULT	IMPOSTORS
• SIMPLE	
• AGGRAVATED	KICKBACKS/FRAUD
BOMB THREATS/BOMBING	KIDNAPPINGS
BURGLARY	LOSS OF INFORMATION
CIVIL DISTURBANCES	ROBBERY
DISTURBANCES	• ARMED
• INTERNAL	• UNARMED
• EXTERNAL	STRIKES
DRUG ABUSE	TERRORISM
GANG ACTIVITY	THEFT
GAMBLING	• VISITOR/CUSTOMERS
HOMICIDES	• STAFF PROPERTY
	• FACILITY PROPERTY
	OTHER - SPECIFY
	(MAKE THESE APPLICABLE
	TO HEALTHCARE FACILITY)

**SECURITY RISK ASSESSMENT SOURCES**

- POLICE STATISTICS (smallest area breakdown available)
- PAST SECURITY INCIDENT REPORTS
- ORGANIZATION FEEDBACK/PERCEPTIONS
- CASE LAW
- INDUSTRY STANDARD PRACTICES
- INSPECTION
- LOCAL/NATIONAL STANDARDS
- CONSULTATION



### Security Risk Action Plan

Hospital Name \_\_\_\_\_

Date \_\_\_\_\_

Reviewer \_\_\_\_\_

DEPARTMENT/AREA	BRIEFLY IDENTIFY ABATEMENT PLAN
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Attach additional documentation as needed.

**Security Abatement / Monitoring Review**

Hospital Name \_\_\_\_\_

Date \_\_\_\_\_

Reviewer \_\_\_\_\_

DEPARTMENT/AREA	DOCUMENT RESULTS TO DATE
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	

Attach additional documentation as needed.

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- <sup>16</sup> "No Security Standards in JCAHO's 1989 Accreditation Manual," Hospital Security and Safety Management, Vol. 9, No. 5, (Port Washington, NY: Rusting Publications, September, 1988), pp. 1-2.
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Statement of Richard P. Miller, Director, G.V. "Sonny" Montgomery Veterans Affairs Medical Center, Veterans Health Administration, Department of Veterans Affairs

**G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi.**

**Security Issues**

Mr. Richard P. Miller became Director of the G.V. (Sonny) Montgomery VA Medical Center in August 1994. As part of initial briefings, the Associate Director, Mr. Richard J. Batlz, explained a carefully laid-out plan to upgrade facility security personnel, policies, procedures, surveillance equipment, and training for both police officers and all employees. Mr. Miller endorsed the plan and the following security issues were concentrated on:

**Improving the quality of the police force.** Like all personnel issues, this is a continuing effort, but one that has already shown results. Inspections of the police service in February and March, 1997, by specialists from VA Headquarters resulted in high praise for the qualifications, training, appearance, and conduct of the facility's officers. Officers at the Jackson VAMC have an average of 16.4 years experience, many with the City of Jackson Police Department, and others with military units, the Bureau of Indian Affairs, and other city and county police departments. No one will mistake the facility's certified police officers for mere guards.

**Surveillance equipment.** A color video camera monitoring system was installed and has been continually upgraded over the few years at a total cost of about \$110,000.

**Security access system.** Installation of computer controlled door locks, identification badges, card readers, parking lot controls and limited door access systems were installed at a cost of about \$95,000. This system provides the ability to allow certain individuals access to specific areas or entrances and to keep a log of their entry and exit.

**Canine program.** In 1995, the facility acquired a canine trained in drug detection and missing patient tracking. Though the dog is not an attack dog, it is a common belief that his presence would reduce any drug activity, assist in locating patients who might become lost, and have an overall calming effect on volatile situations. Although the canine has not yet had to be used to search for lost patients, there is confidence that his presence has a chilling effect on drug activity and the police officers report that his presence does indeed calm argumentative individuals.

**Wandering alert system for nursing home patients.** To protect nursing home residents, the VAMC invested in an electronic system that alerts staff if residents who have diminished capacity wander through an exit door. This was installed at a cost of about \$100,000.

**Bike patrol.** To provide faster and more frequent patrols of the parking areas at the Jackson VAMC, a bike patrol was implemented at minimal cost.

The above-stated projects were underway in varying stages of completion before the first of two tragedies struck the Jackson VAMC.

**Attack on an employee:**

On January 30, 1995, at about 8 a.m., a 65 year old service-connected, disabled veteran who had received care at the hospital for a period of 30 years, attacked an employee -- a VA physician -- in the parking lot near the outpatient entrance to the hospital. He threw sulfuric acid on her face, neck and chest, then departed the area.

Today, this employee remains unable to work, facing additional plastic surgery, and carrying psychological scars that are even more difficult to heal.

In February 1996, the veteran pled guilty in state court and received a 20-year sentence. He died in prison a few months later.

Based on a review of the veteran's VA medical record (which spanned 40 years) and the results of police investigation, the attack apparently was motivated by the physician's refusal to prescribe inappropriate pain-killing drugs that the veteran sought for illegal uses.

In the wake of that attack, police investigations, criminal prosecutors, management, and an ad hoc investigating committee identified concerns that resulted in the following actions:

Elevated the status and scope of the multi-disciplinary Committee for Disruptive and/or Suicidal Behavior. The committee developed policies and procedures (implemented in 1994) by which (1) patients posing a potential threat of disruptive or violent behavior are identified, (2) these patients' names are "flagged" in their computerized records, alerting clerks and clinicians when they have appointments, (3) police routinely respond when such patients are scheduled for an appointment, (4) denial of medication to drug-seeking patients is referred to a committee of doctors instead of a single physician, thereby diluting antagonism,

and (5) a pain management clinic was established to help patients learn to cope with chronic, non-responsive pain.

One full-time employee equivalent (FTEE) was added to police service to enable extra patrolling during normal business hours.

All of the committee recommendations within authority of management were enacted. A recommendation that senior management explore the arming of VA police and the use of metal detectors was examined, but found to be not within the authority of facility management and not likely to have any relevance to an attack such as had occurred.

As an interesting aside to this case, we learned that Federal jurisdiction was not attained when the land was passed from the state to the Federal government in the 1950s; therefore, the FBI and U.S. Attorney's office had to relinquish the case to local and state authority. We worked closely with state leaders, the state legislature, and VA Headquarters officials in obtaining state legislation granting concurrent jurisdiction to both entities. Today, prosecutors can pursue either Federal or state prosecution of crimes committed on the medical center grounds.

The attack on a VA physician was a call to concern, and many changes were made as a result of that concern. But, we felt, and still feel, that the attack was an aberration, not an indication of the nature of the people of Jackson or the State of Mississippi. It was an isolated incident that could not have been prevented by metal detectors or even armed police (unless a police officer was escorting the employee) since it occurred in a parking lot.

In the wake of the attack, the VAMC implemented especially responsive actions as noted above and continued with planned security system improvements.

#### **Murder and Suicide**

Mr. Victor Bowles, a 48 year old service-connected, disabled veteran, entered the hospital about 11:20 a.m., shotgun at the ready position, and within 30 to 40 seconds found Dr. Ralph Carter with a patient. He killed Dr. Carter, then committed suicide.

In addition to the tragic consequences for the families involved, the staff and patients of the VAMC, veterans throughout the state, and the citizens of the City of Jackson in general were shaken.

Investigations by local police and the FBI do not reveal a clue. A psychological autopsy of Mr. Bowles' medical records gives no clue. There are no answers.

A review of the security measures and police service by VA Headquarters experts and other police agencies reveal no flaws and speculated that the incident probably could not have been prevented by any of the measures now being adopting. Indeed, it is believed that this tragic incident is another statistical aberration in no way reflective of the general mood of veteran patient, the veterans of the State, or the other good people of Mississippi.

Since the murder/suicide, the facility has:

- immediately contracted for seven security guards to supplement the 12-officer police force and went to extensive overtime for the Jackson VAMC police,
- authorized six additional certified police officers and have, to date, hired five,
- sought and were granted inclusion in the test program which is evaluating the effect of arming VA police officers,
- arranged for the installation of metal detectors and x-ray devices at hospital entrances (to be installed when officers are armed, since it would be imprudent to attempt to confiscate contraband with unarmed officers),
- limited public entrances to the hospital and will further limit entrances to only two points within the next few weeks as metal detectors are brought online, and will require visitors to sign in,
- fenced the loading dock and other support entrances and placed a guard on duty there to control egress and ingress during normal business hours,
- accelerated plans to relocate the surveillance camera monitor room to the emergency/ambulance entrance where the officer can view the entrance through a large window and control the door electronically (not only will this increase the officer's vision, but it will also increase police visibility to visitors),
- continued upgrading the camera system, with more units scheduled for installation and improved recording to allow cameras to tape for 24 hours, and
- conducted outreach programs with veterans service organizations to identify any existing veteran concerns

and to enlist their support in dealing with complaints and loose talk of threats and disruptive behavior.

The costs associated with these steps are significant. Modifications to door locks, the installation of metal detectors, and other hardware changes and additions will have a one-time cost of about \$175,000 with some nominal recurring costs in maintenance and updating. Six additional police officers will add another \$300,000 annually recurring cost.

The weapons will add an additional \$16,000 in initial costs and a nominal amount of recurring costs associated with training, storage, and maintenance.

Previously, the managers of the Jackson VAMC managed their budget carefully, funding security improvements from normal appropriations, but the massive effort undertaken this Spring caused the Director to seek supplemental funding from the VISN so that the patient care mission could be continued without impact by security concerns. The VISN granted the funds.

POST-HEARING QUESTIONS  
 CONCERNING THE MAY 22, 1997  
 HEARING ON SAFETY AND SECURITY IN THE  
 DEPARTMENT OF VETERANS AFFAIRS

FROM THE HONORABLE LAMÉ EVANS  
 RANKING DEMOCRATIC MEMBER  
 COMMITTEE ON VETERANS' AFFAIRS  
 U.S. HOUSE OF REPRESENTATIVES

**Question 1:** What is the purpose of arming VA police officers? What empirical evidence can you provide the Subcommittee that arming VA police officers will make VA facilities safe? What will be required to achieve safety at VA facilities?

**Answer:** At this time, no general decision has been made to arm VA police. Rather, VA is conducting a pilot project to determine the feasibility of arming VA police officers. The reason VA is considering arming VA police, is to test the appropriateness of providing its officers with a tool that is consistent with their duties and responsibilities and may allow them to better protect themselves and others. VA officers are responsible for providing protection and enforcing the law. One of the tools used by most major law enforcement organizations in the United States (to include the Capitol Police) is a firearm. We believe that the VA Police department is the only major law enforcement organization that does not provide its officers with firearms. VA officers have performed admirably given their circumstances, however, a number of them have paid the ultimate sacrifice. With the addition of firearms, we believe that VA officers would provide a more appropriate intervention. Based upon personal discussions with VA officers and reviews conducted by Office of Security and Law Enforcement staff, it has been concluded that VA officers can function much better if they engage in more inquisitive patrol activity. VA officers are required to conduct investigative stops of suspicious persons as an important part of crime prevention. It is evident that they are not doing enough of this, and also evident that the major reason is an understandable concern that these suspicious individuals may be carrying a concealed weapon. For instance, in the recent incident in Lake City, Florida, a VA police officer made an investigative stop shortly after midnight in the parking lot and was shot with a handgun. The intruder, because he was armed and VA police officers were not, then gained access to the facility, shot up the waiting area, and directly threatened a wheel chair-bound veteran with the firearm. The shooter was later taken into custody by armed officers from the Lake City Police Department. An important part of the evaluation of the pilot program is to determine whether officers are being more vigilant in accomplishing investigative stops. In fact, initial reviews have disclosed that there has been an increase in such stops at the pilot facilities. Additional information regarding this will be available following a more comprehensive review.

There is no "empirical" evidence that arming VA police officers will make VA facilities safe. Likewise, there is no single security feature or law enforcement tool for which there is such "empirical" evidence. As stated above, the firearm is a standard tool in law enforcement. It is VA's position that if it is used correctly it can add to the safety of VA facilities.

Ensuring safety within any space (buildings or grounds) is best accomplished by preventing or limiting access to all or part of the space. This is contrasted by the need for VA medical care facilities to be open to the public, at least during business

hours. VA does not wish to limit access unless it becomes necessary for the safety of all. All VA facilities have some degree of crime and have been subjected to the introduction of weapons. Local conditions, which include crime rate in the area of the facility, on-station criminal activity, weapon introductions and the degree of concern which employees and patients have for their safety, determine the need for the level of security applied. At some VA facilities, conditions have been such as to require the limiting of access and the installation of weapon screening stations. However, at most VA facilities access continues to be without limitation during business hours. This can be accomplished because of the continuing presence of visible, and inquisitive VA police officers who are regularly patrolling grounds and buildings. The presence of a sufficient number of appropriately trained, supervised and equipped officers is the best way to prevent crime and thereby achieve safety at VA facilities.

**Question 2:** What are the possible disadvantages, if any, of arming VA police officers? What percent of private health care facilities have armed police on site?

**Answer:** The major risk of arming VA police officers is that there may be an injury or loss of life of an innocent party caused by the accidental discharge or misuse of a firearm. In an attempt to minimize this risk we have selected a specific firearm and holster, the safety features of which, have been described and demonstrated to the Subcommittee. Also we have provided intensive VA specific training to all of the armed officers regarding escalation of force and use of deadly force as well as the proper and safe use of the issued firearm.

We are unable to provide information regarding the percentage of private health care facilities which have armed police because we are unaware of any source for such information. Regarding the relevancy of this issue, it should be recognized that VA facilities are not private property. They are federal property and their protection is the responsibility of the Secretary of Veterans Affairs. Local police do not patrol VA medical care facilities or provide the continuing uniformed presence needed to prevent crime. Local police may or may not have a continuing presence at a private facility as they frequently do at state run health care facilities. When local police have a continuing presence or when they patrol, they are armed.

**Question 3:** Please give a summary of the VA police officer workforce. Specifically, how many officers does the VA employ, what is average pay for such officers, what background and experience is required to become a member of the VA police force, and how long has the average member of the force been employed as a VA police officers?

**Answer:** Currently there are 1,983 police officers and 43 detectives for a total of 2,026. The average pay for all police officers is \$27,659. This includes those officers in supervisory positions. At the journeymen level, which is either GS-5 or GS-6, the average salaries are \$23,524 and \$25,882, respectively.

The background and experience required to be a member of the VA police force are exactly the same as for anyone who becomes a police officer in the GS-083 Police Officer Series.

VA does not maintain a data base which can provide information regarding how long the average member of the force has been employed as a VA police officer. As a representative sampling, we conducted a manual review of the average time that a badge was

issued to officers at the Little Rock and Dallas VA medical centers and determined it to be 2.5 years.

**Question 4:** What percentage of the VA police force consists of retired law enforcement officers?

**Answer:** VA does not maintain a data base which can provide this information. However, as a sampling, we did accomplish a manual review of questionnaires completed by the 218 most recent attendees of our basic training course at the VA Law Enforcement Training Center (LETC). The results of the review are that 190 of those officers had qualified for their position based upon prior law enforcement experience in the military or with a state or local law enforcement agency.

**Question 5:** Have rigid qualification standards always been in place at the VA? For example, have all current member of the VA police force been subject to the same physical fitness specifications?

**Answer:** Police officers employed by the Department must have met the Office of Personnel Management qualification standards in effect at the time of employment. VA also has had requirements that pre-employment screening be accomplished on each applicant. As you are aware, VA Office of Inspector General Audits conducted in the late 1980s disclosed that neither the qualification standards nor the pre-employment screening were being rigidly applied. Since those audits, VA has made significant efforts to ensure that all standards and screening are being soundly applied. Physical fitness specifications, per se, are different from qualification standards. VA has, for years, required that VA police officer applicants and incumbents (annually) meet specific medical standards. Applicants and incumbents are examined to determine their physical and emotional stability to perform the functional requirements of their position. In terms of physical fitness standards, we have recently added a requirement for students attending the basic police training course at the LETC. All engage in physical fitness training during this course and must successfully complete a physical fitness test designed using standards established by the American Heart Association.

**Question 6:** The background information provided to the Subcommittee staff by the VA indicated that 106 officers have been issued firearm weapon cards. What criteria did you use to decide which officers were suited to take part in the pilot program, and what training was provided to these officers?

**Answer:** Department policy requires an officer to undergo a physical and psychological evaluation prior to participation in the pilot program, and the psychologist's recommendation is the determinative factor in the selection process. The officer must also have successfully completed the Basic VA Police Officer Training Course at the LETC, the firearms training course provided by the LETC staff, and must be physically qualified, emotionally stable and free of any significant criminal record.

The firearms training provided consisted of a 40 hour training course. The training unit itself was provided to the Subcommittee prior to the hearings. An additional copy is attached.

**Question 7:** Mr. Baffa indicated that the total cost of the pilot program at the five current sites is \$124,000. Does this amount also include the training that you indicated will be required of these officers to remain proficient? If not, what do you

estimate will be the cost of providing refresher training to these officers?

**Answer:** No, the \$124,000 figure does not include any costs connected with inservice training. Much of the training will not require additional expenditure, such as use of force and practice drawing from the security holster. The only additional cost will be for such things as targets and ammunition connected with range training. We estimate that the cost for these items will be approximately \$100 per officer, per year.

**Question 8:** VA Directive 0720, Appendix A indicates that a firearm will be issued only to those persons appointed as police officers who have successfully completed the FBI-approved basic VA training course, and FBI-approved firearms training. The FBI's testimony indicates however, that the FBI does not approve or certify other agency training courses, including firearms training. Did the FBI actually approve the VA training courses, and can you please explain to the Committee what the VA directive means when it refers to FBI-approved training?

**Answer:** It is our position that this is a matter of semantics rather than one of substance. It is unfortunate that the language in VA Directive 0720 was not changed prior to publication so as to be consistent with the language in the letters from the FBI Academy, which confirmed the adequacy of VA's basic police officer training and firearm training programs. A part of the process to develop the Directive included meetings between representatives of the Office of Security and Law Enforcement (OS&LE) and Office General Counsel (GC) with representatives of the Department of Justice (DOJ). The DOJ representatives strongly recommended certain language for the Directive including the word "approved" in this particular section. Subsequent to the Directive being concurred with in its current form by Departmental elements, VA Partnership Council and the DOJ representatives, letters were received from both Dr. John Campbell and Mr. Wade Jackson at the FBI Academy indicating the appropriateness of the courses but cautioning that they do not "approve" such training. In retrospect, the language in the Directive should have been changed but it was not. We believe that the letters from Messrs. Campbell and Jackson (attached) speak for themselves, and attest to the relevancy of our training. Also, we know of no Federal organization which "approves" firearm or basic police officer training of other organizations. This includes the Federal Law Enforcement Training Center (FLETC).

