Security basics for long term care facilities

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The need for Long-Term Care (LTC) facilities is growing, the author reports, and along with it the need for programs to address the major security concerns of such facilities. In this article he explains how to apply the IAHSS Healthcare Security Industry Guidelines and the Design Guidelines to achieve a safer LTC facility.

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Recently I had the opportunity and honour to represent IAHSS at a conference entitled "Long-Term Care: A Safe and Secure Environment" in Toronto. The Long-Term Care environment is something that is important to me. Although most of my healthcare security experience has been in the acute care setting, there has always been an element of LTC in my facilities. On a personal note, I also had to deal with it from the perspective of my in-laws and even more so in arranging for care for my mother. In other words, I have experienced Long-Term Care from "both sides of the bed." Added to this is the knowledge that eventually, either my children or I will have to investigate such facilities for my wife and myself.

THE WORLD'S GROWING DEMENTIA POPULATION

It seems as though hardly a week passes by without there being a story in the news about an

elderly person afflicted with Dementia or Alzheimer's disease who wanders away from a retirement home, long-term care facility or their family home. More often than not, these stories have tragic endings.

The population is aging more rapidly now as the "baby boomer" generation (of which I am a member) hits their 60's and 70's. Just as society had to prepare and respond to the boomer generation in the 50's by building schools for us, it is now having to respond by building facilities for us in which we will spend the rest of our lives. In her article "Listen with the Ears of Your Heart', Dorothy Seman says, "Long term care isn't rocket science--it's harder." She also praises long-term care workers as "the angels of this world." Providing care and comfort to not only the resident, but to their families as well requires a certain level of care and compassion.

According to the World Health Organization, (WHO) approximately 35.6 million people around the globe are currently living with dementia. This number is expected to double by 2030 and more than triple by 2050. It is estimated that 80% of LTC Home residents have dementia, 60% have serious mental illness, 70% of older individuals in LTC homes have behavioural problems, 30% have severe issues. The cost of providing this care is rising at an alarming rate. WHO estimates the cost of providing this care to be as high as $293 Billion by the year 2040.

GROWING RECOGNITION OF LTC RESIDENT VIOLENCE

In addition to the problem of patient/resident elopement from LTC facilities is the issue of resident violence. There have been numerous incidents where residents have attacked and seriously injured or killed other residents. In most cases, charges are not laid against the attacker due to their advanced level of Dementia.

In response to a specific incident that occurred in Toronto in June 2001, the Office of the Chief Coroner in the Province of Ontario held an inquest into the death of two residents at the hands of a third resident. Both the residents were deceased from severe head injuries at the scene. Mr. "S" was arrested and charged with double homicide. Mr. "S" had been ad-

mitted to the home less than six hours before the fatal attack. At his arraignment hearing he was sent to a Psychiatric Hospital for assessment, but died from a stroke while being assessed.

The jury heard evidence from 43 witnesses and had 85 exhibits submitted during an inquest of 34 days. The jury deliberated over 9 days. The Coroner's jury reviewed the gruesome details surrounding the deaths, and made 85 recommendations. Not one of those recommendations mentioned security.

In 2012, the Ontario Coroner committee reviewed 20 cases, involving 21 deaths and generated 58 recommendations directed toward the prevention of future deaths.

- **Total number of cases reviewed: 20**
- **Total number of deaths reviewed: 21**
- **Manner of death:**
  - **Natural 5**
  - **Accident 11**
  - **Homicide 3**
  - **Undetermined 2**
  - **Suicide 0**

As with the inquest into the deaths that occurred in 2001, security is never mentioned in this report or in any of their recommendations.

But finally, security is mentioned in the "Guide to the Long-Term Care Homes Act, 2007" in the Province of Ontario. The guide states that it is a "Fundamental Principle" *that a Home is ...to be operated so that it is a place where its residents may live with dignity and in **security**, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.*

Unlike the Building and Fire codes, which both explain in detail how to protect residents from fire, the Ontario Long-Term Care Homes Act does not explain or detail how a home is to achieve security.

THE PRIMARY GOALS OF LTC SECURITY

As Security personnel charged with the responsibility of protecting people in LTC's we have three primary goals, reduce incidents of violence; stop unauthorized entry (theft); stop unauthorized exit, (elopement).

Recently, IAHSS conducted a survey of Long-Term Care facili-

ties across North America. The survey identified 4 top areas of concern

1. Resident aggression/ violence
2. Public aggression/violence
3. Theft from residents and staff
4. Elopement/wandering

APPLYING THE IAHSS INDUSTRY GUIDELINES TO LTC FACILITIES

The IAHSS has developed the Long Term Care Safety & Security Management Guide in response to this survey as a tool to help administrators deal with these concerns.

