FEASIBILITY STUDY ON DEVELOPMENT OF A STANDARD HOSPITAL SECURITY STAFFING FORMULA

A RESEARCH PROJECT CONDUCTED BY THE
OFFICE OF CORPORATE SECURITY ADMINISTRATION
NEW YORK CITY HEALTH & HOSPITALS CORPORATION
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TABLE OF CONTENTS

CHAPTER I
HISTORICAL PERSPECTIVE OF THIS STUDY

CHAPTER II
NATIONAL INSTITUTE OF JUSTICE GRANT

CHAPTER III
RESULTS OF THIS STUDY

APPENDIX

A. NYS Comptroller Audit Report NYC 36-80

B. NYC Police Department Executive Summary

C. HHC Crime and Incident Report

D. HHC Presidents Memorandum

E. Metropolitan Hospital Security Directors Association Report

F. NYC Police Department Allocation Plan

G. Police Function Questionaire

H. Security Workcharts Questionaire

I. Parking Lot Security Questionaire

J. Internal Control Associates Report

K. Personnel Staffing Report

L. Monthly Offenses Report

M. Communications to Industry Sources

N. Corporate Security Advisory Board

O. Staffing Task Force Committee Report

P. Russell Colling Inc. Report

Q. Joint Commission on Accreditation of Hospitals Standards

R. Offense Data

S. Universal Staffing Conversion Formula

PREFACE

This study was undertaken to determine the feasibility of an appropriate staffing requirement criteria to support a cost efficient security manning level at New York City Health and Hospitals Corporation's institutions and facilities. The Corporation provides the largest municipal security service in our nation's health care industry, utilizing an assortment of protective safeguards such as hospital security police, procedural controls, and an array of technological security equipment systems. Presently, over 1,300 Hospital Security Police Officers, legislatively designated as "Peace Officer", are employed by security departments throughout the Corporation. This staffing level had been largely attained through the application of a formula involving the total square footage of the buildings contained in our institutions. Analysis of several security audits strongly suggests that additional criteria be developed to guide facility Executive Directors and their Security Directors in correctly assessing security manpower needs.

The Office of Corporate Security, reviewed the existing literature dealing with manning levels and conducted extensive networking with other health care security professionals. These efforts failed to disclose the existence of a viable staffing formula. Subsequently, Corporate Security petitioned the National Institute of Justice for their help in this matter. The Institute responded by funding a research effort to conduct a study which would determine the feasibility of a standard security hospital police staffing formula that could possibly be replicated throughout the industry.

Inquiry revealed a wide variety of concerns and priorities within the industry. These were further differentially affected by a host of factors such as cultural and political relationships, crime perception and attitudes, homogeneity of patients, visitors and staff, etc. Considerable diversity was found among facilities within the same locale serving similar catchment areas. For example, two hospitals under similar circumstances can assign different philosophies to the protection issue. One administrative authority may perceive a high priority for protection, while another may display a lesser concern. These differing levels of concern cautioned us to provide some flexibility into our formula research. Essentially, what we sought is that which would alert managers to the basic requirements of security yet permit a latitude of application by the Executive Director. An exact formula under such circumstances is not forthcoming; rather, an emphasis focusing on input methodology, built on an understanding of the security rationale, its dimensions and other aspects constituting sound staffing requirements was our primary focus.

With that in mind, the Office of Corporate Security feels optimistic that we have more than "scratched the surface" of this subjective and complex undertaking with a formula which hopefully will be the basis for a standard approach. Corporate Security is equally proud of the research developed by hospital security practitioners borne largely from the experiences and suggestions of fellow practitioners who face the problem of divining the correct manning level to achieve their security mission. It was through their

efforts that our researchers were able to incorporate a number of traditional considerations under one umbrella. In progressing beyond any industry-wide research to date, we believe our study provides security management the ability to examine, test and assess the institution's perceived need against a uniform model. Inasmuch as administrative decision making is not a precise science, the identification of broadbanded key factors provides a significant dimension for the assessment process. It is recognized that individual or even organizational philosophy, as well as the existence of unique cirmcumstances, will cause different weights being given within the managerial perspective. What we should not accept, however, is any of the factors and potential measurements ever being ignored.

Within the Corporation, a number of individuals deserve thanks, particularly Dr. Jo Ivey Boufford, President of HHC and Stephen W. Lenhardt, Vice President, Facilities Management. Both have proven to be strong advocates of security management personnel engaging in what can be termed grassroots research. Within Corporate Security Administration itself, a large measure of appreciation must go to Charles Stettner, who proved to be the "nuts and bolts" of this study project.

With regard to the funding source, our thanks must go to James K. Stewart, Director of the National Institute of Justice, for recognizing that private and public security needs must be addressed if we are to

enhance the nation's commitment to public safety.

In closing, let us suggest that this initial effort is not the final word on hospital or institutional staffing. Rather, in the words of Winston Churchill in describing World War Two's Normandy Invasion, let us suggest "This is not the beginning of the end, but rather the end of the beginning".

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FEASIBILITY STUDY
ON
DEVELOPMENT OF A STANDARD
HOSPITAL SECURITY STAFFING FORMULA

CHAPTER I - HISTORICAL PERSPECTIVE OF THIS STUDY

INTRODUCTION

The New York City Health and Hospitals Corporation is a two billion public benefit Corporation created by the New York State Legislature to meet the medical and health-care needs of New Yorkers and their visitors. The Corporation operates eleven general care hospitals, five long-term care facilities, an Emergency Medical Service, four free-standing Neighborhood Family Care Centers and thirty-one satellite clinics. With 242,582 inpatient admissions, 1.3 million emergency room visits and 4.3 million ambulatory care visits in FY 1986, Health and Hospitals Corporation, often referred to as HHC is the largest single provider of health care in New York City and the largest municipal hospital system in the nation.

The system directly employs over 44,000 people in addition to an affiliation staff numbering in the thousands furnished by numerous medical teaching institutions. Primary facilities are seven days a week, 24 hours a day operations. Many are located in low economic areas of the city and often situated in high incident-of-crime neighborhoods. Female employees often are the majority of work shifts

and are subject to consequent security concerns. Property assets in terms of buildings (100 plus structures), grounds and equipment, amount to billions of dollars. The challenge to protect patients, visitors and assets is a formidable one for the Corporation's Hospital Security Police.