**Question 9:** Testimony from the Nurses Organization of Veterans Affairs (NOVA) suggests a variety of alternatives to arming police officers as a means to improve safety and security at VA hospitals. For example NOVA's testimony list increased security personnel during off hours, improved lighting, beepers for security personnel, badges for all visitors, metal detectors, bullet proof glass, hidden panic buttons, and closed circuit televisions cameras as some possible alternatives. Has VA given consideration to alternatives other than arming VA officers to enhance safety and security at VA facilities? If so, can you describe what alternatives you have considered and the conclusions you reached.

**Answer:** In our judgment it is not so much a question of alternatives as it is one of exploring all options open to the Department and selecting the appropriate tools or enhancements that may be suitable. Depending on the circumstances, any one of the suggestions made by NOVA may or may not be appropriate. VA already requires that bullet proof glass be installed at each

Pharmacy and Agent Cashier window and that adequate lighting be installed at such locations as parking lots, building entrances and pathways. We already use such devices as panic buttons and closed circuit televisions where appropriate. However, we believe that the firearm, as a weapon for police officers, is in an entirely different category from the security enhancements suggested. A weapon is a tool utilized by a police officer to apply the appropriate force for a given situation. VA officers are already armed with a chemical irritant projector and the side-handle baton. These tools allow an officer to utilize up to a certain level of force. A firearm allows the officer to use the highest level of force should it become necessary and only if it becomes necessary. Without that particular tool the officer is at a great disadvantage when confronted by a perpetrator who is armed with a firearm. In such situations the unarmed officer most often cannot prevail and injuries or deaths may result. NOVA suggests that VA install panic buttons. When a VA police officer responds to a panic button, we believe that the VA officer should be equipped to handle any situation which the officer might confront, including protecting patients and VA employees in dangerous situations. The pilot program is designed to test whether it is feasible to accomplish this.

**Question 10:** Mr. Ogden, can you explain to us in detail the steps VA has taken to address the serious problems that have been highlighted in the past concerning the need to closely monitor the pharmaceutical inventory at the various VA facilities? What more needs to be done to protect the security of the addictive drug inventory at VA?

**Answer:** Since 1991/1992, the Veterans Health Administration (VHA) has taken a number of actions to enhance the accountability of pharmaceuticals at VA facilities. Listed below under four major categories are those actions:

**A. VA policy regarding controlled substances:**

- A perpetual inventory of all controlled substance dispensing is required.
- Limited access to controlled substances within pharmacy is required, and documentation regarding access must be maintained.
- The storing and dispensing of controlled substances must occur within locked areas. Electronic access control devices are required for all locations where controlled substances are stored and dispensed within the pharmacy.
- Verification of perpetual inventory within pharmacy every 72 hours is required.
- All completed outpatient prescriptions for controlled substances must be stored in a locked cabinet awaiting patient pick-up. Pharmacy staff must verify the identity of the patient picking up the medication and the patient or patient's agent must sign for the medication.
- A tamper proof seal must be affixed to all controlled substances prescription vials.
- Orders from suppliers for controlled substances are delivered directly to the pharmacy in unopened containers. The accountable officer and pharmacy representative will open container, acknowledge

receipt, and post inventory to pharmacy records. Both the accountable officer and pharmacy representative will verify inventory posting on pharmacy records.

- Any suspected theft, shortages, or suspicious loss must be reported immediately to the Office of the Inspector General, VA police, and VA Headquarters.
- The VA prescription form has been modified two times in 1991 and 1993 to enhance the security features. In addition field facilities are authorized to generate prescription orders for outpatients via other internal use mechanisms. These include at least Electronic Order Entry and alternate paper order forms such as Action Profiles.

B. Rewrite of VA Narcotic Inspection Policy (policy is written, approved and awaiting publication, copy attached):

- VHA administrative personnel conduct monthly unannounced narcotic inspections.
- Wards/patient care areas are randomly surveyed.
- Inspection results must be trended by the medical center director and such results are considered one of the facilities quality management tools.
- In the pharmacy, dispensing actions are checked against posting by the inspector.
- The medical center director must ensure that a training program exists for narcotics inspectors.
- A standard timetable for destruction of outdated controlled substances was established. All outdated controlled substances must be destroyed at least quarterly.
- At ward level, the inspectors must sample dispensing entries against medical administration records.
- Standards for automated dispensing equipment inspections and verification were established.

C. Reduction of inventories:

- All stock of controlled substances have been removed from VA warehouses.
- Overall pharmacy stock, including controlled substances, has been reduced through the use of prime vendor distribution and just-in-time ordering and delivery.

D. Employee Integrity:

- An educational video concerning employee integrity was developed, and released to all facilities. All new and current pharmacy employees must view the video.

- Access to pharmacy service by non-pharmacy personnel has been limited via directive and manual change.
- Information regarding any theft of pharmaceuticals will be released to the respective State Board of Pharmacy.

Regarding other needs for even greater enhancement of controlled substance accountability, VHA has two other action items in process. First, testing of electronic data interchange linkages between our wholesalers and VA's data base regarding purchases is ongoing. At this time, VA's data base will accept such data but at least one vendor is having problems making the interchange function successfully. Soon, this tool will enable pharmacy managers to compare procurement actions to dispensing actions; thus enhancing inventory capabilities. Second, controlled substance accountability for inpatients continues to be addressed as part of a Material Weakness in the Secretary's Annual Fiscal Manager's Integrity Act report. Current time frame estimated for completion is FY 1999 based on the availability of internal resources. This action will enable complete documentation of controlled substance accountability for inpatients and real-time documentation of medication administration at the patient level.

**Question 11:** Please explain, in detail, the steps VA has taken to address the serious problems that have been highlighted in the past concerning the need to closely monitor the pharmaceutical inventory at the various VA facilities? What more needs to be done to protect the security of the addictive drug inventory at VA?

**Answer:** Please see answer to question 10.

**Question 12:** The written testimony provided by the American Federation of Government Employees (AFGE) raises serious questions concerning unacceptable response times and severe staffing shortages at VA fire departments. Are VA patients, employees and firefighters at great risk, as AFGE and the other firefighter unions suggest, and is it true that the situation at most VA fire departments can only be characterized as an accident waiting to happen?

**Answer:** No. Patients, employees and fire fighters are not at "great risk" at VA Medical Centers with in-house fire departments as claimed by the testimony provided by AGFE. Nor is it true that the conditions at these facilities can be characterized as "an accident waiting to happen."

VHA runs a comprehensive fire protection program at all VA facilities. We believe the results are evident in the Department's good record on fire loss experience. All VA fire departments are required to have in place mutual aid systems which permit facility fire fighters to promptly summon assistance from outside departments should it ever be required. By the end of the current fiscal year, all VA Fire Departments will have received an in-depth evaluation which reviews staffing levels, equipment, training and response capabilities. VA Fire Departments are expected to respond to a fire at any location within the medical center in a shorter time frame than is considered acceptable from a community fire department. (VA requirements for fire protection include a response to a medical center by a community fire department with arrival of their fire apparatus within eight minutes. In contrast, VA fire departments are expected to be in position to initiate fire suppression within eight minutes with hose lines deployed. During the 117 interior drills conducted to date, VA Fire Departments have

averaged such a response in 7 minutes and 26 seconds. Most of our departments are capable of even better performance than this, with 55% of the departments evaluated to date averaging less than 7 minutes. The fastest drill time observed was 3 minutes and 47 seconds. Twenty-five percent of the drills have taken less than 5 minutes and 30 seconds).

With few exceptions, VA Fire Departments typically provide a prompt and effective response to incidents at their facilities, which enables the rapid extinguishment of any fire discovered. In addition, many VA facilities are completely protected with automatic fire sprinkler systems which by themselves provide a greater level of protection than is required by National Fire Protection Association standards. The prompt response by VA fire fighters, especially when accompanied by a complete automatic fire sprinkler system at a facility, serves to keep almost all fires which do occur within the incipient stage, and results in these fires being promptly extinguished with an absolute minimum amount of property damage or risk to our patients. It is important to note that, while the number of alarms to which a VA fire department responds may be quite high, the number of actual fires, including such things as overheated computer monitors, trash can fires, etc. is very low. This is because, at those facilities which operate a VA fire department, medical center staff have been trained and repeatedly reminded to call the fire department whenever anything unusual is observed or detected. Consequently, VA fire departments typically run dozens of "smell of smoke" and similar calls for every incident where an actual fire is present. These calls are typically caused by lint on steam radiators in the fall, overheated fluorescent light ballast's, etc. As such, these incidents pose no threat to patients or staff, however they do show up on fire department run sheets as an excessively high number of fire calls.

Regarding concerns in the written testimony on staffing levels and allegations involving OSHA regulations, VA fire departments are staffed to provide a minimum of four fire fighters per shift and are required to operate in compliance with all applicable OSHA standards.

All on-site VA fire departments must comply with all applicable OSHA (Occupational Safety and Health Administration) and NFPA (National Fire Protection Association) regulations regarding occupational safety and health of fire fighters. Current OSHA criteria for the fire service does not establish any minimum staffing levels for fire departments. However, OSHA does require that a minimum of four fire fighters be assembled before an interior structural fire attack can be made on a fire beyond the incipient stage (use of hose lines greater than 1-1/2 inch and use of self contained breathing apparatus).

VA has allowed an exception to the four man staffing standard for a VA fire department via an equivalency process. The medical center may be granted an equivalency permitting on-duty VA fire department staffing to drop to a minimum of three trained, professional fire fighters on duty at all times under the following conditions:

- (1) All structures housing patients overnight are fully protected by an approved, automatic fire sprinkler system installed and maintained according to NFPA standards;
- (2) all structures housing employees and their families overnight are equipped with hard wired smoke detectors;
- (3) local fire departments with which a mutual aid agreement exists are capable of providing prompt "back-up" to the facility fire department during an emergency; and
- (4) the medical center fire department

has a written protocol requiring the summoning of mutual aid assistance immediately whenever an actual fire is discovered.

The primary rationale for this equivalency is based upon the presence of the approved automatic fire sprinkler system throughout the patient occupied buildings. The presence of a complete automatic fire sprinkler system in a facility substantially exceeds NFPA requirements for life safety in an existing healthcare facility. Extensive documentation by the NFPA (National Fire Protection Association) confirms the effectiveness and efficiency of automatic sprinkler systems. In fact, NFPA records contain no incidents where a fire occurred which resulted in multiple fatalities in a structure protected by an approved and properly maintained automatic fire sprinkler system. Sprinklers, by their design, control and limit the spread of fire. Accordingly, individuals within a sprinkler protected structure are far safer than those in a structure lacking this important feature. Because of this additional level of life safety, the equivalency process within VA was initiated several years ago. By employing this equivalency, a medical center may achieve a recurring cost savings of up to \$120,000 per year without adversely effecting the level of life safety provided for our patients, visitors, and staff. VA has been working for several years to achieve complete automatic fire sprinkler protection within our patient occupied buildings.

VA's fire department staffing equivalency process does not conflict with OSHA policy on the occupational safety and health of fire fighters. These equivalencies are to VA policy regarding the level of protection provided to patients housed overnight in our facilities. Automatic sprinkler protection may reasonably be expected to control the spread of any fire which does occur, preventing the fire from growing beyond the incipient stage before fire fighters are on the scene. In addition, and to insure the capability of dealing with a major fire, VA fire departments with equivalencies in place, are required by written policy to immediately summon mutual aid assistance whenever a fire beyond the incipient stage is encountered and to refrain from fighting a fire beyond the incipient stage when only three fire fighters are present.

Of the thirty VA fire departments, ten currently have staffing equivalencies permitting them to operate with a minimum of three fire fighters on duty at all times. These ten medical centers are: (1) Canandaigua, NY; (2) Martinsburg, WV; (3) Hampton, VA; (4) Murfreesboro, TN; (5) Tomah, WI; (6) Knoxville, IA; (7) North Little Rock, AR; (8) Ft. Harrison, MT; (9) Sheridan, WY; and (10) Chillicothe, OH.

The information provided by the AFGE in the written testimony concerning specific facilities is not correct. The testimony references the American Lake Division of the VA Puget Sound Health Care System, stating that they received an award last September as the best VA fire department but that now they are being eliminated through a sharing agreement with Fort Lewis Army Base. The facts pertaining to this facility are somewhat different. First, there was no award for "the best VA fire department." The department at American Lake was evaluated last year under the VA Fire Department Evaluation program and did show very good performance, with one observed drill, having a time of 3:55 minutes, being the best ever observed up to that point in time. Overall performance of this department was rated as "very good." Other claims regarding this facility are addressed in the answer to Question 14. The information about the agreement with Fort Lewis is accurate.

The information provided in the testimony for the other stations is also incorrect. At Chillicothe, Ohio, VA Medical Center for example, the department's maximum on duty staffing is 5, not the 7 noted by AFGE. The minimum number of on duty fire fighters has consistently met VHA's minimum requirements and is fully adequate to operate the department's equipment. There is no lake at Chillicothe, nor does this department perform boat rescue. While there is a volunteer fire department in the area, there is also an extremely high quality, paid professional fire department with a minimum of 12 on duty personnel located slightly over four miles from the medical center and capable of responding to the facility under mutual aid in 9 minutes or less.

VAMC Ft. Meade, South Dakota, is a 250 acre facility, not 8,000 acres. The facility fire department does provide fire suppression to several thousand acres of BLM wild lands on a contractual basis. This was initiated by the facility fire department many years ago in order to improve the department's cost efficiency, and has never proved a problem for the Medical Center. The written testimony by AFGE on staffing numbers are accurate, however, this is a department where the fire fighters work a 72-hour week (24 hours per week per man more than the VA norm), and staffing is fully adequate to maintain a minimum of four fire fighters on duty at all times.

VAMC Battle Creek, Michigan, has repeatedly explored the possibility of combining Police and Fire Fighter positions, however, they have been instructed by VHA Headquarters' Security and Law Enforcement Service, Engineering Management Office, and Human Resources Office that this is not a workable solution. The facility is protected throughout by an approved automatic fire sprinkler system, and a total of 4 (not one) outside fire departments are in the area and can be summoned for assistance via mutual aid when necessary.

The comments concerning VAMC Sheridan, Wyoming, being "staffed so it can operate it's three pieces of equipment on Tuesdays" is confusing. Equipment at Sheridan consists of one 1250 gpm pumper, one 250 gpm brush rig and an ambulance. These units all serve completely different purposes, and there is neither the intention nor the need to "operate it's three pieces of equipment" at the same time. Staffing at this department is below the normal 14 shift personnel and a chief, however, here again this department operates on 72-hour tours of duty, therefore, requiring less staff. The available staffing at Sheridan is sufficient to permit the facility fire department to maintain the minimum level of coverage required by VA policy.

The above information should clarify the concerns raised by the AFGE. VA Fire Departments do provide a wide range of services to our Medical Centers, and, when operating as intended, are a real asset to the facilities in dealing with the full gamut of emergency situations which a Medical Center may encounter. VA Fire Departments are professional, dedicated organizations. In a very real sense, VA Fire Fighters are the nation's "experts" in healthcare fire fighting, as was shown last year when the producers of the Fire Service training series "American Heat" chose to utilize the VA Fire Department at Togus, Maine as a source of expertise when preparing a video training program on healthcare fire fighting which has been distributed worldwide.

VA is extremely proud of its record of fire safety and of the ongoing fire prevention programs which provide this high level of safety to our patients, visitors, and staff. Our VA Fire Departments play a significant role in these programs at those medical centers which operate in-house fire departments. VA Fire Departments also provide an extremely quick initial attack to any

fire which does occur. This in turn has the effect of limiting the spread and scope of any such fire and significantly enhances the overall level of fire safety at the facility. The combination of a comprehensive fire prevention program, coupled with the presence of a VA Fire Department, provides a significantly higher level of life safety to our patients and staff than may be found in most medical facilities.

**Question 13:** The International Association of Fire Fighters (IAFF) contacted our Subcommittee staff with serious concerns. They claim the VA is focusing too much attention on contracting-out VA fire protection, with little, if any, attention being paid to cost effectiveness and patient safety. For example, the IAFF indicated that five separate VA-commissioned cost assessment studies indicated that the VA could most efficiently provide fire protection by using its own fire department, yet the VA went ahead with contracting out plans. Can you speak to these concerns?

**Answer:** Without benefit of the specific information submitted to the Subcommittee staff by the IAFF, we are unable to substantiate any specific conditions in these claims. In the Veterans Health Administration's (VHA) Prescription For Change, one of the objectives is to focus management attention on VHA's key business of providing health care. With this in mind, one of the actions in the Prescription For Change to accomplish this objective is to continue to explore opportunities for contracting out fire suppression services where possible. Of the seven medical centers to eliminate their in-house fire departments within the past ten years, only two medical centers have contracted out for fire suppression. The American Lake Division of the VA Puget Sound Health Care System contracted out for fire suppression services through a sharing agreement with the Fort Lewis Army Base in June 1997 as addressed in Questions 12 and 14. The Livermore, CA Division of the VA Palo Alto Health Care System contracted out services in 1996 to the local county fire department. In both cases, the individual medical centers will achieve cost savings without impacting the level of safety for patients, employees and visitors. All other closures of VA fire departments in the past ten years have been accomplished with the local community taking responsibility for fire suppression services at no cost to VA. This responsibility was transferred when the communities and their fire departments grew to the point where they were capable of meeting minimum VA requirements for fire suppression and they had a legal obligation to provide the service. We believe in all cases, safety of VA patients, employees, and visitors have not been compromised.

**Question 14:** The American Federation of Government Employees (AFL-CIO) contacted the Subcommittee staff about the recent decision to contract-out fire protection suppression at the VA Medical Center at American Lake. Please provide the Subcommittee with the annual cost of operating the American Lake VAMC fire department and the annual value of all other services previously performed by the fire fighters including back-filling for police and safety officers. Also, explain what impact the decision to eliminate the American Lake VAMC fire department will have on the quality of care provided to veterans as well as the risk of loss of or injury to life and property.

**Answer:** The average annual cost (salaries) of operating the fire department at the American Lake Division of the VA Puget Sound Health Care System over the past year was \$469,900. The annual cost of the contract with Fort Lewis Army Base to provide fire suppression services is \$165,900 with the cost to be adjusted annually by CPI. The contract is effective through June 20, 2002. The cost for recurring maintenance and testing of fire

protection systems, previously conducted by the fire department, will be approximately \$20,000 per year.