Additionally, the IAHSS Guidelines Council has developed the IAHSS Healthcare Security Industry Guidelines and the Design Guidelines. The IAHSS Guidelines Council also ensures that our guidelines are applicable to ALL Healthcare facilities regardless of their size, type, or location. The Guidelines are very useful for all levels of security management as well, from the seasoned Security Director in a large facility, to a person who wears many hats in a smaller facility.

Looking specifically at applications for LTC's the Industry Guidelines are divided into eight different categories, but the one category that is most applicable to LTC's is the first section which focuses on "Program Administration"

Program Administration

The Program Administration section is further divided into nine sub-categories. Of the nine sub-categories, the three most applicable are Security Management Plan; Security Administrator; Security Risk Assessments

Program Administration--there must be someone in your facility that has a clearly defined role and job responsibility for Security. Understanding that many of you work in small facilities that may not have a security department or program, nonetheless, you need to identify a person that has overall responsibility. It would be wonderful if that person actually had experience in the field as well.

The Security Management Plan

The need for every facility to have a "Security Management Plan" is so important that it is the very first IAHSS guideline.

01.01 – Security Management Plan

STATEMENT:

Healthcare Facilities (HCFs) will develop a Security Management Plan (SMP). The plan should include preventive, protective, and response measures designed to provide a safe and secure environment.

INTENT:

a. The plan should be based on the risk assessment and needs of the HCF.

Current best practices recommend that a Risk Assessment, (Threat Risk Assessment) should be conducted annually by a qualified security professional.

It is recommended that the initial or original TRA be conducted by an external person. This provides for a fresh perspective or new set of eyes to examine your facility and your program and to help identify areas for improvement. The "Nose Blind" commercial for the product "Febreeze" easily demonstrates this concept. We are so used to seeing things a certain way, often, we don't see them anymore. Also, if yours is the only facility that you have had exposure to, you may think that is the way it should be without seeing what other facilities are doing to resolve these issues or to reduce the risk.

The Security Administrator

Of equal importance is the "Security Administrator". Again, regardless of the size of the facility, a senior person needs to be appointed to this responsibility.

01.03 – Security Administrator

STATEMENT:

Security Administrators play a critical leadership role in Healthcare Facilities (HCFs) security management program.

INTENT:

a. Each HCF should identify an individual, designated by leadership, to be charged with primary responsibility for managing the security program.

b. The designated Security Administrator should be responsible for providing ***or engaging security expertise*** *and possess policy-making authority in keeping with the review and approval process of the HCF.*

The "Security Administrator" guideline clearly states that the Security Administrator is responsible for *providing* ***or engaging security expertise.***

However, if you don't have the specialized knowledge is it incumbent upon you to "Engage Security Expertise." That last comment brings us to this:

When you are seeking outside expertise, the facility needs to ensure that they hire a qualified professional who has specific training and experience in Healthcare Security. There are many companies and individuals that promote themselves as healthcare security "experts". Some of them are. Most are not. The facility Administrator should not necessarily select the lowest bidder or the company that has the flashiest web-site or brochures.

It is important that they ask for references for similar projects. They should look for a direct background in Healthcare. Look closely at their background, their experience; their education and credentials. A person who has experience in Commercial Office Towers or Shopping Malls may not have the requisite experience required for a Healthcare Facility.

APPLYING THE IAHSS SECURITY DESIGN GUIDELINES TO LTC FACILITIES

The next area of focus is the IAHSS Security Design Guidelines. These guidelines are the most recent resource that the IAHSS has made available to its members. Although produced primarily for acute care facilities there are many areas that are adaptable to Long-Term Care applications.

These new guidelines have been very well received by several agencies and they are now mandated in 42 States in the US through the Facilities Guidelines Institute. They were developed to reduce the potential for Crime and to ensure that staff safety is considered in the design of new construction. They rely heavily on the principles of CPTED

INTENT:

The IAHSS Security Design Guidelines are intended to provide guidance to healthcare security practitioners, architects, and building owner representatives involved in the design process in order to ensure that these best practices are considered and integrated, where possible, into each new and renovated HCF space.

Although the IAHSS Design Guidelines were primarily developed for Acute Care facilities, there are two areas that are easily trans-

ferable to the LTC settings. The "Behavioural/Mental Health Areas" and "Infant/Pediatric Departments"

The design of Behavioral/Mental Health (BMH) patient care settings should address the need for a safe treatment environment for those who may present unique challenges and risks as a result of their medical condition. The BMH patient environment should protect the privacy, dignity, and health of patients and address the potential risks related to patient elopement and harm to self, to others, and to the environment. BMH patient areas should be designed considering the need for considerable clinical and security resources and in accordance with legal and regulatory requirements.