B. SECURITY DEPARTMENT PROFILE

Presently HHC provides a security presence of approximately thirteen hundred individuals, who after appropriate training are designated by New York State as Peace Officers with commensurate legal authority and responsibilities not available to a civilian guard force. The security departments and their officers are assisted in their security efforts by published Corporate policies, procedures and regulations establishing internal controls. The Corporation's concern for improved security is reflected in its proposed security equipment projects for FY 88 representing an estimated expenditure of $6,334,457.00. Such proposals include computer based electronic card access control systems, electronic guard tours, and other technologically advanced security enhancements. This equipment will enable the various hospital security departments to provide a higher, more efficient level of service to their facilities. With an emphasis on operational accountability vested with the institutions Executive Director, Health and Hospital Corporation is structured in a decentralized mode wherein each institution is provided the authority and responsibility to accomplish the necessary functions for that facility.

HHC Central Office's primary role is to provide support for the operations of those facilities in the field. Corporate Security plays a similar support role.

Therefore, facilities are somewhat autonomous and each hospital security department is under the direct control of the institution's Executive Director. Due to such decentralization a single staffing formula does not exist within the Corporation. To complicate matters, most Security Directors indicate they manage their units under severe budgetary constraints regarding personnel and equipment. Hospitals experiencing increases in crime or having other security related problems must rely upon their Executive Director to remedy the condition. Because of the institution's natural order of priorities and compelling interests the hiring and deployment of security personnel and equipment purchases are often contingent upon a subjective decision rather than demonstrated need. As a result of traditional reporting procedures there were no direct relationship between crime and incidence statistics and the actual staffing of the security department. Traditionally the size of the facility in terms of square footage set the parameters for security staffing.

C. EXTERNAL SECURITY AUDITS

An audit initiated in 1981 by the New York State comptroller's office (appendix A) reported that there were significant disparities in staffing patterns among HHC institutions.

It stated "The relationship between hospital size and number of security staff varied considerably, ranging from 2,856 to 33,182 square feet per security officer. While other factors may have a significant bearing in staffing the security function, we suggest those inconsistancies exist because each hospital budgets its own security with varying levels of priority in relation to patient care activities. We found that personal service cost for security ranged between .9 and 2.6 percent of total hospital service costs".

Their finding reflects the major focus of this research; deployment of security personnel is more subjective than objective and lacking any standards. A subsequent external audit, conducted by the New York City Police Department upon HHC's request, examined each HHC facility in the system. The report (appendix B) submitted in 1983 represented a comprehensive effort by experienced crime prevention personnel to identify security weaknesses and recommended meaningful improvements. The study reiterated that "each hospital security unit is essentially autonomous and is managed under the direct control of the hospital's Executive Director". In their executive summary the Police Department notes that "Executive Directors, left to allocate their own budget, tend to place security in a low priority category and disperse funds accordingly". Once again a survey indicated that security deployment is contingent upon a subjective decision rather than demonstrated need. The Police Department reports suggest that the Executive Director reaches his/her decision

after estimating the cost of mandated medical services, evaluates other medically related priorities and only then allocates security funds. The process is quite understandable as medical care is the primary mission, resulting in wide disparities among security officers staffing at the various facilities. The Police's recommendation to improve the present deployment method indicated that the allocation of security personnel should be more contingent upon an objective estimate of individual security needs in each facility. Such an objective standard would result in a security budget and personnel adjustment, based on the current needs in each facility. Obviously some form of evaluative criteria in determining institutional need was necessary. A meaningful and accurate incident report was a necessary first step. (Appendix C)

D. EARLY RESULTS OF EXTERNAL AUDITS - REORGANIZATION OF CORPORATE SECURITY

Utilizing the recommendations of the New York State Comptroller's Audit and the New York City Police Department study, the Corporation moved to establish measures to improve the quality and performance levels of the security departments. In June of 1983, the Corporation appointed a former NYPD official and Yonker's Police Commissioner to the post of Assistant Vice President for Corporate Security Administration. His first responsibility was to review security operations in terms of the external audit findings and make recommendations consistent to the decentralized philosophy but compatible with sound security

standards and practices. Corporate Security Administration subsequently initiated a series of positive changes in training by transfering its training site to the campus of John Jay College of Criminal Justice; reorganized the criminal incident reporting system; established a Loss Prevention Bureau and a Crime Prevention Officer Program at the institutional level. An additional dimension to training was the creation of an Instructor Development Program for each institution. Still lacking, however, was the presence of a standard system to adequately address the staffing of security personnel. Some facilities were viewed as overstaffed, others did not appear to have the personnel capability to maintain an acceptable level of security patrol or execute timely responses to calls for service. Most facilities lacked a defined security minimum manning policy which would tentatively state the protection level desired by the administrators of the institution.

The issue of manning levels was addressed by the Office of the President of HHC (Appendix D) in a June 6, 1984 memorandum to facility Executive Directors wherein the Office of Corporate Security Administration was charged with, "establishing a staffing pattern formula to meet the needs of the facilities as closely as possible". The memorandum also stated that all requests for additional personnel would be forwarded to the Assistant Vice President for Corporate Security Administration for approval before any commitments to hire were undertaken by a member hospital or other facility. Additionally, all personnel reductions, as well as all major purchases of

security equipment would also call for prior approval by Corporate Security. This was the first step in the establishment of a systematic and rational approach to security management.