The annual value of all other services previously performed by VA fire fighters encompasses several elements. Many of the additional services they provided were due to the fact that they were available 24 hours a day. These duties consisted of such activities as facilitating snow removal, responding to disruptive behavior calls, etc. These duties are now reassigned to other staff at the facility with no degradation in response or increase in cost. Two positions that did not previously exist have been created to replace some fire department services in the safety and escort functions, and additional funding will be needed to be allocated to cover some maintenance and repair functions and laundry delivery that will no longer be covered by the fire fighters. The cost for these positions and the additional coverage is estimated at \$85,798 per year. The total cost of providing the same level of protection is \$271,698 as compared to \$469,900 for the in-house fire department.

Two additional police positions were recently authorized and are not related to the termination of the facility's fire department. A review of the police staffing determined that a minimum of three police officers at the Seattle Division and two at the American Lake Division should be on duty at all times to assure the safety of employees and security of property. These functions can not be accomplished by the fire fighters since they do not have law enforcement authority.

The decision to contract out fire suppression services at the American Lake Division will have minimal impact on the quality of care provided to veterans at this facility, as well as the level of safety and property protection. The response by the Fort Lewis Army Base fire department is estimated to be well within our minimum fire department response requirement of eight minutes. The North Fort Lewis fire station (one of four on the base) is on property adjacent to the American Lake Division. The fire crew responding to calls at the American Lake Division will travel a dedicated paved road of about one mile. A mutual aid agreement is also in effect between the Fort Lewis Army Base and the Pierce County fire department to provide back up support at the VA should the need arise (see attached decision). This decision was made after a thorough analysis of all issues. The decision to close the facility, fire department was not meant to demean the outstanding efforts of the professional fire fighters who staffed the American Lake Division fire department. All ten fire fighters, including the five temporaries, were offered positions at the facility. Eight have elected to remain, one has chosen to take a position elsewhere in VA and another declined a position. The additional cost savings generated by this decision will be effectively used to enhance care to our patients. The American Lake Division will join the other 143 VA Medical Centers who receive fire suppression services from local community fire departments.

**Question 15:** Describe the purpose of oversight of police operations at medical facilities, describe how this oversight is conducted, the information gained from oversight and the changes, if any, which have resulted from this information? How frequently is oversight conducted?

**Answer:** The purpose of oversight of police operations at medical care facilities is to determine whether the conduct of those operations are consistent with VA policies. Periodic on-site inspections are conducted of each local police operation by an inspector from OS&LE, utilizing a standardized Inspection Guide containing over 100 criteria of policy requirements and

expectations. The findings and recommendations of the inspections are sent through the Chief Network Officer to the facility director for action. The facility responds with an implementation plan. If the facility response is considered to be inadequate in any significant way, a representative of OS&LE makes an appropriate follow-up. Changes that have resulted are facility focused, making them difficult to identify overall. Generally, however, the inspection process has aided in focusing significant attention on security and law enforcement issues Department-wide.

The average time between inspections at any given facility is currently 4.2 years. Since this is an average, some are inspected more frequently than others. If a facility is considered unsatisfactory when inspected, an inspection is conducted again in about one year. Conversely, if a facility is considered highly satisfactory, it will likely be more than 4.2 years before it is inspected again.

**Question 16:** Describe the improvements in local police services at VA facilities during the last four years. Have these improvements been made at all VA facilities?

**Answer:** As stated in the oral testimony we believe VA has made important improvements in local police services during the last four to six years.

We believe that a key to improving our individual police and security operations is to focus on ensuring that our facilities have a sufficient number of qualified and physically functional police officers, who are appropriately trained, supervised and equipped to provide protection and law enforcement services. One method used to facilitate this is to significantly expand and improve our training curriculum. The basic training course was expanded, supervisory training was added to the curriculum, and legal and behavior specialists are now a part of our training center staff. We now provide much improved training to our basic officers and we provide a training course for our new chiefs, annually. To improve services provided at the facilities, we have tailored our inspection process to focus on certain critical elements of a police and security operation. These include ensuring that the appropriate number of officers are on duty, that there are workable communication procedures to ensure timely response, that pre-employment screening requirements are being accomplished, and that both initial and annual physicals and psychological assessments are being accomplished. Other critical elements include ensuring that inservice training is being accomplished, that law enforcement activities are being accomplished in a legally and technically correct manner, that each operation has a current and comprehensive standard operating procedure and that annual physical security surveys are being completed. By focusing on these critical areas and being insistent in our inspection process that they be corrected, we have assured that better services are being provided locally.

To answer the second part of your question, as acknowledged in testimony given, all facilities are not equal in the level of improvements made. But we have made significant progress and we hope to continue to do so as we go forward with the program.

**Question 17:** How many hours a month do VA police officers devote to maintaining their proficiency with firearms and what are the direct and/or indirect costs associated with maintaining proficiency? There are two pilot sites in Chicago, how many hours a month do Chicago municipal police devote to maintaining their proficiency with firearms?

**Answer:** The number of hours and costs for training VA officers vary from month to month. A specific number of hours has not been established. However, there is periodic, mandatory and recommended training.

A. Mandatory refresher training for armed VA police officers consists of the following:

- Semi-annual range qualification;
- supervised monthly training for uniformed officers in safely drawing the firearm from the security holster;
- supervised monthly training for all officers in handgun retention; and
- quarterly training on escalation of force and the use of deadly force.

B. Recommended training for armed officers consists of the following:

- supervised quarterly range training by a certified firearms instructor;
- supervised judgmental training utilizing the Firearm Training System or similar system; and
- supervised training in firing in reduced lighting.

A contact with the Chicago Police Department revealed that there is no periodic firearm proficiency training. That Department requires only annual range qualification. A check with the Cook County Hospital Police revealed the same, and a check with the University of Illinois Police revealed only a semi-annual range qualification.

**Question 18:** During the pilot project, has any VA police officer drawn his or her firearm? Has lethal force been used?

**Answer:** To date, there have been three occasions in which VA police officers have drawn their firearm. On one of the occasions an officer drew her firearm when making an arrest of a burglar; on one occasion one of two officers (both armed) drew his firearm when approaching an individual with a handgun that had just been discharged; and on the third occasion one of two officers (both armed) drew his firearm when approaching an individual who had been reported to be armed. To date no VA police officer has discharged his or her firearm, except on the firing range, and no lethal force has been used.

**Question 19:** As I understand your statement, there is evidence that VA police officers at pilot sites were exercising more vigilance in the key areas of investigative stops and car stops. How do you explain this reported finding? How significant were the changes identified? What steps can be taken to insure VA police officers at non-pilot sites exercise more vigilance in the key areas of investigative stops and car stops.

**Answer:** As indicated in the response to question number 1, there is justified concern on the part of our officers for their own safety when approaching a suspicious person. This is also the case when approaching a vehicle which has been stopped because the driver is believed to have violated a traffic law or because of some other reason. This concern is significantly multiplied

when light is low and visibility is poor. One simply does not know what type of a weapon a suspicious person or a driver passing through VA property may be carrying if any. Our officers are well aware from experience that persons do enter VA buildings and grounds with a variety of weapons capable of being used lethally and that the officers may well be at a significant disadvantage. When these officers believe that they would have at least an even chance should the person they stop be armed, they are more likely to make the investigative stop or car stop.

The findings to date are preliminary, but most facilities have shown some increases in these areas. All showed some increases in the number of car stops, and three of the five showed increases in investigative stops. The most significant increase was at West Los Angeles, where the number of car stops were estimated to have increased from 109 to 323 for the period evaluated. A large volume of drive through traffic at West Los Angeles is a significant issue which VA police must confront. Many of these persons are speeding and causing dangerous situations for pedestrians. The acting Chief at West Los Angeles has indicated that since officers there have been armed, he no longer has to seek out officers to operate the radar detector. He now has volunteers on each shift, everyday.

Officers at non-pilot sites can be encouraged to exercise more vigilance in the key areas of investigative stops and car stops by putting requirements in their performance plans that they do so. However, this will not change the situation of having police officers knowing they are at a potential disadvantage if they encounter an individual who is in possession of a firearm or other lethal weapon. It is well accepted that investigative stops and car stops are among the three most dangerous situations for police officers, with the third being domestic disputes. VA police officers know that these are dangerous situations and they know that all killings of other VA officers by gunfire have been during investigative stop type incidents. VA officers as are all law enforcement officers are, quite cautious when encountering potentially dangerous situations.

**Question 20:** According to your statement, "VA's 160-hour basic course appeared to be consistent with the standards established by the Federal Law Enforcement Training Center (FLETC) and at several state academies." Is VA's 160-hour basic course consistent with the standards established by FLETC and at several state academies? In what respect is it not?

**Answer:** As indicated in the response to question number 8, as a part of the development of the pilot program, we requested a review of our training programs by the FBI Academy. In accomplishing this, we supplied voluminous material regarding our basic police officer training program to John Campbell, Ph.D., FBI Academy Academic Section Chief. Dr. Campbell had agreed to review the basic 160 training course to compare it to the basic officer training course offered at FLETC. By correspondence dated April 29, 1996, Dr. Campbell responded to our request. This response (attachment to Question #8) was the basis for the statement in VA's testimony. Dr. Campbell compared our course of training to similar curriculum design for FLETC and for "several state academies." Dr. Campbell indicated that our 160 hours course, "...appears to be consistent with the standards established by the aforementioned training courses. The curriculum design is appropriate and the reference material, both books and documents, are consistent with those reference materials utilized in Basic Officers Training." Dr. Campbell continued, "...the Basic Training Course for VA police officers appears to be relevant and consistent with basic law enforcement training; however, the FBI

Academy at Quantico, Virginia, does not certify nor accredit the basic law enforcement training course."

We believe that our basic police officer course is consistent with standards established for basic police officer training, whether it be standards of FLETC or standards established by state academies. Since we did not accomplish the review we are not able to say in what way Dr. Campbell may have believed that our training was not consistent with standards of FLETC or those established by state academies. We can say that Dr. Campbell made no recommendations to us for improving our course of training.

Additionally, the basic police training course provided to newly appointed VA police officers has important unique features when compared to traditional law enforcement training. In the training provided at the LETC special emphasis is placed on dealing with patients, diffusing hostile and aggressive behavior with the minimum use of force and providing customer service. Students are taught that their role in the medical center setting is that of a police officer who is skilled to protect their clientele and to function as an integral part of the patient treatment team.

# DEPARTMENT OF VETERANS AFFAIRS



LAW ENFORCEMENT TRAINING CENTER  
NORTH LITTLE ROCK, ARKANSAS

FIREARMS  
TRAINING UNIT 18

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This Training Unit has been prepared solely for the purpose of internal Departmental use. It is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter, civil or criminal, and does not place any limitations on other wise lawful activities of the Department

Part I

**PURPOSE, APPLICATION AND OBJECTIVES**

**1. PURPOSE:** The purpose of this Training Unit is to describe authorized and prohibited uses of a firearm by police officers; to provide guidelines on the use of force, to include deadly force, and to establish training and qualification requirements.

**2. APPLICATION:**

a. This program must be **SUCCESSFULLY** completed by every police officer prior to the issuance of the Department approved firearm. No deviation from program requirements will be authorized.

b. Each police officer authorized to carry a firearm must be provided with a copy of this unit for personal guidance.

**3. OBJECTIVES:**

a. To establish guidelines for the training, issuance and use of the Department approved firearm.

b. To prescribe conditions justifying the use of the firearm and rules of engagement.

c. To establish procedures for reporting and reviewing the use of the firearm.

d. To establish qualification requirements.

## PART II

USE OF FORCE

## 1. INTRODUCTION:

a. VA Policy requires that the use of deadly force by VA police officers be consistent with the guidance from the Department of Justice. On October 16, 1995 the Department of Justice issued a directive concerning the use of deadly force. The following information is consistent with that directive.

b. The Department of Veterans Affairs hereby establishes uniform procedures with respect to the use of deadly force. This section will provide practical guidance for officers who must make grave decisions regarding the use of deadly force under the most trying of circumstances. It has always been the philosophy of the Department of Veterans Affairs that only the minimum amount of force necessary be used by VA police officers to control violent situations. The addition of a firearm as an equipment item for VA police does not indicate any modification in that philosophy. VA police officers who carry a firearm are expected to make every attempt to de-escalate violent and potentially violent situations with the minimum amount of force. The safety of all persons in the area of an incident is of paramount importance.

## 2. PRINCIPLES ON THE USE OF FORCE:

a. The Department of Veterans Affairs recognizes and respects the integrity and value of all human life. Consistent with that primary value, but beyond the scope of the principles articulated here, is the Department's full commitment to take all reasonable steps to prevent the need to use deadly force, as reflected in Departmental training and procedures. Yet even the best prevention policies are on occasion insufficient, as when an officer serving a warrant or conducting surveillance is confronted with a threat to their life. With respect to these situations and in keeping with the value of protecting all human life, the touchstone of the Department's policy regarding the use of deadly force is necessity. Use of deadly force must be objectively reasonable under all the circumstances known to the officer at the time.

b. The necessity to use deadly force arises when all other available means of preventing imminent and grave danger to officers or other persons have failed or would be likely to fail. Thus, employing deadly force is permissible when there is no safe alternative to using such force, and without it the officer or others would face imminent and grave danger. Officers are not required to place themselves, another officer, a suspect, or the public in unreasonable danger of death or serious physical injury before using deadly force.

c. Determining whether deadly force is necessary may involve instantaneous decisions that encompass many factors, such as the likelihood that the subject will use deadly force on the officer or others if such force is not used by the officer; the officer's knowledge that the subject will likely acquiesce in arrest or recapture if the officer uses lesser force or no force at all; the capabilities of the subject; the subject's access to cover and weapons; the

presence of other persons who may be at risk if force is or is not used; and the nature and the severity of the subject's criminal conduct or the danger posed.

d. **Deadly force should never be used upon mere suspicion that a crime, no matter how serious, was committed, or simply upon the officer's determination that probable cause would support the arrest of the person being pursued or arrested for the commission of a crime. Deadly force may be used to prevent the escape of a fleeing subject if there is probable cause to believe:**

(1) The subject has committed a felony involving the infliction or threatened infliction of serious physical injury or death,

(2) The escape of the subject would pose an imminent danger of death or serious physical injury to the officer or to another person.

e. As used in this training unit, "imminent" has a broader meaning than "immediate" or "instantaneous." The concept of, "imminent" should be understood to be elastic, that is, involving a period of time dependent on the circumstances, rather than the fixed point of time implicit in the concept of "immediate" or "instantaneous." (Thus, a subject may pose an imminent danger, or has a weapon within reach, or is running for cover carrying a weapon, or running to a place where the officer has reason to believe a weapon is available).

### 3. LESSER MEANS:

a. **Intermediate force.** If force less than deadly force could reasonably be expected to accomplish the same end, such as the use of the CIP or the side-handle baton, without unreasonably increasing the danger to the officer or to others, then it must be used. Deadly force is not permissible if less force will control a violent or potentially violent situation, although the reasonableness of the officer's understanding at the time deadly force was used shall be the benchmark for assessing applications of this policy.

b. **Verbal Warnings.** Before using deadly force, if feasible, officers will audibly command the subject to submit to their authority. Implicit in this requirement is the concept that officers will give the subject an opportunity to submit to such command unless danger is increased thereby. However, if giving such a command would itself pose a risk of death or serious physical injury to the officer or others, it need not be given.

c. **Warning Shots And Shooting To Disable.**

**Warning shots are prohibited.** Discharge of a firearm is usually considered to be permissible only under the same circumstances when deadly force may be used . . . that is, only when necessary to prevent loss of life or serious physical injury. Warning shots themselves may pose dangers to the officer or others. Attempts to shoot to wound or to injure are unrealistic and because of high miss rates and poor stopping effectiveness, can prove dangerous for the officer and others. Therefore, shooting merely to disable is strongly discouraged.

d. Motor Vehicles And Their Occupants.

Experience has demonstrated that the use of firearms to disable moving vehicles is either unsuccessful or results in an uncontrolled risk to the safety of officers or others. **Shooting to disable a moving motor vehicle is prohibited.** An officer who has reason to believe that a driver or occupant poses an imminent danger of death or serious physical injury to the officer or others may fire at the driver or an occupant only when such shots are necessary to avoid death or serious physical injury to the officer or another, and only if the public safety benefits of using such force reasonably appear to outweigh any risks to the officer or the public, such as from a crash, ricocheting bullets, or return fire from the subject or another person in the vehicle. Except in rare circumstances, the danger permitting the officer to use deadly force must be by means other than the vehicle.

4. USE OF DEADLY FORCE:

a. PERMISSIBLE USES:

(1) **General Statement.** Police officers of the Department of Veterans Affairs may use deadly force only when necessary, that is, when the officer has a reasonable belief that the subject of such force poses an imminent danger of death or serious physical injury to the officer or another person.

(2) **FLEEING FELONS.** Deadly force may be used to prevent the escape of a fleeing subject if there is probable cause to believe:

(a) The subject has committed a felony involving the infliction or threatened infliction of serious physical injury or death; **and**

(b) The escape of the subject would pose an imminent danger of death or serious physical injury to the officer or to another person.

b. **NON - DEADLY FORCE.** When force other than deadly force reasonably appears to be sufficient to effect an arrest or otherwise accomplish the law enforcement purpose, deadly force is not necessary.

c. **VERBAL WARNINGS.** If feasible and if to do so would not increase the danger to the officer or others, a verbal warning to submit to the authority of the officer shall be given prior to the use of deadly force.

d. **WARNING SHOTS.** WARNING SHOTS ARE  **PROHIBITED.**

e. **VEHICLES.**

(1) Experience has demonstrated that the use of firearms to disable moving vehicles is either unsuccessful or results in an uncontrolled risk to the safety of officers or others. **Shooting to disable a moving motor vehicle is prohibited.** An officer who has reason to

believe that a driver or occupant poses an imminent danger of death or serious physical injury to the officer or others may fire at the driver or an occupant only when such shots are necessary to avoid death or serious physical injury to the officer or another, and only if the public safety benefits of using such force reasonably appear to outweigh any risks to the officer or the public. Except in rare circumstances, the danger permitting the officer to use deadly force must be by means other than the vehicle.