Specifically, these guidelines provide recommendations that address security basics such as access control; perimeter fencing; restricted areas; Intercoms; placement of CCTV systems; duress alarms, etc.

CONFRONTING HEALTHCARE'S 'OPEN DOOR' PRACTICE

The biggest challenge to healthcare facilities today is our "open door" practice. People can walk into any healthcare facility without question almost anytime that they want. Some hospitals have even gone to 24 hour visiting in the belief that it enhances the patient experience. They seem to forget that staffing levels drop in the evening and nights.

Although it is impossible to completely restrict and control access in an acute care facility, it is much easier to do so in a long-term care facility. After all, this is where people live. Like an apartment building or a condo tower, you can't just walk into those. Often, the main entrance is locked and there is a Security Guard in the lobby. While the option of placing a Security Guard in a lobby may not in some cases be a viable, cost-effective option, LTC facilities need to ensure that the entrances are properly secured to prevent unauthorized entry or exit.

There are of course many people that live in LTC's who are "residents" and are free to come and go as they please without restriction, (just as they would if they were living in a Condo or a house). Tempered with that, is the need to ensure that they are secure and that residents/patients are not capable or competent to make safe and appro-

priate decisions and perhaps may wander outside when it is not safe for them to do so.

REDUCING RISK EXPOSURE

Risk can never be truly eliminated, but it can be reduced. In order to reduce and mitigate the risks we need to follow standard Risk Management principles, (also called risk reduction). A common definition for Risk Management is that it is "a systematic reduction in the extent of exposure to a risk and/or the likelihood of its occurrence".

There are four types of Risk Management

- **Risk Acceptance** – understanding that there is a risk, but that the risks do not have a high possibility of occurring. On the other hand, it also means that you understand that there is a risk of occurrence, but that is the nature of the business you are in.

For example, if we drive a car, we understand that there is a chance that we may be involved in a car accident, but we consider the risk of an accident to be low and still choose to accept that risk.

- **Risk Avoidance** - the action that avoids any exposure to the risk whatsoever. Risk avoidance is usually the most expensive of all risk mitigation options. It generally means that we chose not to do or be in this type of business.

Using the example of driving a car, we choose to avoid the risk of being in a car accident by deciding that we will not drive or be a passenger in any form of motorized transportation.

- **Risk Limitation** - This strategy limits a company's exposure by taking some action. An example of risk limitation would be a company accepting that an event may occur and avoiding their exposure by having regular training, strong and robust policies – Patient lift devices is an example.

Again, using the car analogy, we can choose to drive at times of the day when traffic volume is lower or to avoid highways.

- **Risk Transference** - is the involvement of handing risk off to a willing third party. However, that does not eliminate repercussions to your facility in the event of an incident.

And lastly, using the car analogy for the final time, we can choose to take taxi cabs everywhere we need to go. That, however, still means that the risk of us being in a car ac-

cident still exists.

APPLYING CPTED PRINCIPLES TO LTC FACILITIES

CPTED is a proactive design philosophy built around a core set of principles that is based on the belief that the proper design and effective use of the built environment can lead to a reduction in the fear and incidence of crime as well as an improvement in the quality of life. CPTED goes well beyond conventional approaches to safeguarding the environment by exploiting natural forms of surveillance, access control and territorial reinforcement in a deliberate attempt to present a psychological deterrent for the purpose of positively influencing human behaviour as people interact with the environment.As we move closer to the area, item or person we are trying to protect, the harder it should be to get to it.

In the case of a Long-Term Care Facility, again, how hard is it for someone to get in, walk down a hallway and enter a resident's room. Of equal importance, how hard is it for a resident to get out? In most cases, the main entrance lobby is a danger zone as it is the primary entry-exit point and is often unattended, unmonitored or unsupervised. This is the area that requires the most attention.

ANSWERING THE CHALLENGES OF LTC SECURITY

As a Healthcare Security Professional, I have always approached the security practices, policies that I develop and technology that I install from a personal view. How safe would my loved one be in this environment? How comfortable and safe would they feel? How comfortable would I be leaving them here? I think that there are many instances where this is not considered when plans are initiated.

The utilization of security controls such as card readers, locks, CCTV technology, wander alert systems and other technology must be carefully considered when planning security for a Long-Term care facility. We must balance the need and desire to protect those that are at risk whilemaintaining the rights to freedom and privacy to those resident that are at a lower risk. Residents, (and their families) must be provided with an environment where they feel safe, but not in prison.