E. INITIAL RESEARCH FINDINGS

With its new responsibility to establish a staffing pattern formula to meet the needs of all Corporate facilities, Corporate Security conducted a research effort of fact-gathering to determine if a manning formula existed which could be suitably applied or adapted to our security organization. Research consisted of an examination of literature such as of texts, manuals and tracts written by acknowledged leaders in the security field, particulatly hospital security, and publications of industry associations. Peer networking was similarly conducted. The research revealed extensive information regarding such specific subjects as manpower deployment, patrol methods, security protection philosophy, disaster control, investigative functions, parking lot control, etc. However, we did not find a manpower allocation plan or security staffing formula which adequately identified specific factors that must be considered before a valid manpower staffing determination could be reasoned, extrapolated and applied. Such sources as the Joint Commission on Accreditation of Hospitals (JCAH), which currently provided accreditation to approximately 7,400 hospitals and facilities throughout the United States, publish operational guidelines

and standards for hospitals, yet do not contain a security staffing formula or manpower allocation plan. A five volume industry reference standard, the Protection of Assets Manual, published by the Merrit Co. does address the issue of the number of personnel required for a viable guard operation by advising that, "The complexity of a facility and the number of employees determine the number of guards needed to some extent. However, the amount of sensitive work being done in the facility being protected against industrial espionage or other hazards also influence the size of the guard operation". The manual further advises that the number of guards required for a facility usually depends on three (criteria): The number of pedestrain, automobile, truck and railroad gates, the hours they are open; the number of patrols necessary to protect the buildings, installations, and grounds that require policing; and the amount of escort and special assignments. The manual in our judgment, does identify important factors which should be considered by security managers endeavoring to assess their manpower needs. Unfortunately it is not a formula that identifies explicit functions which could be quantified by a performance time factor, and thereby permit the security manager a determination of necessary manpower needed to perform those functions. The formula HHC Corporate Security sought would enable the manager to adequately staff an institution within the parameters set both by administrative security policy, and the acutal security

circumstances present at the particular facility. Obviously not an easy task.

In the absence of a detailed security staffing formula applicable to our health-care system in the current literature, Corporate Security broadened its research to include inquiry of several metropolitan area and international professional security associations and law enforcement agencies. Responses to these inquires were helpful. For example, the New York City Metropolitan Hospital Security Directors Association forwarded their "Report of security Labor Distribution Survey" (appendix E). This report represented an early effort to identify some specifics relating to security staffing needs. It identified a range of staffing needs focusing on two factors:

1. Number of patient beds and
2. Type of hazard area (Information contained in this MSHDA Report, served to highlight, again, that a specific formula to determine manpower needs for hospital security had not been developed).

The New York City Police Department was extremely cooperative in their response to our inquiry regarding a manpower allocation plan. Using the Police Department's Patrol Allocation Plan as a model, they developed the framework for a proposed security allocation plan within the Corporation. Unfortunately,

a key presumption of their model called for all security personnel to be centrally controlled, whereas HHC is organizationally structured in a decentralized mode. Several security considerations mentioned in their work, namely fixed post, unique situations, total crime and non-crime incidents, (calls for service) should however be considered as valid input criteria for a manpower allocation plan. (appendix F)

CHAPTER II - NATIONAL INSTITUTE OF JUSTICE GRANT

A. PROBLEM IDENTIFICATION AND RESOLUTION

The results of our early research confirmed that the security industry in general, and health-care security in particular, did not have a well developed, comprehensive manning formula which could be applied by Corporate Security to determine the correct number of staff necessary to safeguard it's varied and unique health-care facilities. Our research effort however, did provide us with information on the subject which could be analyzed, classified and possibly serve as a data base resource to develop this needed staffing formula. Presently, HHC provides the largest single security service in municipal health care. The challenge to protect patients, employees, visitors and physical assests is acutely felt by our hospital Security Directors and by Corporate Security. It was decided that the Corporation itself would conduct a study to determine, to the extent possible, the approximate staffing requirement criteria necessary to support a cost-effective security manning level.

To accomplish this objective, HHC petitioned the National Institute of Justice for their participation in this project. The rational for such a project was that a well developed and valid staffing formula could have a positive security impact on the entire health care industry. Cited, among other justifications, were the results of a recent N.I.J. study of private

security "The Hallcrest Report" which concluded that the private security industry is going to play an increasingly important role in the future safety of our citizens. Any success in this endeavor would assist the industry in achieving an important goal. N.I.J. agreed, and granted the Corporation funds to "conduct a study to determine the feasibility of a standard security hospital staffing formula.

B. RESEARCH PARAMETERS

Contractural obligations of the grant required the Corporation's performance of ten principal tasks listed below, to ensure complete fact-gathering on the problem.

1) Conduct an evaluation and analysis of the security methods of operation utilized at each facility.
2) Inititate, distribute a questionaire instrument to Security Directors and others involved in security operations.
3) Communicate with such sources of information as American Hospital Association, Hospital Association of New York, the International Association for Hospital Security, American Society for Industrial Security and the Metropolitan New York Director of Security Association.
4) Conduct interviews among Hospital Executive Directors, Security Directors et. al.
5) Conduct interviews among users of service.
6) Obtain services of Security Consultant services for independent review.
7) Determine key workload factors such as bed population, crime and unusual occurrences, Emergency Room visits, etc.

8) Analyze reports, audit post descriptions to determine greater utilization of security technology in lieu of personnel.

9) Develop performance standards and work schedulling possibilities.

10) Collect workload volumes.

C. SECURITY METHODS OF OPERATION

Evaluation and analysis of the security methods of operations utilized at each facility were undertaken by Corporate Security. The format utilized various methods of inquiry including questionnaire response, consultant surveys and reports, security department workcharts and schedules, staff analysis of field inspections, and hospital security department reports filed at the Central Office Records and Information Unit. Several questionnaires (Appendices G.H.I.) dealing with Security Police Functions, Security Workcharts and Parking Lot Security were circulated to all HHC Security Directors in an effort to identify the full range of department responsibilities, functions, workload factors, and work volumes. The services of a security consultant firm, Internal Control Associates, (ICA) located at 120 Wall St., New York City were engaged to assist us in the data gathering, evaluation and analysis phase of this study. Internal Control Associates consist of specialists in the health-care field and was instrumental in constructing the aforementioned questionnaire dealing with Security Police functions. The consultants reviewed and reported on the security operations and staffing requirements at several of our

hospitals; (Appendix J); conducted interviews of key personnel, inspected equipment, reviewed records of thefts, incidents, etc. Also interviewed were Security Directors in selected Veterans Administration and voluntary hospitals relative to their staffing structures, formulas and general philosophy. Past reports of HHC, NY State Auditors, and NYC Police Department Security surveys were furnished to them for use in their review.