**(2) WEAPONS MAY NOT BE FIRED SOLELY TO DISABLE A MOVING VEHICLE.**

**(3) Weapons may be fired at the driver or other occupant of a moving vehicle only when:**

(a) The officer has a reasonable belief that the subject poses an imminent danger of death or serious physical injury to the officer or another.

f. **VICIOUS ANIMALS.** Deadly force may be directed against dogs or other vicious animals when necessary in self - defense or defense of another, and the benefits of such force outweighs the risks to the safety of the officer or other persons.

**g. DEFINITIONS:**

(1) **Deadly force** is the use of any force that is likely to cause death or serious physical injury. When an officer of the Department uses such force, it may only be done consistent with this policy. Force that is not likely to cause death or serious physical injury, but unexpectedly results in such harm or death, is not governed by this policy.

(2) **Probable cause, reason to believe or a reasonable belief.** for purposes of this Training Unit, means facts and circumstances, including the reasonable inferences drawn therefrom, known to the officer at the time of the use of deadly force, that would cause a reasonable officer to conclude that the point at issue is probably true. The reasonableness of a belief or decision must be viewed from the perspective of the officer on the scene, who may often be forced to make split - second decisions in circumstances that are tense, unpredictable, and rapidly evolving. Reasonableness is not to be viewed from the calm vantage point of hindsight.

## PART III

**ROLE AND SPECIFICATIONS OF THE SEMIAUTOMATIC PISTOL,  
HOLSTER AND AMMUNITION**

1. Since the decision has been made to arm selected V A police personnel with a semiautomatic firearm, it has been determined that a double action only system will be utilized. This semiautomatic system only allows the weapon to be fired with a deliberate stroke of the trigger mechanism. This type of system has been proven to be the easiest and safest system for police personnel to operate and to be trained with. The double action only semiautomatic system has been referred to as a revolver with a magazine. Each of the selected persons will attend an approved firearms transitional pistol course of training to ensure that they are completely familiar with the operation and safe weapons handling of the selected handgun. All officers will be required to qualify on an approved course of fire with the issued handgun and duty ammunition on a semiannual basis.

2. The authorized semiautomatic pistol for selected personnel must meet the following criteria: It must be 9mm Luger caliber (9 x 19) semiautomatic pistol with double action trigger mechanism only. The frame will consist of an aluminum alloy with steel slide. The safety features must include a magazine disconnect, firing pin safety, and trigger weight nine to eleven pounds set at the factory. **NO MODIFICATIONS OR ALTERATIONS ARE ALLOWED**, such as "trigger shoes, extended slide stops, extended magazine release and no after market extended magazines." The sights will consist of front and rear trijicon night sights.

3. The holster authorized by the Office of Security and Law Enforcement must be equipped with a minimum of three safety features. The holster will be equipped with a thumb break release, an internal safety feature, and a tension release. The holster must be black in color and constructed of high quality material. All uniform personnel will be issued dual magazine carriers with Velcro closure and four (4) belt keepers of matching material. The holster familiarization will consist of 200 draws in the presence of a firearms instructor.

The holster for plain clothes officers authorized by the Office of Security and Law Enforcement must be equipped with a minimum of one safety feature, a thumb break retaining device. The holster will be of a design to be carried for a strong side draw. The holster will be equipped with a paddle type retainer, adjustable retention screw and thumb break release. The holster must be black in color and constructed of high quality material. All plain clothes personnel will be issued a single magazine carrier with Velcro closure and belt clip.

4. Issued duty ammunition will be 9mm Luger caliber, 124 grain brass jacketed hollow point, **NO SUBSTITUTIONS ARE ALLOWED**. All qualification courses will be fired with issued duty ammunition. Issued duty ammunition will be expended every six (6) months during range qualification and new duty ammunition will be issued. The 9mm Luger caliber, full metal case, 124 grain cartridges may be used for training purposes only.

**PART IV****TRANSITIONAL PISTOL TRAINING**

**1. PHASES OF TRAINING:** Transitional pistol training is divided into two phases: **Preparatory marksmanship training and range firing.** Each phase may be divided into separate instructional steps. All marksmanship training must be continually progressive. Once the officer becomes proficient in the fundamentals of marksmanship, the officer will then progress to the advanced techniques of **tactical marksmanship.** Tactical marksmanship techniques should only be practiced after the basic marksmanship skills have been acquired.

**2. FUNDAMENTALS:**

a. The main use of the pistol is close range engagement of lethal force encounters with quick, accurate fire. In shooting encounters, it is not the first round fired that wins the encounter, but the first accurately fired round. Accurate shooting results from knowing and correctly applying the elements of marksmanship. The elements of pistol marksmanship are:

- \* Grip
- \* Aiming
- \* Breath Control
- \* Trigger Squeeze
- \* Target Engagement
- \* Positions

**b. Grip**

(1) The handgun must become an extension of the hand and arm. It should replace the index finger in pointing at any object or target. A firm, uniform grip must be applied and acquired to the pistol grip. A proper grip is one of the most important fundamentals of rapid or quick fire shooting.

(2) **One - hand Grip:** Holding the handgun in the non - firing hand; form a V with the thumb and forefinger of the strong hand ( firing hand). Place the handgun in the V with the front and rear sights in line with the firing arm. Wrap the lower three fingers around the pistol grip, applying equal pressure with all three fingers to the rear. Allow the thumb of the firing hand to rest alongside the handgun without pressure. Grip the weapon tightly with sufficient pressure to leave a light grip panel impression in the palm of the strong hand. At this point, the necessary pressure for a proper grip has been established. Place the trigger finger between the tip and second joint so that it can be squeezed to the rear. The trigger finger must work independently of the remaining fingers. **NOTE:** If any of the three fingers on the grip is relaxed, the grip must be reapplied.

(3) **Two - hand Grip:** The two - hand grip allows the officer to steady the firing hand and provides maximum support during deliberate or rapid fire shooting. The non - firing hand becomes a support mechanism for the firing hand by wrapping the fingers of the non - firing hand around the firing hand. Two - hand grips are recommended for all types of handgun shooting.

**WARNING**

**IF THE NON - FIRING THUMB IS PLACED TO THE REAR OF THE PISTOL THE RECOIL FROM THE PISTOL SLIDE COULD CAUSE PERSONAL INJURY.**

(a) **Fist Grip:** Grip the handgun as described in the paragraph above. Firmly close the fingers of the conferring hand over the fingers of the firing hand, ensuring that the index finger from the non - firing hand is between the middle finger of the firing hand and the trigger guard. Place the non - firing thumb alongside or on top of the firing thumb. The index finger of the support hand should be in contact with the bottom of the trigger guard. This grip is commonly referred to as a clam shell.

(b) **Palm Supported Grip:** This grip is commonly referred to as the cup and saucer grip. Place the non - firing hand under the firing hand, wrapping the non - firing fingers around the back of the firing hand. Place the non - firing thumb over the middle finger of the firing hand.

(c) **Weaver Grip:** Applied the same as the fist grip. The exception is that the non - firing thumb is wrapped over the firing thumb.

(4) **Isometric Tension:** As you raise your arms to the firing position you apply isometric tension. This is commonly know as the push - pull method for maintaining weapon stability. Isometric tension is when you apply forward pressure with the firing hand and pull rearward with the non - firing hand with equal pressure. This creates an isometric force but never so much to cause the officer to tremble. This steadies the pistol and reduces barrel rise from recoil. The supporting arm is bent with the elbow pulled downward. The firing arm is fully extended with the elbow and wrist locked. The officer must experiment to find the right amount of isometric tension to apply. Remember, the firing hand should exert the same pressure as the non - firing hand. If the pressure is not equal, a missed target could result.

(5) **Natural Point of Aim:** The officer should check their pistol grip positioning for the use of a natural point of aim. To accomplish this check, grip the handgun and sight properly on a distant target. While maintaining the grip and stance, close your eyes for three to five seconds. Open your eyes and check for proper sight picture. If the point of aim is disturbed, make the adjustments to your stance to compensate. If the sight alignment is disturbed, you adjust the grip to compensate by removing the handgun from the firing hand and reapplying the grip. The officer will repeat this process until the sight alignment and sight placement remain almost the same when you open your eyes. This enables the officer to determine and use a natural point of aim once you have sufficiently practiced. This is the most relaxed position for holding and firing the handgun.

c. Aiming

(1) Aiming is sight alignment and sight placement. Sight alignment is the centering of the front blade in the rear sight notch. The top of the front sight is level with the top of the rear sight and is in correct alignment with the eye. For correct sight alignment, you must center the front sight in the rear sight. You will then raise or lower the top of the front sight so it is level with the top of the rear sight. There should be an equal amount of light on both sides of the front sight as you look through the rear sight. You will always introduce the sights of the pistol into your line of sight. The front sight must remain perfectly clear.

(2) Sight placement is the positioning of the handgun's sights in relation to the target as seen by you when you aim the handgun. A correct sight picture consists of correct sight alignment with the front sight placed under the center mass of the target, commonly referred to as a six o'clock hold. The eye can focus only on one object at a time at different distances. Therefore the last focus of the eye is always on the front sight. When the front sight is seen clearly, the rear sight and target will appear hazy. Correct sight alignment can only be maintained through focusing on the front sight. The bullet will strike the target even if the sight picture is partly off center but still remains on the target. Sight alignment is more important than sight placement. Since it is impossible to hold the handgun completely still, you must apply trigger squeeze and maintain correct sight alignment while the handgun is moving in and around the center of the target. This natural movement of the pistol is referred to as the wobble area. The officer must strive to control the limits of the wobble area through proper breath control, trigger squeeze, positioning and grip

(3) Sight alignment is essential for accuracy because of the short sight radius of the handgun. For example, if a 1/10 - inch error is made in aligning the front sight in the rear sight, the officer's bullet will miss the point of aim by approximately 15 inches at a range of 25 yards. The 1/10 - inch error in sight alignment magnifies as the range increases - - at 25 yards it is magnified approximately 150 times.

(4) Focusing on the front sight while applying proper trigger squeeze will help you resist the urge to jerk the trigger and anticipate the actual moment the handgun will fire. Mastery of trigger squeeze and sight alignment requires practice.

d. **BREATH CONTROL:** The officer must learn to hold their breath properly at any time during the breathing cycle if you wish to attain accuracy that will serve you in violent lethal encounter. This must be accomplished while aiming and squeezing the trigger. While the procedure is simple, it requires explanation, demonstration, and supervised practice. To hold the breath properly you take a breath, let it out, then inhale normally, let a little out until comfortable, hold and then fire. It is difficult to maintain a steady position keeping the front sight at a precise aiming point while breathing. You should be taught to inhale, then exhale normally, and hold your breath at the moment of the natural respiratory pause. The shot must then be fired before you feel any discomfort from not breathing. When multiple targets are presented, you must learn to hold your breath at any part of the breathing cycle. Breath control must be practiced during dry - fire exercises until it becomes a natural part of the firing process.

### e. Trigger Squeeze:

(1) Improper trigger squeeze causes more misses than any other step of preparatory marksmanship. Poor shooting is caused by the aim being disturbed before the bullet leaves the barrel of the handgun. This is usually the result of jerking the trigger or flinching. A slight off center pressure of the trigger finger on the trigger can cause the handgun to move and disturb the officer's sight alignment. Flinching is an automatic human reflex caused by anticipating the recoil of the pistol. Jerking is an effort to fire the handgun at the precise time the sights align with the target.

(2) Trigger squeeze is the independent movement of the trigger finger in applying increasing pressure on the trigger straight to the rear, without disturbing the sight alignment until the handgun fires. The trigger slack, or free play, is taken up first, and the squeeze is continued steadily until the hammer falls. If the trigger is squeezed properly, you will not know exactly when the hammer will fall; therefore, you do not tend to flinch or heel, resulting in a bad shot.

(3) To apply correct trigger squeeze, the trigger finger should contact the trigger between the tip of the finger to the second joint ( without touching the pistol anywhere else). Where contact is made depends on the length of your trigger finger. If pressure from the trigger finger is applied to the right side of the trigger or pistol, the strike of the bullet will be to the left. This is due to the normal hinge action of the fingers. When the fingers on the right hand are closed, as in gripping, they hinge or pivot to the left, thereby applying pressure straight to the left. ( If you are left handed, this action is to the right.) You must not apply pressure left or right but increase finger pressure straight to the rear. Only the trigger finger must perform this action. Dry - fire training improves straight to the rear without cramping or increasing pressure on the hand grip.

(a) Officers who are good shooters hold the sights of the handgun as nearly on the target center as possible and continue to squeeze the trigger with increasing pressure until the weapon fires.

(b) Officers who are bad shooters, try to " catch their target" as their sight alignment moves past the target and fires the pistol at that instant. This is called **ambushing**, which causes trigger jerk.

(4) **Follow through** is the continued effort in maintaining sight alignment before, during and after the round has been fired. Releasing the trigger too soon after the round has been fired results in an uncontrolled shot, causing a missed target.

### f. Target Engagement:

(1) To engage a single target, you apply the method previously discussed. When multiple perpetrators are engaged, the **CLOSEST** and **MOST DANGEROUS** individual is engaged first and should be fired at with a minimum of three shots. You then traverse and acquire the next target, aligning the sights in the center of mass, focusing on the front sight,

apply trigger squeeze and fire. You must ensure your firing arm elbow and wrist are locked during all engagements. If you missed the first target and have fired upon the second target, index back to the first target and engage it. Some problems in target engagement are as follows:

- \* Indexing targets too fast
- \* Moving the handgun before the head
- \* Recoil anticipation
- \* Trigger jerk
- \* Heeling

(2) **Indexing too fast.** This occurs when the operator is moving the pistol faster than the head and eyes are unable to keep the front sight focused. This is observed as a quick panning motion with the handgun.

(3) **Moving the handgun before the head.** It is important when engaging multiple perpetrators to move the head first, then move the handgun, attain sight alignment, and trigger squeeze to complete the firing sequence. Move the head first to visually make target acquisition, sight alignment, and then trigger squeeze.

(4) **Recoil anticipation.** When you first learn to shoot, you may begin to anticipate recoil. This reaction may cause you to tighten your muscles during or just before the hammer falls. You may fight the recoil by pushing the handgun downward in anticipating or reacting to its firing. You may lift the handgun upward in anticipating or reacting to its firing. In either case, the rounds will not strike the point of aim.

(5) **Trigger jerk.** This occurs when you see that you have acquired a good sight picture at center mass and "snap" off a round before the good sight picture is lost. This may become a problem, especially when you are learning to use a flash sight picture. This is a quick snapping motion of the trigger finger.

(6) **Heeling.** This condition is caused by tightening the large muscle in the heel of the hand to keep from jerking the trigger. Officers having problems with jerking the trigger try to correct the fault by tightening the bottom of the hand, which results in a heeled shot. Heeling causes the strike of the bullet to hit high on the firing hand side of the target. Officers can correct shooting error by knowing and applying correct trigger squeeze.

g. Positions:

(1) A qualification course is fired from the standing, kneeling, crouch and prone positions. All of the firing positions described must be practiced so they become natural movements, during qualification and tactical firing. Though these positions seem natural, practice sessions must be conducted to ensure the habitual attainment of correct firing positions. You must be able to assume correct firing positions quickly without any conscious effort. Pistol marksmanship requires you to rapidly apply all the fundamentals at dangerously

close targets while under high levels of stress. Assuming a proper position to allow for a steady aim is critical to your survival.

- \* Standing without support
- \* Standing with support
- \* Kneeling without support
- \* Kneeling with support
- \* Crouch
- \* Prone

(2) **Standing without support.** Face the target. Place the feet a comfortable distance apart, approximately shoulder width apart. Extend the firing arm and attain a two - handed grip. The wrist and elbow of the firing arm are locked and pointed towards the target center. Keep the body straight with the shoulders slightly forward of the buttocks, and the knees should be slightly bent or unlocked.

(3) **Standing with support.** Using available hard cover for support -- for example, a tree or wall to stand behind. Standing behind a barricade with the firing side on line with the edge of the barricade. There are two methods to attain this position. (a) Place the wrist or back of the non - firing hand at eye level against the edge of the barricade. Introduce the firing hand to the non - firing hand to attain a two - hand grip to assume the firing position. Lock the elbow and wrist of the firing arm. Move the foot on the non - firing side forward until the toe of the boot touches the bottom of the barricade. (b) Place the knuckles of the non - firing hand at eye level against the edge of the barricade. Introduce the firing hand to the non - firing hand to attain a two - handed grip to assume the firing position. Lock the elbow and wrist of the firing arm. Move the foot on the non - firing side forward until the toe of the boot touches the bottom of the barricade. Caution must be used in this position, if too much pressure is applied to the knuckles of the non - firing hand against the barricade, injury may occur during the firing sequence.

(4) **Kneeling without support.** In the kneeling position, ground on the firing side knee as the main support. Vertically place the foot, used as the main support, under the buttocks. Rest the body weight on the heel and toes. Rest the non - firing arm just above the elbow on the knee not used as the main body support. Use the two handed grip for firing. Extend the firing arm, lock the firing arm elbow and wrist to ensure solid arm control. An alternative to this position: Ground both knees and placing the buttocks on the heels of the feet. The officer rocks back gently and then attains a two - handed grip for firing. Extend the firing arm, lock the firing arm elbow and wrist to ensure solid arm control.

(5) **Kneeling with support.** Using available hard cover for support -- for example, a low wall, tree, or vehicle. Place the firing side knee on the ground. Bend the other knee and place the non - firing foot flat on the ground, pointing toward the target. Extend arms alongside and brace them against available cover. Lock the wrist and elbow of the firing arm. Place the non - firing hand around the fist to support the firing arm. Rest the non - firing arm just above the elbow on the non - firing side knee. Contact with the barricade may be

established with the non - firing wrist, back of hand, or forearm once a firing position has been attained.

(6) **Crouch.** Use the crouch position when surprise targets are engaged at close range. Place the body in a forward crouch (Boxer's Stance) with the knees bent slightly and trunk bent forward from the hips to give faster recovery from recoil. This is **NOT an EXAGGERATED CROUCH or DEEP CROUCH position.** Place the feet naturally in a position that allows another step toward the target. Extend the handgun straight toward the target, and lock the wrist and elbow of the firing arm. It is important to consistently train with this position, since the body will automatically crouch under high levels of stress. This position is also faster to change direction of fire.

(7) **Prone.** Lie flat on the ground, facing the target. Extend the firing arm towards the target with the arm locked. bring the non - firing hand in a support position underneath the firing hand on the ground. Bend the left knee up slightly below waist level. Push with the left knee and foot rolling the body towards the firing side. The head is kept in a straight line with the handgun and the strong side cheek will make contact with the firing arm bicep. Keep the firing arm and wrist locked for the firing sequence. This position is a modified prone rifle position. The alternative is to lie flat on the ground, facing the target. Extend the arms directly in front with the firing arm locked. The arms may have to be bent slightly, unlocked for firing at high targets. Rest the butt of the handgun on the ground for single, well aimed shots. Wrap the non - firing hand fingers around the fingers of the firing hand. Face Forward. Keep the head down between the arms as much as possible and behind the weapon.