Key workload factors such as hospital census, crime and unusual occurrences, emergency room visits, etc., and the volume of work, were determined from the results of the previously mentioned questionnaires. Even HHC annual reports, and the analysis of hospital security department reports filed at the Central Office Records and Information Unit were utilized, (Appendices K.L.). These hospital security department reports were of particular importance as they indicated the number of security personnel currently employed by each facility within the Corporation and contained statistical information on the number of criminal offenses and property losses sustained by the facilities, as well as the total number of calls for service (Appendix L) received at each security department.

D. EXTERNAL INFORMATION SOURCES

Establishment of proper staffing levels for security departments ideally requires input by all users of this service. It was felt that the experience of other medical centers, hospitals and medical associations would be an invaluable resource which

could be utilized in the search for a standarized staffing formula capable of nation-wide application. Communications to this effect (Appendix M) outlining our objectives and needs including our first generation results, were sent to various associations, organizations and practitioners in the health services and security industry. The material included several broad-banded staffing factors, supplemented with standarized guidelines and procedures to insure uniformity of the input data. Also provided for their comments were a series of pertinent questions designed for the consideration of a security manager involved in the process of assessing manpower needs. Critiques by the recipients of the material were requested, in addition to any further input they could provide towards the establishment of a uniform staffing formula. Sources polled included the American Hospital Association; the Hospital Association of New York; the American Society for Industrial Security, the national membership of the International Association for Hospital Security; and the establishment of a HHC Corporate Security Advisory Board, (Appendix N). The Advisory Board is comprised of Security Directors employed by major corporations headquartered in the New York City Metropolitan area.

E. INTERNAL INFORMATION SOURCES

Hospital Executive Directors bear the responsibility of exercising independent management control over their assigned facility. Security policy and budget control are functions of the Executive Director. However, operational control is generally exercised by an administrative deputy. The Security Director generally

reports to an administrator in charge of several additional units. For example, the Assistant Executive Director of Support Services may also manage transportation, communication, etc. Since the decisions of these individuals impact greatly upon security staffing, soliciting their input into the development of a staffing formula was of importance to our project.

Communication and interviews were initiated with hospital administration through the use of questionnaire instruments and consultant interviews. Corporate Security addressed the staffing issue at monthly meetings held with the Directors of Security. A Task Force Committee on staffing was initiated, (Appendix O) comprised of Security Directors and officers representing typical facilities. The Assistant Vice President, Corporate Security Administration sought and received information relative to security staffing levels and manning problems during his personal interviews conducted among Executive Directors. In addition, Central Security staff conducted field security inspections and surveys throughout the past year, interviewing hospital administrative staff members on the problems attendant to security staffing.

F. INDEPENDENT PROBLEM REVIEW

Two security consulting firms, the aforementioned Internal Control Associates, located at 120 Wall St., New York City and Russell Colling, Inc. of 333 East 19th Avenue, Denver, Colorado were contracted by the Corporation to assist in the development of this study. A third organization, the New York City Police Department, rendered its valuable services on a pro bono basis.

Internal Control Associates services were utilized for several important aspects of this study including questionnaire design, interview of key personnel at various facilities both within and outside of the Corporation, inspection of technical security systems currently "on line" at several facilities, and security surveys of two facilities in an attempt to compare the adequacy of existing security staffing at those facilities (Appendix J).

Russell Colling is a nationally known speaker, lecturer and consultant on hospital security. Presently he is Director of shared Security services at the midtown Hospital Association of Denver, which serves several major hospitals in the area. Mr. Colling was Founding President and is currently on the Board of Directors and Training Committee of the International Association for Hospital Security. He is also a member of the American Society for Industrial Security and the National Safety Council. He was consulted to identify a model hospital security officer staffing requirement at a typical health care facility. Colling was also asked to enumerate the major factors needed to calculate the manhours required to accomplish the security mission (Appendix P). Further, his effort would reflect a model conversion table to identify security manpower. The model was based on hourly workloads, which would relate manpower needs to staffing requirements and other correlated factors. The research material provided for his review included staffing factors and patrol post guidelines,

procedures criteria, and sample questions to be answered by security managers seeking to determine adequate security staffing.

G. APPLIED SECURITY TECHNOLOGY

It is generally agreed that greater utilization of present technology through the introduction and application of physical security systems can positively impact the staffing requirements within an organization. Such physical security systems as closed circuit television, computerized access control, lighting and intrusion detection systems, can supplement and in some instances supplant security officers.

An efficiently managed protection department must consider the installation of various physical controls to reduce its vulnerabilities and not rely entirely upon costly personnel to accomplish its security goal. For example, a properly fenced and lighted parking lot, continually scrutinized by closed circuit television and monitored at a security operations console may very well negate the need for the "fixed post" presence of an officer at that location.

Regarding the integration of personnel and technology it was found that security concerns appear to have benefited with the advent of a recently introduced electro-magnetic door locking system. Doors equipped with such protective devices remain in a continually locked position until an emergency situation develops,

at which time the locks are automatically released. Most important, however, the technology is consistant with existing fire safety codes.

Corporate Security particularly through the efforts of its Loss Prevention Bureau encourages security technology application throughout the Corporation. The application and proper utilization of such security systems can enhance productivity by performing many of the routine tasks and functions formerly assigned to officers. This permits the Director of Security wider latitude of personnel resource allocation within security operations.

H. PERFORMANCE STANDARDS AND MANPOWER ALLOCATION

The decentralized organizational structure of HHC transmits to the Executive Director of each facility the power and authority to perform the primary functions of that institution. Performance standards, manpower allocation and work schedules for security departments are currently determined separately by each corporate facility. These elements of work performance must be considered by Corporate Security in the development of a staffing pattern formula.

A study of HHC security conducted by the New York State Comptroller's office cited the absence of clearly defined lines of authority, direction and responsibility which contributed to disparities in staffing patterns. The report stated that each hospital independently determined its own security needs and services and recommended that assigning a greater role to Central Security as a supervising and coordinating authority

might effectively correct this situation. Another survey made by the New York City Police Department reported that, "Each hospital security unit currently uses its own set of regulations and procedures. While there are many similarities, there are also many variations". They recommended, "that hospital security units should be managed using uniform procedures and forms. The present practice of permitting hospitals to develop their own procedures results in a distortion of corporate security goals and substantial differences in the quality of security. Uniform procedures, emanating from the corporate office, would tend to foster greater efficiency and effectiveness".

HHC requires strict adherence by all of its member institutions to the uniform standards for the operation of hospitals and other health related facilities and services as established by the Joint Commission on Accreditation of Hospitals (JCAH). The Commission is a national organization whose primary purpose is to promote high quality in the provision of health care and related human services. Standards developed by JCHA are specifically referred to in the federal laws (Public Law 89-87; 92-603) regulating hospital services for Medicare and Social Security. Hospitals accredited by the Joint Commission are therefore automatically "deemed" to be in compliance with the federal laws and regulations. Life safety and security standards have been established by JCHA (Appendix Q) and contain requirements related to the staffing, equipping, operation, and maintenance of security measures designed

to produce safe characteristics and practices and to eliminate, or reduce to the extent possible, hazards to patients, hospital staff and visitors.

Therefore if Corporate Security were to be successful in developing a staffing formula guideline in such a diverse number of health care institutions, we had to bridge the deficit cited in prior external audits with individual accountability required by HHC's decentralized role.

As earlier noted, HHC requires adherence by all of its member institutions to the uniform standards for the operations of hospitals as set forward by JCAH. These standards are therefore common to, and binding upon, all security departments throughout the Corporation. Performance standards and work schedules impacting upon such security staffing requirements as exit/entry control, identification badge programs, visitor passes, bomb threats and civil disturbances, disaster and evacuation contingencies, parking areas and walkways, surveillance equipment, closed circuit television and alarm systems, were among the many inputs addressed by Corporate Security. All such considerations fall within the scope of the guidelines established by JCAH, the governing board of Corporate Directors, and federal or local laws.

Consistent with the spirit and philosophy of decentralization, the research attempted a consensus-type approach. Formulation of

performance standards and work scheduling possibilities were developed by the creation of standing committees among the Security Directors Council.

These committees address important issues of common interest such as arrest and summons standards, fire safety, training, investigation, disaster controls. etc. Corporate Security assists their efforts by providing staff support to the various committees and sub-committees; acting as a resource information collator, questionnaire disseminator, central record-keeper and Corporate policy mentor.

This feasibility study led us into many aspects of security management and research. While much needs to be sorted out, analyzed and evaluated, much has been accomplished in our quest for a security staffing standard:

- The publication of Corporate-wide policies and Promulgated Policies.
- Creation of an HHC Corporate Security Advisory Board.
- Instituted a series of in-house task forces focusing on issues such as Arrest/Summons Policy, Personal Staffing Standard workcharts.
- Establishing monthly Crime/Incident report detailing crimes, incidents, arrests, injuries and property losses.
- Established a National Network among security managers via the International Association of Hospital Security.
- Established a Monthly calls-for-service report.

This effort enlisted a number of concerned security professionals willing to attack a situation which, to date, has had no solution forthcoming. Hopefully this first generation effort will assist security managers in coping with today's problems while encouraging others to greater success.

CHAPTER III - RESULTS OF THIS STUDY

A. - OPERATIONAL RESPONSIBILITIES

Because of the scope of HHC medical operations it was necessary to use a number of survey instruments (see appendix) to identify staffing similarities and, conversely, its differences. If we could agree to universal standards, quantification would be possible. Once we are able to quantify an aspect, then it becomes a basis for comparative measurements. The degree of difficulty in standardizing can be observed from the survey's findings.

As expected, analysis of our research regarding security methods of operation disclosed that the assigned responsibilities and functions vary considerably among the Corporation's security departments. For example, we found that five (5) hospitals indicated their officers act as witnesses to property checks of patients' valuables conducted by nursing staff, while four (4) responded that officers voucher or safeguard patients' property directly. Three (3) responses indicated officers control or supervise the control function for property vouchering. Two indicated officers' involvement "after hours" only - 5:00 p.m. to 9:00 a.m., and one (1) indicated officers' involvement with psychiatric emergency room patients' property only. In answer to the question, "Are security-police assigned any non-patrol duties relative to parking lot operation such as collecting fees, operating gates, etc." eleven (11) departments answered in the

affirmative, while four (4) were not required to perform these duties. Of those responding in the affirmative two (2) indicated these duties were performed by officers only when available manpower permitted.

Security department involvement in materials management was not undertaken in ten(10) of the hospitals, and of the five (5) reporting in the affirmative, one (1) indicated that the Crime Prevention Officer etches identification numbers on property. Three (3) departments, from a total of fifteen (15) polled, reported that they render such first-aid services as C.P.R., transportation of injured, etc. Evaluation of loss patterns within the hospital are conducted by eleven departments while four (4) reported no involvement in this area. Two (2) facilities require this function to be performed by the Crime Prevention Officers and, at one (1) facility, loss patterns are evaluated yearly based on information supplied by Corporate Security Administration. Three (3) of the facilities reported that their loss patterns are determined through quarterly studies by their respective administration.

Investigative response to thefts of patients, visitor and hospital property vary by facility and reflect the following:

- o Uniformed officers investigates...nine (9) facilities.
- o Supervisory officer investigates or reviews uniformed officers's activity...six (6) facilities.
- o Non-Uniform officer investigates...seven (7) facilities.

- o Crime Prevention officers investigate or conducts a "follow-up" activity...six (6) facilities.
- o NYC Police Department investigates one (1) facility.
- o Community Affairs Officers or Patient Relations Representative investigate one (1) facility.

Internal Control Associates, a security consultant firm, assisted us in the evaluation and analysis phase of this study. A specialist in the health care field, the firm examined security operations at several Corporate hospitals in addition to a limited view of operations of Veterans Administration and voluntary hospitals. Their report (appendix J) recommends that operational staffing levels be established by analysis of the following criteria:

- o The number of personnel required to staff posts mandated by law or Corporation policy, detex, crime prevention, training, investigations, etc.
- o The number of personnel required to provide security, based upon a careful evaluation of security related incidents previously experienced.