## PART V

## OPERATION

Part V. (Operation) will provide guidance and direction in the loading of the Department approved firearms.

**1. Initial loading with the slide locked to the rear:** This method has the advantage of allowing the officer to check the handgun visually and physically by looking down the magazine well and feeling the firing chamber to ensure that the weapon is ready to receive ammunition. The steps for this procedure are as follows:

a. Point the muzzle of the handgun in a safe direction.

b. Keep the finger out of the trigger guard and off the trigger.

c. Pull the slide to the rear and push up on the slide stop to lock the slide back. This is best accomplished by using the "push-pull" method. PUSH forward with the strong hand holding the weapon, while PULLING the slide to the rear with the weak hand.

d. Visually and physically check the magazine well and firing chamber to ensure the weapon is ready to receive ammunition.

e. Insert a fully loaded magazine into the weapon and tug on the floor plate to ensure the magazine is fully seated.

f. Allow the slide to go forward by:

(1) Depressing the slide stop, allowing the slide to go forward and chambering a round. This should be accomplished with the thumb of the weak hand. This allows a two hand control advantage as the weapon may seem to "leap" out of the hand.

(2) Grasping the rear grasping grooves of the slide with the weak hand and pulling the slide back, releasing the slide and allowing the slide to "sling shot" forward, chambering the round.

**NOTE:** Do not allow the weak hand to "ride" the slide forward. A malfunction may occur if the weak hand "rides" the slide forward while chambering a round.

g. Holster the handgun and engage all security devices.

h. The loading sequence is now completed.

**2. Initial loading with the slide forward:** This procedure may be preferable if the officer is left handed, or having trouble locking the slide to the rear, or when wearing gloves. The steps are as follows:

- (a) Point the muzzle of the handgun in a safe direction.
- (b) Keep the finger outside of the trigger guard and off the trigger.
- (c) Insert a loaded magazine and tug on the floor plate to ensure the magazine is fully seated.
- (d) Pull the slide to the rear with the weak hand and then release the slide to allow it to "sling shot" forward to chamber a round. Be careful not to ease or allow the weak hand to ride the slide forward, as this may cause the slide to NOT go into battery resulting in a malfunction.
- (e) Holster the handgun and secure all security devices.

**NOTE:** Officers will receive 3 loaded magazines when they receive their issued firearm for their assigned tour of duty. There will not be any loose ammunition issued in addition to the 3 loaded magazines.

**3. UNLOADING:** Unloading is performed as carefully as possible with no time limits and under no stress. Many accidents occur due to improper unloading procedures. Unloading should be performed as follows:

- (a) Keep the muzzle of the handgun pointed in a safe direction.
- (b) Remove the finger from the trigger guard and off the trigger.
- (c) Remove the magazine and place the magazine in a pocket or in the belt line.
- (d) Using the push - pull method, grasp the rear grasping grooves of the slide and rack the slide back with sufficient force to eject any live round from the chamber. The officer should visually observe the round in the firing chamber eject. Rack the slide back several times. **NOTE: Never place your hand over the ejection port if there is a round in the firing chamber, and never attempt to catch an ejecting round. Covering the ejection port with the hand could allow the round to fall back into the ejection port, causing the ejector to strike the primer of the cartridge, detonating in your hand.** At this point the handgun should be unloaded.
- (e) Grasp the slide and lock it to the rear position.
- (f) Visually and physically inspect the pistol to ensure it is unloaded.

**NOTE: IF THE OFFICER HAS ANY DOUBT THAT THE FIREARM IS LOADED, REPEAT THE UNLOADING PROCEDURE UNTIL SATISFIED THAT THE FIREARM IS UNLOADED.**

**4. Technique of proper grip and draw:** The initial draw is designed to familiarize the officer with the location of the holstered pistol and proper grip technique.

(a) Begin with the strong hand extended, palm down, elbow bent, locating the holster or pistol grip with the elbow.

(b) Swing the strong hand directly to the grip of the handgun, establishing a strong hand grip on the handgun. The strong hand should have acquired a firing position on the grip.

(c) After the strong hand grip is established, the strong side thumb locates the thumb break safety device and is prepared to unsnap the device for the draw. The strong hand should now be properly positioned for the draw.

(d) Releasing the thumb break safety device, draw the handgun straight up. As soon as the handgun clears the top of the holster, the weak hand seeks out the firing hand and a two handed firing grip is established. Keep the firing hand trigger finger out of the trigger guard and off the trigger. Point the muzzle forward while raising the handgun to eye level and lock the firing hand wrist. **NOTE:** The weak hand should be moving towards the strong hand immediately at the onset of the draw. Both hands should be at a belt level position from the onset of the draw.

(e) The head should move as little as possible during this process.

**5. Malfunctions - Primary method of Immediate Action : Tap, Rack, Assess.**

a. **TAP!** The bottom of the magazine with the palm of the weak hand to ensure it is fully seated. This is a sharp blow to the floor plate of the magazine.

b. **RACK!** The slide with sufficient force to clear any defective round in the firing chamber, stove piped casing, and to also chamber a new round in the firing chamber.

c. **ASSESS!** Bring the handgun back up to a firing position and fire if an appropriate target is present and circumstances still call for shots to be fired.

**NOTE:** The above described procedure will clear most malfunctions that occur in the use of a semiautomatic pistol.

**6. Secondary method of Immediate Action. Double Feed.**

a. **RIP!** Rip or remove the magazine from the handgun to clear a double feed or defective magazine from the handgun. This is accomplished by pulling on the floor plate of the magazine with the weak hand fingers to extract the magazine. **NOTE: DISCARD THIS MAGAZINE, DO NOT ATTEMPT TO SAVE THIS MAGAZINE.**

b. **WORK!** Work the slide to the rear to clear any defective round from the firing chamber and magazine well. Lock the slide to the rear position.

c. **TAP!** Tap or insert a fresh magazine, as the magazine may have been the source of the malfunction. It is always preferable to have a fully loaded magazine in the handgun if possible.

d. **RACK!** Rack the slide to the rear utilizing the sling shot method to chamber a round in the firing chamber.

e. **ASSESS!** Fire at the target if appropriate.

**7. Emergency Reload / Speed load:** Emergency reload / Speed load are the terms used when you have expended all rounds in the magazine of the handgun and the slide is locked to the rear. In a lethal force confrontation this constitutes an **EMERGENCY. YOU MUST:**

a. Recognize that the slide of the handgun has locked back to the rear.

b. Establish a grip with the weak hand on the fresh magazine.

c. Depress the magazine release with the strong hand while bringing the handgun to the mid torso area and tilt the handgun slightly with the empty magazine well pointed towards the body ready to receive the fresh magazine.

d. With the index finger of the weak hand along the front spline of the magazine, insert the magazine into the magazine well with enough force to fully seat the magazine.

e. Bring the handgun back up on target and allow the slide to go forward by:

(1) Depressing the slide stop with the thumb of the weak hand. (This is a common method used by right handed persons).

(2) Grasping the rear grasping grooves of the slide with the weak hand and sling shot the slide forward. (This is a common method used by left handed persons and those wearing gloves). This method may also be preferred during high stress situations where finding the small slide stop could be difficult.

(3) **FIRE IF APPROPRIATE.**

**8. Tactical reload:** This procedure is accomplished by dropping the magazine from the pistol while a round is still in the chamber. This procedure should be exercised when you know that you have lost count of the number of rounds that you have expended and you are preparing to move from a covered position. You have the opportunity to reload, but may still be in the threat zone. This procedure allows you the ability to speed up the loading time, because you do not have to manipulate the slide, and fully load the weapon again to capacity. You should:

a. Remove the finger from the trigger and trigger guard while bringing the handgun to the mid torso area.

b. Grasp a full magazine with the weak hand.

c. The weak hand with the fresh magazine approaches the floor plate of the magazine that is in the handgun. Depress the magazine release with the thumb of the strong hand. Catch the magazine that is in the handgun in the palm of the weak hand and then grasp the extracted magazine between the third and fourth fingers.

d. With the index finger of the weak hand along the front of the magazine spline, insert the fresh magazine into the magazine well. Place the extracted magazine into a pocket for future use if needed.

e. Bring the handgun back upon target and **fire if appropriate.**

f. This magazine exchange should be utilized from behind cover and prior to moving from cover or at any point the officer loses count of rounds expended. **ALWAYS MOVE FROM COVER WITH A FULLY LOADED HANDGUN.**

9. **Tactical magazine exchange:** Tactical magazine exchange procedure is the process of exchanging magazines in the handgun to allow the officer to top off the handgun while saving the partially loaded magazine for future use. This procedure is not as fast as the other reloading procedures, and is best performed from behind hard cover. You should:

a. **Use hard cover if available.**

b. Remove the finger from the trigger guard and off the trigger.

c. Bring the pistol to the mid torso level and tilt the handgun magazine well towards the body to be in position to receive the fresh magazine.

d. Remove the fresh magazine from the pouch with the weak hand and with the weak hand index finger along the front spline of the magazine.

e. Bring the magazine to the base of the grip and remove the magazine from the pistol by depressing the magazine release and catching the partially loaded magazine in the weak hand.

f. Rotate the extracted magazine in the pistol between the little finger and ring finger of the weak hand.

g. Insert the fresh magazine by rotating the old magazine down and the new magazine into the magazine well and lock the fresh magazine into place.

h. The magazine may be retained in your hand or :

i. Place the partially loaded magazine in the waistband or pocket. **DO NOT REPLACE THE PARTIALLY LOADED MAGAZINE INTO THE MAGAZINE POUCH CARRIER.**

j. The tactical magazine exchange is completed.

## PART VI

## COURSE OF FIRE

1. The objective of firearm training is to develop V A police officers into safe and competent firearms handlers. It is the officers responsibility to act in a mature manner and use common sense in safe handling procedures with the firearm. The following safety standards and range rules will be adhered to by all officers engaged in firearms training. Any item not clearly understood should be brought to the attention of an instructor for further explanation. Infractions of or disregard for firearm safety will not be tolerated and will be dealt with promptly and firmly by training staff personnel.

a. **SMOKING ON THE RANGE IS PROHIBITED EXCEPT IN DESIGNATED AREAS. OFFICERS THAT SMOKE WILL BE REQUIRED TO KEEP DESIGNATED SMOKING AREAS NEAT AND ORDERLY.**

b. **SAFETY RULES AND REGULATIONS.**

(1) **ALL FIREARMS TRAINING WILL BE CONDUCTED IN THE STATIC MODE UNTIL FURTHER NOTICE.**

(2) **ALL FIREARMS ARE TO BE UNLOADED WHILE ON THE RANGE AND SECURED IN THE HOLSTER WITH ALL SAFETY DEVICES SECURED.**

(3) **NO HANDLING OF FIREARMS BEHIND THE FIRING LINE UNLESS DIRECTED TO BY THE RANGE MASTER OR THE FIREARM IS RECEIVING MINOR REPAIRS.**

(4) **WHEN ON THE FIRING LINE: KEEP YOUR FINGER OFF THE TRIGGER! DO NOT PLACE YOUR FINGER INSIDE THE TRIGGER GUARD UNTIL YOU ARE POINTING THE FIREARM AT THE TARGET. THIS IS ESPECIALLY IMPORTANT WHEN DRAWING THE FIREARM FROM THE HOLSTER.**

(5) **WATCH THE MUZZLE. THE MUZZLE OF ALL FIREARMS WILL BE POINTED DOWN RANGE AT ALL TIMES WHEN NOT HOLSTERED.**

(6) **EACH TIME A FIREARM IS HANDLED FOR ANY PURPOSE, POINT THE MUZZLE IN A SAFE DIRECTION. OPEN THE ACTION AND MAKE AN INSPECTION TO INSURE THAT THE FIREARM IS UNLOADED. NEVER TRUST MEMORY AND CONSIDER EVERY FIREARM AS LOADED UNTIL YOU HAVE PROVEN OTHERWISE. NEVER TURN IN OR ACCEPT A FIREARM UNLESS THE ACTION IS OPEN.**

(7) **CHECK THE FIREARM FOR BARREL OBSTRUCTIONS BEFORE LOADING. HEAVY GREASE IS CONSIDERED AN OBSTRUCTION.**

**(8) DO NOT LEAVE A LOADED FIREARM UNATTENDED. UNHOLSTERED FIREARMS WILL HAVE ACTIONS OPEN AT ALL TIMES WHEN NOT BEING FIRED.**

**(9) ACTIONS OF ALL FIREARMS WILL BE OPEN WHEN BEING TRANSPORTED TO AND FROM THE RANGE UNLESS HOLSTERED.**

**(10) DO NOT HANDLE ANY FIREARMS ON THE FIRING LINE WHILE THERE IS ANYONE DOWN RANGE.**

**(11) NEVER SPEAK TO ANYONE ON THE FIRING LINE UNLESS YOU ARE EXPERIENCING PROBLEMS; AND THEN RAISE YOUR NON FIRING HAND AND KEEP THE FIREARM POINTED DOWN RANGE.**

**(12) IF YOU SHOULD BE SPOKEN TO WHILE ON THE FIRING LINE, DO NOT TURN AROUND TO MAKE A REPLY.**

**(13) NEVER SNAP OR PRACTICE DRY FIRING AT ANY TIME OR ANYWHERE EXCEPT IN THE PRESENCE OF A QUALIFIED FIREARMS INSTRUCTOR.**

**(14) DO NOT LOAD UNTIL THE COMMAND IS GIVEN. NEVER ANTICIPATE THE RANGE COMMANDS.**

**(15) HOLSTERED FIREARMS WILL HAVE ALL SAFETY DEVICES SECURED AT ALL TIMES EXCEPT WHILE IN THE PROCESS OF DRAWING THE FIREARM.**

**(16) IN THE EVENT THAT THE FIREARM IS ACCIDENTALLY DROPPED, REPORT THIS TO THE INSTRUCTOR IMMEDIATELY, WHO WILL INSPECT THE FIREARM TO INSURE IT WILL FUNCTION. DO NOT PICK THE FIREARM UP, LET IT LIE AND NOTIFY AN INSTRUCTOR. FIREARMS THAT COME INTO CONTACT WITH THE GROUND DURING THE RUNNING OF A TACTICAL COURSE WILL BE REPORTED IMMEDIATELY TO AN INSTRUCTOR FOR INSPECTION.**

**(17) IF A CARTRIDGE FAILS TO FIRE, STOP THE ACTION AND WAIT UNTIL THAT STAGE OF FIRE IS COMPLETED, KEEPING THE MUZZLE POINTED DOWN RANGE, THEN REPORT IT TO AN INSTRUCTOR BY RAISING YOUR NON SHOOTING HAND.**

**(18) NEVER FIRE A SUCCEEDING SHOT FOLLOWING THE MALFUNCTION OF A CARTRIDGE UNTIL THE BARREL HAS BEEN EXAMINED TO DETERMINE IF A BULLET IS LODGED IN THE BARREL.**

## PART VI

## COURSE OF FIRE

1. The objective of firearm training is to develop V A police officers into safe and competent firearms handlers. It is the officers responsibility to act in a mature manner and use common sense in safe handling procedures with the firearm. The following safety standards and range rules will be adhered to by all officers engaged in firearms training. Any item not clearly understood should be brought to the attention of an instructor for further explanation. Infractions of or disregard for firearm safety will not be tolerated and will be dealt with promptly and firmly by training staff personnel.

a. **SMOKING ON THE RANGE IS PROHIBITED EXCEPT IN DESIGNATED AREAS. OFFICERS THAT SMOKE WILL BE REQUIRED TO KEEP DESIGNATED SMOKING AREAS NEAT AND ORDERLY.**

b. **SAFETY RULES AND REGULATIONS.**

(1) **ALL FIREARMS TRAINING WILL BE CONDUCTED IN THE STATIC MODE UNTIL FURTHER NOTICE.**

(2) **ALL FIREARMS ARE TO BE UNLOADED WHILE ON THE RANGE AND SECURED IN THE HOLSTER WITH ALL SAFETY DEVICES SECURED.**

(3) **NO HANDLING OF FIREARMS BEHIND THE FIRING LINE UNLESS DIRECTED TO BY THE RANGE MASTER OR THE FIREARM IS RECEIVING MINOR REPAIRS.**

(4) **WHEN ON THE FIRING LINE: KEEP YOUR FINGER OFF THE TRIGGER! DO NOT PLACE YOUR FINGER INSIDE THE TRIGGER GUARD UNTIL YOU ARE POINTING THE FIREARM AT THE TARGET. THIS IS ESPECIALLY IMPORTANT WHEN DRAWING THE FIREARM FROM THE HOLSTER.**

(5) **WATCH THE MUZZLE. THE MUZZLE OF ALL FIREARMS WILL BE POINTED DOWN RANGE AT ALL TIMES WHEN NOT HOLSTERED.**

(6) **EACH TIME A FIREARM IS HANDLED FOR ANY PURPOSE, POINT THE MUZZLE IN A SAFE DIRECTION. OPEN THE ACTION AND MAKE AN INSPECTION TO INSURE THAT THE FIREARM IS UNLOADED. NEVER TRUST MEMORY AND CONSIDER EVERY FIREARM AS LOADED UNTIL YOU HAVE PROVEN OTHERWISE. NEVER TURN IN OR ACCEPT A FIREARM UNLESS THE ACTION IS OPEN.**

(7) **CHECK THE FIREARM FOR BARREL OBSTRUCTIONS BEFORE LOADING. HEAVY GREASE IS CONSIDERED AN OBSTRUCTION.**

**(8) DO NOT LEAVE A LOADED FIREARM UNATTENDED. UNHOLSTERED FIREARMS WILL HAVE ACTIONS OPEN AT ALL TIMES WHEN NOT BEING FIRED.**

**(9) ACTIONS OF ALL FIREARMS WILL BE OPEN WHEN BEING TRANSPORTED TO AND FROM THE RANGE UNLESS HOLSTERED.**

**(10) DO NOT HANDLE ANY FIREARMS ON THE FIRING LINE WHILE THERE IS ANYONE DOWN RANGE.**

**(11) NEVER SPEAK TO ANYONE ON THE FIRING LINE UNLESS YOU ARE EXPERIENCING PROBLEMS; AND THEN RAISE YOUR NON FIRING HAND AND KEEP THE FIREARM POINTED DOWN RANGE.**