The recommendations were based upon their observations of post placement at several of the hospitals which they had studied. They reported that while variations in security requirements are obviously based on the volume of visitors, patient population, number of psychiatric beds, methadone clinics, etc., certain similarities exist in every hospital. Each must maintain certain patrol coverage mandated by law, fire codes and other

governmental regulations. All hospitals cover what can be described as "essential" post requirements, i.e.; posts at entrances to provide security for hospital property and to direct patient and visitor traffic, posts at emergency rooms and psychiatric emergency rooms to maintain order and prevent patient elopement. The remainder of the posts appeared to be arbitrarily created by individual directors of security or as a result of some incident which disturbed the professional staff or aroused community concern.

Facility design was found to be an important consideration affecting security operations and staffing. Their report cited that the design of one Corporate hospital (Woodhull Hospital Center) tends to make the most cost effective security measures expensive. There were twenty-three (23) openings from which entry to the interior of the complex could be achieved:

- Fourteen (14) doors to the hospital from street level.
- Six (6) loading bays.
- Two (2) entrances to the rear yard.
- One (1) ramp to the 4th floor parking area.

Internal Control Associates observed that their review of various hospitals confirmed that security staffing requirements are largely unique to each institution. They concluded that any precise formula developed on such information as square feet, patient census, bed size, etc., would not have

wide applicability and therefore recommended that operational staffing levels be established by analysis of the criteria mentioned in their report.

B. - FORMULA DEVELOPMENT

A tentative "first draft" staffing allocation formula (see appendix M) was developed by Corporate Security based upon data gathered from the publications of security experts, advice from professional associations, the in-put of practicing security organizations, findings of our security consultants and the considered submissions of our staff. Formulation of the design for this initial allocation model represented an attempt to identify all the measurable factors necessary to calculate the manhours required to accomplish the security mission as performed at a given facility. Responsibilities, functions and tasks were broad-banded into what we concluded were the eleven basic staffing factors common to all our security departments. For example all departments utilize security posts, both fixed point and roving patrol. We therefore request from each department:

- o The total number of security posts.
- o The total number of hours that these posts are manned during each calander week.
- o Request that a post description and post orders be furnished for each post.

Crime level and type of offenses being experienced by an institution directly impact upon staffing needs. Sufficient

manpower must be available to assure the personal safety of patients, staff and visitors while buildings, property and equipment must be safeguarded against criminal activity. It is for this reason that a criminal offense indice was incorporated into the staffing formula. The attached (appendix R) offense data covering the first eleven months of 1986, indicated the intensity of crime being experienced by our departments. Reported felonies for the year to date stand at 1,547, misdemeanors at 2,253 and violations number 1,309. Our staffing formula factors in the total hospital facility crime activity reported to the Security-Police during the last twelve months for each category, including arrests, desk appearance tickets and summonses.

Non-criminal incidents which generate calls for service by security officers are broad-handed under a staffing factor termed "Maintenance of Order". Each incident in this category must be one that has been recorded or logged, and required a significant action be taken or activity engaged in by a security officer. Representative activities included in this area, but not restricted to those mentioned are:

- Fire-alarm or drill
- Accident-investigation
- Disturbance
- Dispute
- Disaster
- Safety inspection

- o Missing-recovered property
- o Open doors-investigation
- o Traffic control
- o Visitor control
- o Staff-patient-motorist assist
- o Escort

Concomitant functions is a further staffing factor designed to surface special security department responsibilities requiring the performance of additional activities and tasks beyond those called for by the previously mentioned "factor". The attempt here is to identify those responsibilities which ordinarily may be performed by another department within the facility, but may now be performed wholly or in part by the security department. Representative programs may include but would not necessarily be restricted to:

- o I.D. card processing/control
- o Parking permit processing/control
- o Key control
- o Locksmithing
- o Employee training
- o Money control
- o Flag protocol
- o Fire brigade duties

Unique security situations such as a contruction project at a facility requiring the assignment of a special post (s)

may become the temporary responsibility of the security department. A staffing factor, titled "Special Situations" called for the listing of all extraordinary, but relatively long term temporary responsibilities necessitating the assignment of additional security officers over an extended period of time and causing a considerable drain on the available staffing pool. Consideration is given to such events as special posts created in response to unusual environmental hazards, unique conditions or concerns present in the contiguous community, and identifiable events that occur on a regular cyclical basis.

Patient population and makeup, both permanent and transient reflect upon manpower needs. The "Population Profile" factor identifies such manpower intensive units as psychiatric wards, methadone and alcoholic clinics, homeless shelters, and emergency rooms. Equally important is a factor that identifies the non-patient profile present in each facilities' buildings and grounds, such as the number of persons visiting patients and tradespeople who may be making deliveries, pickups, calling on staff, or performing equipment maintenance and repairs.

Vehicle parking in both concessioned and non-concessioned lots, as well as "on street" parking permitted within the campus of facilities is factored into our formula. Information requested in this report will identify the average number of vehicles traveling through and/or parked at the facility during weekdays and weekends, in addition to the average number

parked in each lot during each duty tour. Provision is made to surface for examination, the security problems associated with these parking lots.

"Land Area" considerations were incorporated into the manpower formula in recognition of the fact that land mass and topography vary greatly among our institutions, ranging from less than one (1) acre, to a facility which encompasses over 400 acres. "Building Patrol" demands also vary, depending upon the variables of total square footage, numbers of floors, type of occupancy, and hours of usage. "Environmental Profile" factors view the impact upon security of the community at large making up the catchment area of the facility.

Copies of our proposed security staffing formula were forwarded for critique and further input to the American Hospital Association, the Hospital Association of New York State, Health and Hospitals Corporate Security Advisory Board, the membership of the International Association of Hospital Security, the consultant firms retained through this grant, and to a Corporate Security Staffing Task Force. As security management professionals, they were requested to expand, modify or refute the material. Their critque of these staffing factors would help us to develop a management tool for our institutions, sufficiently flexible for application by any security manager required to determine proper security staffing levels.

C. - CRITIQUE OUTCOME

Responses to our request for critiques regarding the proposed staffing allocation plan resulted in a number of substantive changes and additional procedural steps being added to our initial effort. For example, respondees recommended that a security survey should be conducted at each facility and a decision made as to the physical and electronic security that could be put in place at respective facilities as a precursor to the issue of manpower resolution. Further suggestions forwarded by our respondents noted that only one staffing scheduling formula, approved by Corporate Security, should be utilized by all facilities and must consider vacation time, projected or experienced sick time, holidays and other time off security personnel might receive, such as personal days. Because of these suggestions Corporate Security amended its staffing allocation plan to include a manpower scheduling formula (appendix S) that can be universally applied to local HHC security departments.

Other respondents raised the issue that the quality of supervision is a key element of employee work performance impacting not only upon the quality of work but the sufficiency of work performed and consequently, the number of staff required to accomplish its goals. Corporate Security while in agreement, did not incorporate supervisory practices directly into the staffing allocation plan but does address the issue by requiring all superior officers to attend a 35 hour management refresher

course each year. Upon initiating such a staffing allocation plan management courses will include additional supervisory awarness training to ensure successful implementation of this plan.

Criticisms regarding the cataloging of Basic Hospital Security Staffing Factors identified certain areas of possible deficiency. Several important changes and additions were made to the catalogue including the deletion of some tasks found to be redundant that would have negatively affected the "time spent" outcome; the definition of some terms used in factor guidelines were found to be inexact and therefore changed. Other respondents cited the lack of an explanatory rationale to justify factors dealing with local conditions specific to each hospital. This last problem was addressed through the inclusion of a narrative presentation of staffing requirements prepared by consultant Russel Colling. His presentation will accompany the staffing request preparation package.

D. - CRITICAL ISSUES TO BE RESOLVED

Problems attendant to the final development of a system-wide manning formula will be resolved upon receipt of the completed Basic Hospital Security Staffing Factors from our various member hospitals. Upon receipt we will then wrestle with the weight to be assigned to the various factors and categories, based upon our assessment of the relative merits of the listed activities to the total experience of the hospital security organization.

Questions remain regarding some staffing factors in respect to danger to life or well being, the value of the loss experience, and the patient, staff or visitor fear-level. The answers to these questions must be determined to correctly assess the level necessary to warrant the cost of a security presence at a patrol post. (Admittedly, this is a subjective calculation which permits variations from facility to facility, unless one person or authority acting for the Corporation makes these judgements).

Would the presence of a security-police officer at a patrol post be expected to prevent or substantially reduce the danger, loss, or fear, given the human concern for such incidents, or would the application of some creative management tactic such as a closed circuit television camera equipped with two way communication capability respond correctly to this real human concern in a cost effective manner? If physically assigned is there some other function the officer could serve at the post without diminishing his preventive effectiveness.

At the conclusion of an experimental time period, a re-evaluation should be made in terms of the actual reduction of incidents. Perhaps some non-labor-intensive technology or change in hospital procedure could impact on the problem.

Admittedly, these are subjective calculations which permit variations from facility to facility. The guidelines were adjusted to include a calculative time period of twelve months.

whereupon the existence of actual data will be available.

A further problem exists in that while staffing may indeed be "mandated" by Federal Law, State Statute, by City ordinance or by contractual agreement, it may also be mandated in a very real sense by court decisions in civil cases. The latter may have assigned liability to a hospital for negligence in failing to provide security personnel at some particular, place, time or circumstance. Consideration should be given to routinely monitor adverse litigation in order to make effective manning adjustments.

Resolution of the problems cited above, combined with the weighted application of the indices derived from "time studies" resulting from facility responses to our Standard Staffing Factors will lead to development of a reliable formula applicable system-wide. This additional quantification will be based on the average handling time spent for recurring kinds of events, functions, tasks and service calls reported by the facilities for these factors.

E. STANDARD STAFFING GUIDELINES

The desired facility protection level determined by administrative philosophy, policy and budget will guide the security manager in the choice and application of possible protection safeguards. Security manpower as one of these safeguards is the foundation for security patrol and service response capability.

Our staffing factors will enable the manager to calculate manhours required to accomplish the protection level desired. Eight factors serve as staffing requirement prompters, guiding the managers' efforts towards the proper informational input necessary to satisfactorily complete major factors nine, ten and eleven. These major factors result in a prioritized listing of facility patrol posts and identify assigned departmental tasks; showing the number of manhours necessary for proper performance. From these factors the manager can calculate:

- Optimal siting of patrol posts to accomplish the security mission
- Desired response time apportioned to "calls for service"
- Desired frequency of inspectional patrol
- Assigned routine department activities and tasks
- Non-scheduled temporary activities and tasks
- Manhours required to accomplish the defined security mission
- Conversion of required manhours to a full-time-equivalent employee basis

Universal Hospital Staffing Factors

Standard hospital security staffing factors utilized to calculate total manhours required at a healthcare institute are:

- Factor 1 - Population Profile

This factor draws up for consideration the protection demands inherent to the makeup of a patient population. For example phychiatric wards, methadone clinics, alcoholic clinics and emergency rooms can affect staffing requirements and should be

evaluated during this post assessment and priority selection process. List the in-patient services provided by your facility giving the bed capacity for each service. List the outpatient services provided by your facility, showing the days and hours of operation and the total number of patient visits during the last twelve months for each service.

o Factor 2 - Non-Patient Profile

This factor draws up for the security manager's consideration during the post allocation process the protection demands inherent to the non-patient population present at the facility. Consider the average non-patient population present in each building of your facility for which you have security responsibility during:

Weekdays	Tour 1 _____	Tour 2_____	Tour 3_____
Weekends	Tour 1 _____	Tour 2_____	Tour 3_____

o Factor 3 - Vehicle Parking

Parking lots often generate security problems and must be considered a principal security manpower requirement. To facilitate post selection and priority assessment list for your facility and each satellite the average number of vehicles parked in each non-concessioned parking lot during:

Weekdays	Tour 1_____	Tour 2_____	Tour 3_____
Weekends	Tour 1_____	Tour 2_____	Tour 3_____

a) Summarize the security problems associated with these parking lots.

b) Summarize any security problems that you feel should be addressed for parking lots that are concessioned. Are provisions for security contained in vendor contracts.

c) If "on street" parking is permitted within the campus of your facility or satellite (s) summarize any security problems associated with this practice.

o Factor 4 - Land Area

Type and intensity of perimeter and grounds patrol are influenced by the geographic area of responsibility given the security department. Determine the total area in square miles of your facility. Does the size and topography indicate a need for vehicular patrol? Have physical security measures such as walls, fences, lighting, C.C.T.V., etc. been optimally utilized? Does a records search for past occurrences in the area reveal a specific protection need or will routine inspectional patrol suffice?

o Factor 5 - Building Profile

To assist the security manager in planning for a correct level of building patrol a study should be undertaken of building engineering plans and a security survey conducted. Optimum use of physical safeguards should be utilized consistant with cost effectiveness, to assist security forces. Planners should remember that any warning system is valueless unless supported by prompt security force action in the event of need. Selection of physical security systems as adjuncts to manpower should be dependent on effectiveness, reliability, cost, and maintenance required. The situations and

conditions at the particular building to be protected determine which devices or systems are efficient and practical.