**(12) IF YOU SHOULD BE SPOKEN TO WHILE ON THE FIRING LINE, DO NOT TURN AROUND TO MAKE A REPLY.**

**(13) NEVER SNAP OR PRACTICE DRY FIRING AT ANY TIME OR ANYWHERE EXCEPT IN THE PRESENCE OF A QUALIFIED FIREARMS INSTRUCTOR.**

**(14) DO NOT LOAD UNTIL THE COMMAND IS GIVEN. NEVER ANTICIPATE THE RANGE COMMANDS.**

**(15) HOLSTERED FIREARMS WILL HAVE ALL SAFETY DEVICES SECURED AT ALL TIMES EXCEPT WHILE IN THE PROCESS OF DRAWING THE FIREARM.**

**(16) IN THE EVENT THAT THE FIREARM IS ACCIDENTALLY DROPPED, REPORT THIS TO THE INSTRUCTOR IMMEDIATELY, WHO WILL INSPECT THE FIREARM TO INSURE IT WILL FUNCTION. DO NOT PICK THE FIREARM UP, LET IT LIE AND NOTIFY AN INSTRUCTOR. FIREARMS THAT COME INTO CONTACT WITH THE GROUND DURING THE RUNNING OF A TACTICAL COURSE WILL BE REPORTED IMMEDIATELY TO AN INSTRUCTOR FOR INSPECTION.**

**(17) IF A CARTRIDGE FAILS TO FIRE, STOP THE ACTION AND WAIT UNTIL THAT STAGE OF FIRE IS COMPLETED, KEEPING THE MUZZLE POINTED DOWN RANGE, THEN REPORT IT TO AN INSTRUCTOR BY RAISING YOUR NON SHOOTING HAND.**

**(18) NEVER FIRE A SUCCEEDING SHOT FOLLOWING THE MALFUNCTION OF A CARTRIDGE UNTIL THE BARREL HAS BEEN EXAMINED TO DETERMINE IF A BULLET IS LODGED IN THE BARREL.**

**(19) NEVER PROCEED TO THE TARGET AREA WITHOUT THE COMMAND OF THE RANGE OFFICER. ALL FIREARMS SHALL BE PLACED IN HOLSTERS AND SECURED BEFORE LEAVING FROM THE FIRING LINE .**

**(20) HEARING AND EYE PROTECTION WHILE ON THE RANGE IS MANDATORY FOR ALL PERSONNEL .**

**(21) ANY INJURY SUSTAINED DURING FIREARMS TRAINING, REGARDLESS OF HOW MINOR THE INJURY, WILL BE REPORTED TO AN INSTRUCTOR IMMEDIATELY .**

**(22) ANYTIME ANY UNSAFE ACT IS OBSERVED WHICH ENDANGERS SOMEONE , THE OFFICER HAS THE RESPONSIBILITY TO SHOUT, "CEASE FIRE" AND IMMEDIATELY RAISE THE NON SHOOTING HAND.**

**(23) TALKING WILL BE KEPT TO A MINIMUM WHILE ON OR NEAR THE FIRING LINE. EXERCISE COURTESY WHILE OTHER OFFICERS ARE SHOOTING OR RECEIVING ADDITIONAL INSTRUCTION.**

**ALL SAFETY PRECAUTIONS MUST BE STRICTLY ADHERED TO.**

**ALWAYS USE EXTREME CAUTION TO AVOID ACCIDENTS AND INJURIES.**

**IF YOU DO NOT UNDERSTAND THE INSTRUCTIONS, RAISE YOUR NON SHOOTING HAND AND ASK THE INSTRUCTOR THE QUESTION.**

2. Qualification Course of Fire: This course of fire is designed to test the officer's ability with a handgun used in a realistic fashion. Depending upon the magazine capacity of the pistol, the officer will have to change magazines at different points in the course. It is the officer's responsibility to change magazines at whatever point it becomes necessary.

a. Fifty (50) round Pistol Qualification Course.

This qualification course requires fifty (50) rounds of fire. All shots will be directed to the center mass area of the target.

1. The officer will proceed to the twenty five (25) yard line with an unloaded and holstered pistol and three (3) magazines loaded with five (5) rounds each. Two (2) magazines will be secured in the double magazine pouch on the duty belt and one (1) magazine secured in a jacket or trouser pocket. The officer will be given the command to load the pistol. The officer will then insert one (1) magazine loaded with five rounds into the magazine well and then introduce a live round into the chamber (safe loading procedure). The officer will then holster a loaded weapon and secure all safety devices.

At the twenty five (25) yard line, ten (10) rounds will be expended with **NO TIME LIMIT**. This will be strong handed shooting utilizing the two handed standing unsupported

position. This exercise is designed to familiarize the officer with the known distance of twenty five (25) yards. Upon completion of firing, the officer will holster an unloaded and safe weapon and engage all safety devices. These shots **WILL NOT** be counted for qualification score. The line will then be made safe. The officer will then move downrange on command to assess their respective target. These shots will be marked to identify them as being fired from the twenty five (25) yard line.

The officer will then load three (3) magazines to eight (8) or fifteen (15) rounds depending on the magazine capacity of the pistol.

2. The officer will then move to the fifteen (15) yard line. The officer will have two (2) fully loaded magazines secured in the magazine pouch and one fully loaded magazine secured in a jacket or trouser pocket. On command the officer will insert one (1) fully loaded magazine into the magazine well and then introduce a live round into the chamber (safe loading procedure). The officer will then holster a loaded weapon and secure all safety devices.

At the fifteen (15) yard line fifteen (15) rounds will be expended with imposed time limits. This will be strong handed shooting utilizing the two handed standing unsupported position. On command the officer will:

a. Fire three rounds with a ten (10) second time limit. The officer will then holster a loaded weapon and secure all safety devices.

b. Fire three rounds with an eight (8) second time limit. The officer will then holster a loaded weapon and secure all safety devices.

c. Fire three rounds with a six (6) second time limit. The officer will then execute a Tactical magazine exchange, placing the replaced magazine into a weak side trouser or jacket pocket. The officer will then holster a loaded weapon and secure all safety devices.

d. Fire three rounds with a six (6) second time limit. The officer will then holster a loaded weapon and secure all safety devices.

e. Fire three rounds with a six (6) second time limit. The officer will make the weapon safe and holster an empty and safe weapon. The officer will then engage all safety devices. The officer will then reload all magazines to capacity.

3. The officer will then move to the seven (7) yard line. The officer will have two fully loaded magazines secured in the magazine pouch and one magazine secured in a jacket or trouser pocket. On command the officer will insert a fully loaded magazine into the magazine well of the pistol and then introduce a live round into the chamber (safe loading procedure). The officer will then holster a loaded weapon and engage all safety devices.

At the seven (7) yard line fifteen (15) rounds will be expended with imposed time limits from the standing two handed unsupported position. On command the officer will:

a. Fire three rounds with a nine (9) second time limit. The officer will then holster a loaded weapon and secure all safety devices.

b. Fire three rounds with a six (6) second time limit. The officer will then holster a loaded weapon and secure all safety devices

c. Fire three rounds with a four (4) second time limit. The officer will then execute a speed reload magazine exchange. The officer will then assume a low two handed gun ready position.

d. Fire three rounds with a four (4) second time limit. The officer will then assume a low two handed gun ready position.

e. Fire three rounds with a four (4) second time limit. The officer will then make the pistol safe and holster and engage all safety devices. On command the officer will then retrieve any item on the ground that is needed. The officer will then reload two magazines with five (5) rounds each. Two loaded magazines will then be secured into the magazine pouch and one magazine secured into a jacket or trouser pocket.

4. The officer will then move to the five (5) yard line. The officer will have two (2) loaded magazines secured in the magazine pouch and one (1) empty magazine secured in a jacket or trouser pocket. On command the officer will then insert a loaded magazine into the magazine well of the pistol and then introduce a live round into the chamber (safe loading procedure). The officer will then holster a loaded weapon and secure all safety devices.

At the five (5) yard line, ten (10) rounds will be expended with a fifteen (15) second time limit. All firing will be from the standing one handed only firing position. On command the officer will:

a. Draw and fire five (5) rounds with the strong hand only. Execute a speed reload. Transfer the pistol to the weak hand only and :

b. Fire five (5) rounds with the weak hand only. The officer will then make the pistol safe and holster. The officer will then engage all safety devices. On command the officer will retrieve all items from the ground that they may need.

5. The target that will be utilized over this course of fire will be the FBI Q target. Scoring will be counted at 2.5 points per hit inside the Q outline and all hits outside the Q outline will be counted as a miss or minus 2.5 points. All hits on the outline border will be counted as a miss or minus 2.5 points. Total possible score is one hundred (100) points.

(1) At the twenty five (25) yard line, ten (10) rounds will be expended with **NO TIME LIMIT**. This will be strong hand shooting only from the standing two handed position. This exercise is designed to familiarize the officer with the known distance of 25 yards. These shots will not be counted for qualification score.

(2) At the fifteen (15) yard line, fifteen (15) rounds will be expended with imposed time limits from a two handed standing unsupported position.

- (a) Three (3) rounds fired with a ten (10) second time limit.
- (b) Three (3) rounds fired with an eight (8) second limit.
- (c) Three rounds fired with a six (6) second limit. Tactical magazine exchange.
- (d) Three (3) rounds fired with a six (6) second limit.
- (e) Three (3) rounds fired with a six (6) second limit.

(3) At the seven (7) yard line fifteen (15) rounds will be expended with imposed time limits from the two handed standing unsupported position.

- (a) Three (3) rounds fired with a nine (9) second time limit.
- (b) Three (3) rounds fired with an six (6) second time limit.
- (c) Three (3) rounds fired with a four (4) second time limit. Speed reload of magazine exchange.
- (d) Three (3) rounds fired with a four (4) second time limit.
- (e) Three (3) rounds fired with a four (4) second time limit.

(4) At the five (5) yard line ten (10) rounds will be expended with a fifteen (15) second time limit

- (a) five (5) rounds strong hand only
- (b) five (5) rounds weak hand only

(5) The target that will be utilized over this course of fire will be the FBI Q target. Scoring will be counted at 2.5 points per hit inside the Q outline and all hits outside the Q outline will be counted as a miss or minus 2.5 points. Total possible score is 100 points.

3. The officer must score a minimum of 80% to successfully pass the Pistol Qualification Course. If the officer fails to achieve this standard, additional remedial training will be required to correct the deficiencies and a date and time will be scheduled for requalification. If the officer fails a second time, the officer will not be certified and the matter will be referred to the Chief of Police and Security Services for further action.

## PART VII

## CARE AND MAINTENANCE

## 1. Maintenance.

a. Your weapon will require to be maintained on a monthly basis. The officer should field strip the assigned firearm a minimum of once every thirty days. The officer should not attempt to disassemble the firearm beyond this point. The office should inspect the field stripped firearm for lubrication, damage, and cleanliness. All damage should be reported to an instructor or designated armorer for repairs.

b. The weapon will be cleaned by field stripping the firearm down to basic components. The barrel bore and chamber will be cleaned by brushing these areas with a good powder removing solvent and bore brush. This is accomplished by cleaning from the firing chamber towards the muzzle. Wipe the areas clean with patches or a swab. Using a small brush dipped in solvent, remove all deposits from around the breech of the barrel, firing chamber, extractor, and residue on the frame with a light brushing and solvent. After cleaning the entire firearm use a cloth to apply a light coating of high quality gun oil to all external surfaces and wipe clean. Re-lubricate the slide rails and lubrication points on the receiver of the pistol. After the initial cleaning, there is usually some residue in the barrel that works out and becomes apparent within 24 - 48 hours. This may be removed with a bristle brush and a light reapplication of powder removing solvent after which the oil film should be re-established on all surfaces.

## 2. Field Stripping.

## a. Disassembly.

(1) Remove the magazine by depressing the magazine release button and inspect and clear the firing chamber. Allow the slide to travel forward. Place the magazine into a pocket.

(2) Place the grip of the firearm into the strong hand.

(3) Take the weak hand with the palm pointed down and place the weak hand on top of the slide. Place the index finger on the right side of the receiver frame onto the take down button.

(4) With the weak hand index finger depress the take down button holding pressure on the button.

(5) With the thumb on the left side of the lower receiver, slowly rotate the take down lever to the down position.

(6) The upper slide assembly and barrel should then move forward on the slide rails.

- (7) With the weak hand, slowly pull the slide assembly forward and off of the frame.
- (8) The firearm is now in two pieces, the lower receiver and slide assembly.
- (9) Pick up the slide assembly with the weak hand with the front sight pointed down and place the slide assembly into the palm of the weak hand.
- (10) You will observe a coil spring assembly with a metal rod that is inserted into an assembly facing you.
- (11) Capture the tension on the spring assembly by pressing forward on the base of the guide rod pin. Maintain pressure on this assembly or the guide rod may be ejected and cause injury. Lift out this assembly and set aside.
- (12) With the slide assembly still in the palm of the weak hand, apply light forward pressure directly on the barrel assembly at the firing chamber. The barrel will tilt forward slightly and then move forward. Lift on the rear of the barrel assembly and remove from the slide assembly. The firearm is now field stripped.
- (13) The officer should have four components: Lower receiver, slide assembly, barrel, and the guide rod and coil spring.

**NO FURTHER DISASSEMBLY IS RECOMMENDED.**

**b. Reassembly:**

- (1) Place the slide in the palm of the weak hand with the rear of the slide facing your body. The front sight is pointed toward the floor.
- (2) Replace the barrel assembly into the slide assembly. Make sure the barrel is seated properly.
- (3) Insert the guide rod into the coil spring housing.
- (4) Insert the coil spring and guide rod into the spring guide assembly.
- (5) Hold pressure against the base of the guide rod and push it forward enough to engage the small radial machine cut in the barrel lug. Be careful that it does not become disengaged, fly out and cause injury.
- (6) Pick up the lower receiver with the strong hand and rotate the frame where the magazine well is pointed up.
- (7) Align the slide rails with the slide assembly rail slots at the rear of the slide.

(8) Move the rear of the slide onto the front slide rails and continue to move the slide towards the rear of the receiver.

(9) As the slide moves past the take down assembly you will hear an audible click.

(10) Depress the take down assembly button and rotate the take down lever to the up position.

(11) Check on reassembly by working the slide several times and then lock the slide to the rear.

(12) Reload and holster the firearm, securing all security devices.

## PART VIII

**SHOOTING REVIEW TEAM PROCEDURES****1. Background:**

a. An administrative review will be conducted by the Office of Security and Law Enforcement (OSLE) of incidents involving firearm discharges at or by V A police (not including training).

b. The issues addressed during the shooting incident review relate to those facts which may have directly or indirectly contributed to the shooting incident. The issued handgun will be collected into evidence in the event the action resulted in a fatality or serious physical injury. The involved officer will be immediately issued a service pistol upon collection of the firearm into evidence.

**2. Response:**

a. Upon notification of a shooting incident, the Office of Security and Law Enforcement (OSLE) will activate a shooting incident review team composed of those appointed to conduct a thorough administrative review of the matter.

b. If matters relating to possible police officer misconduct surface, the OSLE will be notified of the circumstances immediately.

3. **Investigation:** The shooting incident review will include but will not be limited to the determination of the facts and circumstances related to the incident. At the conclusion of the review, the members of the shooting incident review team will confer with the Office of Security and Law Enforcement (OSLE) to report their findings, conclusions, and recommendations.

4. **Report:** The shooting incident review team will report the facts and circumstances of the review in writing to the DAS as soon as the investigation is completed. This does not preclude the requirement for immediate reporting of the incident and periodic updates. Each of the following areas will be addressed:

a. A synopsis of the case and circumstances which existed prior to the incident.

b. Synopsis of events of the incident, specifically addressing the following areas:

(1) Identification, assignment, and positions of all persons present during the incident, to include personnel, other law enforcement personnel, witnesses, and suspects.

(2) Suspect identification, to include name, date of birth, home address, criminal record, reputation, pending criminal charges, and arrest status.

(3) Description and identification of all involved firearm(s) and expended ammunition and identity of possessor at the time of the incident.

(4) Description of verbal warnings given to the suspect.

(5) A chronology of the first and successive rounds.

(6) Identification and date of involved officer's current firearms qualification.

(7) The basis for the decision that the use of deadly force was required.

(8) Identification of all injured persons, to include cause and extent of injuries, and medical treatment.

(9) Identification of all property damage, to include cause, value of damage, and responsible party.

(10) The date and time of notification to the OS&LE.

c. Any unique factors contributing to the incident (e.g. weather, equipment, communications, misinformation, tactics).

d. Recommendations as to:

(1) Procedural or policy changes as outlined in V A orders or memoranda.

(2) Training requirements.

(3) Safety issues.

e. Attachments to the report:

(1) Copies of all statements and reports of interview.

(2) Copies of all official reports from investigating agencies.

(3) A schematic of the shooting scene, depicting the distances of all shooting participants from the suspect(s).

(4) Photographs, as required.

5. Administration:

a. Upon review of the shooting incident written report, the OS&LE may mandate an additional investigation. The OS&LE may also establish a committee to further study the

incident and/or make additional inquiry or action based on the recommendations of the shooting incident review team.

b. Upon acceptance of the written report, the OS&LE will provide a copy of the report, to the affected Chief, Police & Security Service.

## PART IX

**POST SHOOTING PROCEDURES**

1. **Reporting Requirements (Firearm Discharge).** The discharge of any firearm, (except in training ) either intentional or accidental by a V A police officer in conjunction with V A law enforcement activities requires reporting as follows:

a. **Involved Police Officer.** The officer will immediately report the incident to their supervisor. Such supervisor shall immediately report the facts and circumstances of the shooting incident to the Chief, Police & Security Service.

b. Chief, Police & Security Service shall immediately report the facts and circumstances of the shooting incident to the Office of Security and Law Enforcement Inspector assigned to their region, and to the V A Law Enforcement Training Center (LETC) , North Little Rock , AR. As soon as practicable, the Chief shall transmit a written report of the incident to the Office of Security and Law Enforcement and to the V A LETC in North Little Rock, AR.

2. **Responsibilities (Post - Shooting Incident).** It is the responsibility of all Police and Security Service employees to show sound judgment during and after an incident in which a firearm was discharged. The following information is transmitted to ensure appropriate reaction and follow up to a shooting incident.

a. Determine the physical condition of any injured person and render first aid where appropriate. Request emergency medical aid, as appropriate, and notify local law enforcement authorities of the incident and location.

b. Liaison with other agencies with investigative jurisdiction in the incident should be quickly established to prevent duplication of effort and conflict of jurisdiction. It is V A police officer's duty and responsibility to cooperate with any lead investigative agency, making witnesses and evidence available.

c. Should the involved officer's firearm be secured for evidentiary purposes or ballistics examination, another weapon will be issued to the officer, unless there is cause to the contrary.

d. A VA police officer involved in a shooting incident should be encouraged to contact their spouse or family as soon as possible. If the officer has been injured, and so requests, the officer's family will be contacted in person by a designated officer. In the case of seriously injured officer, notification of the family should be done immediately and in person. The officers on duty will also be notified of the injured officer's condition, in order to provide an accurate response to family members seeking information. It is important that family notification occur before press and or media accounts appear.

e. The scene of the shooting incident should be processed for evidentiary purposes. Evidence from the scene should include:

- (1) A diagram showing the location of each officer and the location where each shot was fired.
- (2) Photographs showing the involved officer's field of view at the time of the firearm discharge.
- (3) Photographs showing the location of any shooting victim(s).
- (4) Evidence gathered, including blood, spent cartridges, weapons, and fingerprints.
- (5) All involved firearms should be examined for ballistic comparison with any recovered bullets. An inventory should be maintained pertaining to the firearms' possessor, firearm description, type of ammunition, and number of spent rounds.
- (6) The general area of the scene canvassed for witnesses. Witnesses to the shooting incident should be encouraged to submit written statements.
- (7) Copies of reports from all involved law enforcement or emergency department personnel.
- (8) Copies of all telecommunications tapes pertaining to the initial call to emergency personnel, etc., if any.
- (9) Copies of all hospital, autopsy, laboratory, and photographic records.

3. Post - Shooting Reactions:

a. There is a wide variation of reactions to shooting incidents. Research indicates that the majority of law enforcement officers involved in shootings experience moderate to severe trauma reactions.

b. Officers either directly or indirectly involved in a shooting incident are referred to the V A Employee Counseling Service.

**REFERENCES**

\_\_\_\_\_. Combat Training with Pistols and Revolvers. FM 23 -35. Headquarters, Department of the Army. Washington, DC 1988

\_\_\_\_\_. FBI Double Action Pistol Course. Federal Bureau of Investigation, U.S. Department of Justice, Quantico, VA

\_\_\_\_\_. Safety Instruction & Parts Manual For Centerfire Pistols Double Action Only, Beretta U. S. A. , 17601 Beretta Drive, Accokeek, MD 20607

**FACILITY IMPLEMENTATION PLAN**

1. The purpose of this Facility Implementation Plan is to describe authorized and prohibited uses of the issued firearm by V A police officers. All V A police officers will adhere to firearms procedures and guidelines outlined by the Office of Security and Law Enforcement.
2. Since the decision has been made to arm selected V A Police personnel with a semiautomatic firearm, it has been determined that a double action only system will be utilized. The authorized semiautomatic pistol must be 9mm Luger caliber, with double action trigger mechanism only. The frame will consist of a light alloy with steel slide. The safety features must include a magazine disconnect, firing pin safety devices, and trigger weight of nine to eleven pounds set at the factory. **NO MODIFICATIONS OR ALTERATIONS ARE ALLOWED**, such as "trigger shoes, extended slide stops, extended magazine release, no after market extended magazines, or grip adapters." The sights will consist of front and rear Trijicon night sights.
3. The holster authorized by the Office of Security and Law Enforcement must be equipped with a minimum of three safety features. The holster will be equipped with a thumb break release, an internal safety feature, and a tension release. The holster must be black in color and constructed of high quality material. All personnel will be issued dual magazine carriers equipped with Velcro closure and four (4) belt keepers of matching material. Holster familiarization will consist of 200 draws in the presence of a firearms instructor.
4. Issued duty ammunition will be 9mm Luger caliber, 124 grain, brass jacketed hollow point, **NO SUBSTITUTIONS ARE ALLOWED**. Training ammunition will be 9mm Luger caliber full metal case 124 grain. All qualification courses will be fired with issued duty ammunition. Issued duty ammunition will be expended every six (6) months during range qualification and new duty ammunition will be issued.
5. A Pistol Qualification Course conducted on a semiannual (6 month) basis will consist of 50 rounds of duty ammunition. The course of fire is designed to test the officer's proficiency with the issued pistol. A minimum score of 80% is required to successfully pass the Pistol Qualification Course. Additional remedial training will be given within 30 days to officers failing to achieve this standard and a date and time will be scheduled for retesting. Officers failing a second attempt will not be certified and the matter will be referred to the Chief, Police and Security Services for further action.
6. Officers will be armed only while performing official duties and activities. Armed assignments will include vehicle, foot, bicycle and K - 9 patrol and while stationed at magnetometers and other fixed posts.
7. The firearm will not be worn off V A property except when the officer is transporting prisoner(s), while in route to another V A facility or in the performance of any official capacity designated by the Chief, Police and Security Service.

8. Only those officers who have successfully completed their physical examinations within the past 12 months and have newly completed psychological assessments will be armed. Questions which are designed to determine an officer's suitability to be issued a firearm, will be included in the psychological assessment interview. Armed officers must maintain current physical examinations and psychological assessments.

9. A police officer's authority to carry a firearm will be suspended by the Office of Security and Law Enforcement at any time evidence is received or developed which would cause a reasonable person to conclude that this authority should be revoked. The officer's authority to carry the firearm will remain suspended until the matter has been promptly and thoroughly investigated by the facility and / or the Office of Security and Law Enforcement and successfully adjudicated.

**CHECK LIST**

1. **STORAGE:** Each facility will be required to provide an approved storage area for firearms and related equipment.

**ALL FIREARMS WILL BE SECURED IN A LOCKED FIREPROOF SAFE / VAULT WHEN NOT ISSUED FOR DUTY USE.** The Chief, Police and Security Services will determine the appropriate location for this area.

**ITEMS TO BE MAINTAINED IN THE SAFE / VAULT:**

- A. All firearms for duty issue
- B. All pistol magazines
- C. Pistol storage rack(s)
- D. All duty and training ammunition
- E. Weapons Log
- F. Dehumidifying material or device
- G. Magazine storage box

Cleaning equipment may also be stored in appropriate containers in the safe / vault. These items may be stored in a separate container and may include the following items:

- a. Commercial cleaning solvent in a sealed container
- b. Commercial lubricating oil or synthetic lubricant
- c. Cleaning rods - appropriate size and lengths
- d. Cleaning patches
- e. Appropriate size cleaning bore mops
- f. Appropriate size cleaning bronze or steel bore brushes
- g. Medium size common screwdriver
- h. Toothbrush style wire brush

**2. ISSUANCE / RETURN OF ISSUED DUTY FIREARMS AND AMMUNITION:**

Officers may only carry the Agency issued firearm and approved issued ammunition. Firearms will be issued only by a designated officer by the Chief, Police and Security Services. Each officer would be issued their assigned firearm, magazines, and appropriate ammunition at the beginning of each tour of duty. It would be the Officer's responsibility to examine the firearm serial number to ensure that they have received the properly assigned weapon. The officer then would initial off on a daily weapons log. At the completion of the Officer's tour of duty, the officer would return to the issue point and return the firearm, magazines, and appropriate ammunition. The officer would then complete the daily weapons log. The firearm, magazines, and appropriate ammunition would then be placed into storage.

**3. CLEANING AREA:**

The Chief, Police and Security Service would designate a cleaning area location for maintaining proper maintenance of firearms. This area would be well ventilated and well lighted. This would be a **NO SMOKING AREA**. A small table may be appropriate in this area.

**4. TRAINING PLANS:**

All firearms training plans must be reviewed and approved prior to any implementation or any modifications of existing firearms training plans by the Officer of Security and Law Enforcement.

**5. ARMORER'S REPORTS.**

Agency issued firearms will be kept in a clean and serviceable condition. Issue firearms will be subject to inspection without notice by the Chief, Police and Security Service, firearms instructor or armorer. All agency issued firearms must be annually inspected and detailed cleaned by a designated certified armorer. This inspection is independent of the normal field stripping maintenance that the manufacturer may suggest. It will be the armorer's responsibility to maintain detailed records on each firearm that is issued for duty use. Officers will not make any modifications, repairs, or adjustments to Agency issued firearms. Agency armorers will make any repairs or adjustments they are qualified to make. Other repairs will be referred to a manufacturer authorized repair center.

**6. MALFUNCTION REPORTS.**

It will be the responsibility of the designated firearms instructor or armorer to maintain detailed records on agency issued firearms in the event an officer experiences a misfire, malfunction or sustains damage to any agency issued firearm. The effected officer will notify the designated armorer as soon as possible once the problem is diagnosed. The firearm instructor or armorer will submit a written report to the Chief, Police and Security Service as soon as possible.

**7. PROFICIENCY REPORTS:**

All officers will maintain proficiency in the use of the issued firearms in accordance with the training standards of the Office of Security and Law Enforcement. Records will be maintained by the designated firearms instructor or armorer. All officers failing to meet the minimum proficiency level will undergo remedial training. If after remedial training, the officer is unable to meet the Agency's minimum proficiency level, the firearms instructor will notify the Chief, Police and Security Service in writing. The effected officer will be prohibited from carrying the issued firearm until such time as the officer is able to qualify with the firearm.

#### **8. INSPECTION OF DUTY GEAR AND ISSUED WEAPONS:**

The Chief, Police and Security Services or a designated representative may inspect the issued duty belt, related equipment, and firearm without notice. Any item found to be unsafe, unserviceable, worn, or broken will be replaced as soon as possible. All unauthorized equipment is prohibited and the officer will be subject to disciplinary action.

#### **9. LOADING AND UNLOADING PROCEDURE AREAS:**

The Chief, Police and Security Services will designate an area for officers to load and unload firearms. It is recommended that this area will be out of public or hospital staff view. This area will be equipped with a large metal container (fifty five gallon drum) filled at least three quarters full of loose sand type material. The metal container will be mounted on a frame that maintains an approximate forty five degree angle. The container will have an approximate four inch by four inch opening at one end to place the muzzle into the opening. There must be a minimum of twelve inches of thickness of the sand type material inside the container.

The officer will receive the issued firearm with the slide locked to the rear and the magazine out. The officer will visually inspect all the issued magazines for damage and if the magazines are loaded to capacity. The officer will then proceed to the loading / unloading area maintaining the strong index finger outside of the trigger guard and off the trigger. The officer will then place the muzzle into the opening on the barrel, insert a loaded magazine into the magazine well, check to make sure the magazine is seated and locked into place. The officer will then activate the slide stop, allowing the slide to travel forward chambering a live cartridge. The officer will then holster and secure the firearm and all holster securing devices. The firearm is now considered to be loaded and ready for duty use. The officer would then complete the weapons log.

The officer will return the issued firearm to the issuing officer or designated person by the Chief, Police and Security Services at the completion of their tour of duty. The officer will proceed to the loading / unloading area. The officer will then remove the magazine from the firearm while it is still secured in the holster. The officer will utilize the strong hand thumb, placing the thumb between the duty belt and lower frame of the firearm. The officer will then activate the magazine release. The officer will then extract the magazine from the firearm utilizing the strong hand. The officer will then place the extracted magazine from the firearm into a trouser or coat pocket. The officer will then extract the firearm from the holster, maintaining the strong index finger outside of the trigger guard and off the trigger, place the muzzle of the firearm into the barrel opening, then pull the slide to the rear, extracting the live cartridge from the firing chamber. The officer should not attempt to catch the extracted cartridge from the firing chamber but allow it to fall freely. The officer should then retract the slide a minimum of three times, lock the slide back to the rear and then make a visual inspection to insure no live cartridges are in the firing chamber. The officer should receive the firearm with the slide locked back to the rear with an empty magazine well. The officer would then return all issued magazines and ammunition and complete the weapons log.

**10. ARMED RESPONSE TO LOCKED WARDS:**

If the situation dictates the officer to respond to a locked ward, certain considerations must be undertaken. The officer will be required to disarm the firearm prior to entering any locked ward. The officer will remove the magazine and live cartridges from the issued weapon. This is accomplished by placing the strong hand thumb between the duty belt and lower frame of the firearm. The officer then activates the magazine release. The officer will then remove the magazine from the magazine well with the strong hand. The extracted magazine is then placed into a trouser or jacket pocket. The officer will then inspect and insure that all holster safety features are engaged and secured. The firearm is not removed from the holster during this entire process. The live cartridge in the firing chamber is incapable of being fired while the magazine is out of the magazine well.

**11. UNINTENTIONAL AND ACCIDENTAL DISCHARGES:**

In the event that the officer experiences any unintentional or accidental discharge of a firearm resulting in property damage, serious physical injury or death of an individual, the effected officer will immediately notify their immediate supervisor. The supervisor will then notify the Director of the facility and notify the Office of Security and Law Enforcement. The Chief, Police and Security Services will also initiate an investigation into the mitigating circumstances surrounding this event. Copies of this investigative report will be faxed to the Office of Security and Law Enforcement and a courtesy copy faxed to the Law Enforcement Training Center as soon as feasible.

**12. INTENTIONAL DISCHARGING OF FIREARM / OFFICER INVOLVED SHOOTING:**

In the event that the officer experiences any intentional discharge of a firearm resulting in the serious physical injury or death of an individual, the effected officer will immediately notify their immediate supervisor. The supervisor will then notify the Chief, Police and Security Services. The Chief, Police and Security Services will notify the Director of the facility and notify the Office of Security and Law Enforcement and other appropriate Law Enforcement agencies. The Chief, Police and Security Services will initiate an investigation into the mitigating circumstances surrounding this event. Copies of this investigative file will be faxed to the Office of Security and Law Enforcement and a courtesy copy faxed to the Law Enforcement Training Center as soon as feasible.

The responding Officer to an Officer Involved Shooting will:

- a. Stabilize and secure the scene.
- b. Check on the well being of the officer and people located at the scene.
- c. Call for medical assistance as needed.
- d. Notify the on duty Supervisors and request adequate assistance.

The responding Supervisor will:

- a. Insure that the Chief, Police and Security Services is notified.
- b. Insure that the Director of the facility is notified.
- c. Insure that the appropriate outside Law Enforcement agencies are notified.
- d. Insure that the Crime Scene is secured and protected.
- e. Secure the Officer's firearm by taking custody as expeditiously as possible.

1. **THIS WILL NOT BE DONE IN PUBLIC VIEW**

2. The firearm will be handled as evidence.
3. The officer will be issued another firearm as soon as practical.

The involved Officer will be removed from the scene as soon as practical:

- a. **The officer will leave the scene in the FRONT seat of a Police unit.**
- b. The officer should not be left alone, another officer or a person of the officer's choosing should stay with them until the officer is home with a family member or friend.

The Chief, Police and Security Services will insure that the investigation of the event will be completed in a timely fashion and keep the Director of the Facility and the Office of Security and Law Enforcement abreast of the on going investigation.

The officer that is involved in the shooting incident must realize that they are subject to the same investigative procedures as would apply to any other criminal investigation, including the application of the Miranda Warnings.

The responding officers and supervisors arriving at a shooting scene should determine from the involved officer that a shooting incident took place, if the officer is injured, and if there are any other persons involved in the incident. Descriptions or the identity of other persons involved should be obtained. The on site supervisor will ensure that the involved officer is not questioned about the incident until a supervisor of the investigations division arrives and assumes control of the investigation.

Investigators will conduct the investigation in a fair and impartial manner, as in any other criminal investigation. The involved officer will be informed of the Miranda Warnings and asked to assist investigators in reconstructing the incident.

DEPARTMENT OF VETERAN'S AFFAIRS POLICE DEPARTMENT  
FIREARMS ARMORER'S REPORT  
REPORT # \_\_\_\_\_

DATE: \_\_\_\_\_

WEAPON: \_\_\_\_\_

SERIAL NUMBER: \_\_\_\_\_

V.A.P.D. NUMBER: \_\_\_\_\_

\_\_\_\_\_ DETAIL CLEANING ( ANNUAL)

\_\_\_\_\_ MALFUNCTION TYPE \_\_\_\_\_

\_\_\_\_\_ INSPECTION

\_\_\_\_\_ DAMAGE

DESCRIBE TYPE OF MALFUNCTION / DAMAGE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DESCRIBE REPAIR ACTION TAKEN OR CLEANING RESULTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INSPECTION RESULTS:

- \_\_\_\_\_ WEAPON CLEAN (OPERATOR MAINTENANCE SATISFACTORY)
- \_\_\_\_\_ WEAPON DIRTY (OPERATOR MAINTENANCE UNACCEPTABLE)
- \_\_\_\_\_ MECHANICAL DEFECTS OR ABNORMAL WEAR NOTED
- \_\_\_\_\_ NO MECHANICAL DEFECTS OR ABNORMAL WEAR NOTED

DATE RETURNED TO OFFICER: \_\_\_\_\_

FIREARMS INSTRUCTOR / ARMORER: \_\_\_\_\_

ATTACHMENT TO QUESTION #8  
Campbell Letter

U.S. Department of Justice



Federal Bureau of Investigation

In Reply, Please Refer to  
File No.FBI Academy  
Quantico, Virginia 22135

April 29, 1996

Mr. Ronald R. Angel, Director  
 VA Law Enforcement Training Center (OTA/NLR)  
 2200 Fort Roots Drive  
 North Little Rock, Arkansas 72114

RE: Department of Veterans Affairs' (VA) letter,  
 dated February 28, 1996, to  
 Section Chief John H. Campbell  
 FBI Academy, Quantico, Virginia,  
 and subsequent meeting with Director Ron Angel,  
 VA Law Enforcement Training Center

Dear Director Angel:

As reflected in discussions regarding the request to review the VA Police Officer Basis Training Course, the FBI Academy is not specifically or directly involved in basic law enforcement training. However, a review was conducted of the recommended training program to determine relevancy as a course for preparation of basic VA police. This course of training was compared to similar curriculum design not only for the Basic Officers Training provided at the Federal Law Enforcement Training Center in Glynco, Georgia, but that provided by several state academies. The proposed 160-hour course appears to be consistent with the standards established by the aforementioned training courses. The curriculum design is appropriate and the reference materials, both books and documents, are consistent with those reference materials utilized in Basic Officers Training.

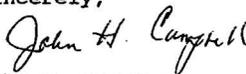
It is further noted that the Criminal Justice Department at the University of Arkansas at Little Rock has also reviewed and recognized this basic training course and provided college accreditation for its successful completion.

This review was conducted within the parameters and scope requested by you, and, in conclusion, the Basic Training Course for VA police officers appears to be relevant and

Mr. Ronald R. Angel

consistent with basic law enforcement training; however, the FBI Academy at Quantico, Virginia, does not certify nor accredit the basic law enforcement training course. The FBI is pleased to assist the VA in this matter. If further assistance is deemed necessary, please contact me at 703-640-1103.

Sincerely,

A handwritten signature in cursive script that reads "John H. Campbell".

John H. Campbell  
Section Chief

ATTACHMENT TO QUESTION #8  
Jackson Letter

U.S. Department of Justice

Federal Bureau of Investigation



In Reply, Please Refer to  
File No. 0271-26 Sub A

FBI Academy  
Quantico, Virginia 22135

June 11, 1996

Mr. Scott Charny  
Acting Chief, General Litigation  
and Legal Advice Section  
Criminal Division  
U.S. Department of Justice  
10th and Constitution Avenue, Northwest  
Washington, D.C. 20530

Dear Mr. Charny:

The purpose of this letter is to bring closure to an issue that has delayed the implementation of a Department of Veterans Affairs (DVA) firearms training program which requires approval by the Department of Justice (DOJ).

The FBI Academy was asked to review a curriculum proposed by the DVA which would allow that agency to have an autonomous firearms training program. This proposal had the full support of the Secretary of the DVA but required the imprimatur of the DOJ.

- 1 - Mr. Jeff Fogle  
Department of Justice  
10th and Constitution Avenue, Northwest  
Washington, D.C. 20530
- 1 - Mr. Harold Gracey  
Chief of Staff (OOA)  
Department of Veterans Affairs  
810 Vermont Avenue, Northwest  
Washington, D.C. 20420
- 1 - Mr. William Harper  
Director, Police and Security Services  
Department of Veterans Affairs  
810 Vermont Avenue, Northwest  
Washington, D.C. 20420

Letter to Mr. Scott Charny

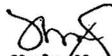
I was initially contacted by Mr. Jeff Fogel of your staff who asked for my opinion of the adequacy of the DVA proposal. I expressed to Mr. Fogel that, based upon information that was available at the time, the FBI could not and would not comment upon or endorse the DVA proposal. Since that time, however, the DVA has provided both me and FBI Academy Academic Section Chief John Campbell, Phd., with voluminous information about their proposed training program, including specific course content, lesson plans, courses of fire, and qualification requirements. It was both my opinion and that of Dr. Campbell that the proposal was (1) adequate for its intended purpose and (2) consistent with similar programs in the federal law enforcement community. This opinion was formally expressed to Mr. Ron Angel, Director of DVA Training Operations, and Mr. William Harper, Director of DVA Police and Security Services who subsequently provided the information to Mr. Fogel.

Mr. Fogel reportedly requested additional information regarding the comparability of the DVA firearms (as opposed to purely academic) program to similar programs taught at the Federal Law Enforcement Training Center (FLETC), Glynco, Georgia, before approving the DVA training proposal.

I recently visited FLETC and personally discussed the DVA proposal with FLETC's Chief Firearms Instructor, an individual tasked with oversight of the firearms training programs of FLETC's 76 tenant agencies. Based upon this conversation, I can unequivocally state that the course content and qualification requirements of the DVA proposal exceed or are equivalent to the generic training offered by the FLETC staff and the firearms related training programs of most federal agencies, with the exception of the Federal Bureau of Investigation and the Drug Enforcement Administration.

I hope this will satisfy the DOJ's requirements for approval of the DVA proposal. If I can be of further assistance, please contact me @ (703) 640-1185 or by fax @ (703) 640-1498.

Sincerely Yours,



Wade M. Jackson, Jr.  
Unit Chief  
Firearms Training Unit

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

VHA HANDBOOK 1108.2  
(Date)  
Transmittal Sheet

**INSPECTION OF CONTROLLED SUBSTANCES**

1. **REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook provides procedures for implementing a Controlled Substance Inspection Program.
2. **SUMMARY OF MAJOR CHANGES:** This VHA Handbook incorporates requirements regarding the implementation of a Controlled Substance Inspection Program, and the responsibilities thereto.
3. **RELATED DIRECTIVE:** None.
4. **RESPONSIBLE OFFICE:** The Chief Consultant, Pharmacy Benefits Management Strategic Health Group (119) is responsible for the contents of this Handbook.
5. **RESCISSIONS:** This VHA Handbook rescinds VHA Manual M-2, Part I, Chapter 2.
6. **RECERTIFICATION:** The document is scheduled for recertification on/or before the last working day of (month) 2002.

Kenneth W. Kizer, M.D., M.P.H.  
Under Secretary for Health

Distribution: RPC: 1490 is assigned.  
FD

Printing Date: /97

(Date)

VHA HANDBOOK 1108.2

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**INSPECTION OF CONTROLLED SUBSTANCES**

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(Date)

VHA HANDBOOK 1108.2

**INSPECTION OF CONTROLLED SUBSTANCES****1. PURPOSE**

It is Department of Veterans Affairs (VA) policy that a Controlled Substance Inspection Program be implemented at all VA medical facilities and clinics. This Handbook provides the direction to implement this policy.

**2. DEFINITION AND AUTHORITY**

Controlled substances subject to inspection consist of drugs and other substances by whatever official name, common, or usual name, chemical name, or brand name designated, that are listed in Title 21 Code of Federal Regulations (CFR) Schedule II 1308.12, Schedules III 1308.13, Schedule IV 1308.14, and Schedule V 1308.15

**3. SCOPE**

Areas to be inspected are pharmacy, wards, clinics, laboratories, and all other areas having Schedule II to V controlled substances.

**4. RESPONSIBILITIES OF MEDICAL FACILITY DIRECTOR**

Directors of VA medical facilities, domiciliaries, outpatient clinics, and regional offices with outpatient clinics are responsible for establishing an adequate and comprehensive system for controlled substances to ensure safety and control of stocks.

a. The Directors of VA medical facilities, domiciliaries, outpatient clinics, and regional offices with outpatient clinics are to establish a local written medical facility policy on the use and inspection of controlled substances. There will be a monthly unannounced controlled substance inspection. The inspections will randomly survey all wards and storage areas to ensure the element of surprise. The Inspectors will physically count and certify the accuracy of controlled substances at each site inspected. No inspector will inspect the same area 2 months consecutively

b. The Director at each facility is responsible for reacquainting the staff with all current VA directives, including those relating to physical security. The facility Director, or designee, must maintain written records of all inspections. The Director, or designee, is to trend inspection results to identify potential problem areas for improvement.

c. The facility Director must ensure that a program for orientation and training of inspecting officials is established and followed. Each medical facility must maintain documentation on all orientation and training provided.

d. The facility Director appoints, in writing, one or more disinterested person(s) (who will not be pharmacists, nurses, physicians, or supply officials), as controlled substance inspectors.

e. The medical facility Director appoints an adequate number of inspectors to meet the needs of the facility. There is to be a rotation of inspectors to ensure that no single inspector will conduct more than six monthly inspections in a 12 month period. A portion of the inspectors rotates out of the inspection team each year.

#### **5. RESPONSIBILITIES OF CHIEF, PHARMACY SERVICE**

a. The Chief, Pharmacy Service, or designee, will submit monthly to the appointed responsible inspecting official(s), a complete list by wards and clinics of the serial and sheet number of VA Form 10-2638, Controlled Substance Administration Record. This list will provide all serial numbers that are available on the Nursing Units and storage areas to be inspected. The inspecting official uses this list in the monthly check of wards' and clinics' controlled substance stocks and records to confirm that all records and stocks are available for inspection. The inspecting official will have access to the inactive VA Form 10-2638, or electronic equivalent returned to the pharmacy since the last inspection. Facilities utilizing automatic replenishment will provide records for controlled substances as requested. The records used in monthly inspection may be part of the Decentralized Hospital Computer Program (DHCP) system or automated controlled access dispensing equipment.

b. The Chief, Pharmacy Service, and Chief, Acquisition and Materiel Management (A&MM) Service, will keep current copies of 21 CFR, Part 1300 to end in their office and in the master controlled substance storage location.

#### **6. RESPONSIBILITIES OF THE INSPECTING OFFICIAL**

The inspecting official certifies by memorandum to the facility Director, the accuracy of the records and inventory of the controlled substances that have been inspected. Wards and clinics will be specified. The lists used by the inspecting officials in conducting the inspection are to be returned promptly to the pharmacy.

#### **7. PHYSICAL INVENTORY OF PHARMACY**

The Chief, Pharmacy Service, or designee, is present during the monthly inventory and inspection. The physical inventory and inspection includes all stock of Schedule II to V controlled substances, outdated stock, and records (VA Forms 10-2320, Schedule II, Schedule III Narcotics and Alcohol Register, 10-2638, 10-2477 F, Security Prescription Form, and electronic equivalents).

a. The inspecting official(s) certifies the accuracy of the records by dating and signing VA Form 10-2320, or electronic equivalent for each drug or preparation at the time of inspection after completing the following actions:

(1) The inspector physically counts and reconciles each controlled substance for accuracy and completeness. The inspector weighs all unsealed powders and measure all liquids with a

**(Date)****VHA HANDBOOK 1108.2**

volumetric cylinder. *NOTE: The inspecting official should not open any sealed packages of controlled substance for actual count unless there appears to be evidence of tampering.*

(2) The inspecting official reviews receiving reports by comparing entries on the voucher copies furnished to them by A&MM Service, or Prime Vendor Receiving reports, against all entries of quantities received on VA Form 10-2320 in the pharmacy. The calculations (quantity received plus previous balance minus quantity dispensed equals present balance) will be checked for accuracy for each drug or preparation during each inspection.

*NOTE: To verify the accuracy of vault inventory records the inspectors should randomly verify the information from the following documents which support the dispensing activities in the master inventory: Prescriptions, Active VA Form 10-2638 (or electronic equivalent), Inactive Form 10-2638.*

b. All excess, outdated, unusable, returned controlled substances must be inspected monthly and destroyed at least quarterly. The inspecting official ensures any drug stock removed from inventory for destruction since the last inspection, is properly logged into the record of drugs awaiting destruction.

#### **8. PHYSICAL INVENTORY OF THE NURSING UNITS AND STORAGE AREAS.**

a. The head nurse, nurse manager, or, in their absence, the nurse in charge of the clinic or ward inspected is to be present during the inventory and inspection of controlled substances.

b. An actual physical count of controlled substances on hand will be taken and reconciled for accuracy and completeness. The calculations (quantity received plus previous balance minus quantity dispensed equals present balance) will be accomplished and proved for each drug or preparation during each inspection.

c. To verify entries the inspectors will compare a sample of ward dispensing entries to patient records to verify that amounts removed from clinic or ward inventories were supported by doctors' medication orders and drug administration records in the patients' charts. The inspectors will compare a sample of any transfers from one Controlled substance area to another.

d. The Inspector will sign and date VA Form 10-2638 (or electronic equivalent) or enter signature in DHCP verifying accuracy of records on the nursing unit or other storage area.

#### **9. PHYSICAL INVENTORY OF AUTOMATED DISPENSING EQUIPMENT ON NURSING UNITS AND OTHER STORAGE AREAS.**

Where medical facilities use automated dispensing equipment for controlled substances (i.e., Access, SureMed, Pyxis, Meditrol and others), these should be linked to DHCP for Admission, Discharge, and Transfer (ADT) information.

a. The medical center must have specific written instructions for the inspectors on how to inspect each automated dispensing device.

b. Each inspector is assigned a temporary access code for the automated dispensing equipment for the period covering the inspection only.

c. An actual physical count of controlled substances on hand will be taken and reconciled for accuracy and completeness. The calculations (quantity received plus previous balance minus quantity dispensed equals present balance) are to be accomplished for each drug or preparation during each inspection. Audit reports are to be run from both DHCP and the automated dispensing equipment and reconciled against the physical inventory.

*NOTE: To verify entries the inspectors should compare a sample of ward dispensing entries logged in the automated dispensing equipment to patient records to verify that amounts removed from automated dispensing equipment on the clinic or wards were supported by doctors' medication orders and drug administration records in the patients' charts.*

d. The Inspector will sign and date VA Form 10-2638 or electronic equivalent in the automated dispensing equipment or enter signature in DHCP verifying accuracy of records in the automated dispensing equipment according to local written policy.

#### **10. PROCEDURE IN CASE OF DISCREPANCY OR LOSS OF CONTROLLED SUBSTANCES**

a. In cases of inaccuracy in balance of records, the inspecting official(s) will report the discrepancy to the accountable official (e.g., Chief, Pharmacy Service, Head Nurse) who will determine the cause to the satisfaction of the inspecting official(s); and make a report of findings to the facility Director, who will take appropriate action.

b. In the case of accidental loss, suspected theft, diversion, or suspicious loss, the procedures outline in VHA Handbook 1108.1, paragraph 8, will be followed.

**Department of  
Veterans Affairs**

**Memorandum**

Date: June 24, 1997  
 From: Director (663/00), VA Puget Sound Health Care System  
 Subject: Ken Faulstich, Chief Network Office (10NB), Office of Engineering Management and Field Support  
 American Lake Division Fire Department

1. The following is provided in response to the Congressional request for further information on the decision to discontinue the American Lake Division Fire Department and replace it with contract services from the adjacent Fort Lewis Army Post.
2. The annual cost of operating the Fire Department at VA Puget Sound Health Care System's American Lake Division is conservatively estimated at \$469,881. The annual cost of the contract with Fort Lewis is \$165,900. There will also be some recurring needs for fire suppression system maintenance and testing estimated at no more than \$20,000 per year.
3. The annual value of all other services performed by the fire fighters encompasses several elements. Many of the additional services they provided were because they were on duty 24 hours a day and convenient (e.g. receiving after-hours oxygen delivery, facilitating snow and ice removal, responding to disruptive behavior calls --"Code Greases"--, etc.) These duties have now been reassigned to other staff, with no degradation in response or increase in cost. The additional costs for fire suppression system maintenance and testing are included in the annual costs above. Two positions that did not exist before have been created to replace some fire department services in safety and escort functions, and additional funding will need to be allocated to cover some maintenance and repair functions and laundry delivery that will no longer be covered by the firefighters. The cost for these positions and the additional coverage is estimated at \$85,798 per year. The additional police positions recently authorized are unrelated to the termination of local fire services. A review of our police staffing determined that a minimum of three officers at Seattle and two at American Lake should be on duty at all times to assure the safety of employees and the security of property. These functions cannot be accomplished by the firefighters since they do not have law enforcement authority.
4. The decision to eliminate the American Lake Division Fire Department will have no impact on the quality of care provided to veterans nor will it increase the risk of injury or property loss. The contract with Fort Lewis requires them to respond to any fire emergency at this facility in 8 minutes or less (the VA standard). Trial runs indicate that response time would be well under that figure. The North Fort Lewis station (one of four on Post) is on property adjacent to the American Lake Division and is adequately manned and equipped. Crews responding to VA calls will travel a dedicated paved road of about a mile to the VA. As is common in most firefighting communities, there are mutual aid agreements in effect between Fort Lewis and Pierce County. Pierce County would provide back-up support to Fort Lewis at the VA, should the need arise, and is able to accomplish this within required time frames.
5. A decision such as this is never made without a thorough analysis of all issues, cost being only one of them. Certainly it is not meant to demean the efforts of the fine men who have staffed our department. We believe that the cost savings generated by this move can be effectively used to enhance care to our patients, but it is not a decision that would have been made at the risk of patients or staff. Should you require any additional information, please contact Sandy Nielsen, Associate Director, at 206 764-1340.

  
 Timothy B. Williams

Congressman Snyder to Charles F. Rinkevich, Director, Federal Law Enforcement Training Center, Department of Treasury

QUESTIONS SUBMITTED BY THE HONORABLE VIC SNYDER

1. Your statement refers to great projected savings from all training being done at FLETC because of an estimated per diem rate of \$152 per day. Isn't that an inaccurate method of analysis since the VA security police trainees get no per diem, and the VA houses them on the VA hospital grounds in North Little Rock at VA expense?

Answer:

The FLETC currently conducts training for 70 Federal law enforcement agencies, including the VA's Office of the Inspector General. The statement on projected savings is based on the workload projections provided by the 70 participating agencies and is a comparison of the General Service Administration's per diem rate in major cities as opposed to the meals and lodging cost at FLETC. In this context, it is a very accurate calculation of the savings. For the VA, a more accurate comparison would be the cost of meals and lodging at North Little Rock vice those at FLETC. The per day costs at FLETC are: \$10.73 for meals; \$9.53 for lodging; and \$5.00 for miscellaneous per diem (this item is discretionary and may or may not be paid pending the decision of the bureau head). Since FLETC does not know the costs incurred by the VA to house and feed trainees in North Little Rock, a comparison cannot be provided. The VA can probably provide the costs at North Little Rock.

2. When an agency contracts with you to provide training to their trainees, please describe the length of basic training, and the cost to the agency. Please include any travel expenses so I will know the total cost to the agency both per week and for the total duration of the training.

Answer:

Federal agencies do not "contract" with FLETC for training. Essentially, the FLETC is a voluntary association with each agency's participation governed by a Memorandum of Understanding. When an agency becomes a participating member; i.e., signs a Memorandum of Understanding, the FLETC and the Treasury Department provide the facilities (dormitory, cafeteria, classrooms, and specialized facilities for physical, driver, firearms, and computer training) and equipment required to conduct the training. The FLETC/Treasury/Office of Management and Budget funding policy is that the FLETC also funds the direct cost of basic training. The participating agencies are responsible for their respective student costs of travel and en route per diem, and reimburse the FLETC for meals and lodging. The direct costs of basic training include items such as: utilities for the classrooms, printed text material, role players, support contract services, ammunition, and materials/supplies used in the conduct of training. The FLETC offers several basic training programs, each with different lengths. The VA would attend the 8-week Mixed Police Basic Training Program and the students are in residence for 61 days. The current costs are:

Meals	\$654.53
Lodging	581.33
Tuition	1,016.29
Miscellaneous	<del>614.88</del>
Total	\$2,867.03

Per the funding agreement, the participating agencies reimburse the FLETC for the first two items (meals and lodging amounting to \$1,235.86) and the FLETC funds the last two (tuition and miscellaneous amounting to \$1,631.17). The weekly cost to the agencies attending this program would be approximately \$166 and the total cost is \$1,236 (rounded).

The agencies are also responsible for student travel. Since the FLETC is not involved in the travel, an estimate of those costs cannot be provided.



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