The following important building profile characteristics should be considered when determining patrol coverage for buildings where you have responsibility to provide security including unoccupied/unused buildings requiring coverage:

a) Total square footage

b) Number of floors

c) Main occupancy or use of each building

d) Criticality of the building

e) Vulnerability of the building

f) Accessibility to intruders, visitors and employees

g) Locations of areas to be protected

h) Construction of building

i) Hours of operation

j) Availability of other forms of protection

k) Initial and recurring cost of security systems compared to cost of possible property or information loss

o Factor 6 - Environmental Profile

Conditions existing in the community at large often affect security levels within a hospital. Nearby schools, entertainment centers, transportation depots, playgrounds, factories, slums, etc. could generate security problems. The relationship the facility has with the community needs to be explored. Do community groups use hospital resources such as meeting rooms? Does security interact with the community by providing training in safety awareness or crime prevention techniques? Are hospital authorities concerned about employee,

patient, visitor safety while making their way to public transit facilities after work tours or while visiting or upon discharge? Is an escort service provided? The security manager should consider such peripheral agendas and environmental conditions as they will affect staffing requirements.

o Factor 7 - Criminal Offense Indices

Total hospital facility crime activity, encompassing felonies, misdemeanors, and violations are profiled statistically for managerial review. Criminal offenses which have been reported to the Security Police during the last twelve months are examined to ascertain the day of the week, time, number, location, type and severity of each occurrence. A determination of priority post coverage is then made on the basis of these statistics and incorporated into Patrol Posts, Factor 9.

o Factor 8 - Maintenance of Order

Work activity involving incidents responded to by security officers acting in their peace keeping and service role is measured by this factor. Consider the total number of all recorded incidents which generated calls for service that have been responded to by the Security-Police during the last twelve months. Each incident must be recorded and performance time logged, and requires a significant action be taken or activity engaged in by a security officer (s). Consider only those functions and activities which were actually being performed by officers in a specific situational environment. Representative activities should include but would not necessarily be resticted to:

- Fire, alarm or drill
- Accident, investigation
- Disturbance
- Disaster
- Safety inspection, report
- Burglar, alarm
- Vandalism
- Property, missing or recovered
- Open door, investigation
- Court appearance
- Traffic control
- Motorist assist
- Escort

A determination of priority post coverage is then made on the basis of these statistics and incorporated into Factor 9.

- Factor 9 - Security Posts

List the total number of security posts; fixed, roving or other and the number of hours that these security posts require manning. Utilizing the following guidelines, list for your facility each Hospital Security Post as per the example shown below. Beginning with the post rated as having the highest measure of importance and list each subsequent post in a descending order of priority coverage. Designate each post as a fixed (F), or roving patrol (R), and give the total number of hours that the post is manned for each calendar week. A post description with accompanying Post Orders should be furnished for each post listed.

Example Post List

POST NUMBER (PRIORITIZED)	TYPE	HOURS MANNED PER WEEK
3	F	168:00
1	R	40:00
4	F	84:00
5	F	56:00
2	R	16:15

Guidelines for Staffing Factor Number 9

A security post is defined operationally as any location or area at which an activity or combination of activities occurs which necessitates the presence of a trained security police officer (s). This includes coverage of "Fixed" and "Roving Patrol" post requirements. This definition indicates that a security-police officer's capabilities, characteristics or reactions are required on or at the post in question. Obviously, priority is not merely synonmous with the number of hours required. A priority could relate to an urgent deployment required for a minimum period of time.

The following kinds of functions, activities or needs, while not all-inclusive, should be considered when designating an area or location as a post:

- Security Control at facility entrances and exits; lobbies and elevator; trauma and special treatment centers such as emergency rooms and methadone clinics; vehicle traffic and parking.
- Security Patrol of buildings, grounds and perimeters; crime prone and safety hazard locations.

- o Security Inspection of fire, safety, accident and security conditions and/or equipment.
- o Duties required by law, regulations, policy etc.

Its important to note that the post definition requires that security police officers capabilities, characteristics or reactions are considered physically necessary on the post. If the physical assignment is at a location other than the proposed post (for example, where a C.C.T.V. camera and audio transcriber would permit personal recognition for access-control purposes to be accomplished), then the proposed location may not require security-police staffing assignment. Once the institution has determined that a post is necessary under the suggested criteria, a determination must be made as to the precise periods during which it must function. For example, an access-control post for monitoring an out patient clinic which operates 0900 to 1700 hours Monday through Friday only, is evidently not needed between 1700 and the following 0900 daily, or on weekends. The techniques for determination of post hours involve charting actual events and activities occurring at or through the post, over a 24 hour, seven day time frame. For example, if personnel access is the activity, flow counts over various time intervals such as 30 or 60 minutes, or longer, will indicate the level or density of movement and occupancy. If it appears that these variables are very heavy for brief periods, it is clear that an economy is possible if the post is manned only for the peak density of movement or occupancy and the security-police officer rotated to another interim

assignment during the off-peak period (s). This same technique should be followed for posts which control vehicular movement, visitor control and other time-related activities.

Having determined the operational need for a security post, and the days and hours at which that need exists, you will know the number of hours in each of the conventional three shifts during which the post must be staffed.

Post Orders and Descriptions are the most important written instructions for the Security-Police Force. The post Description describes in detail the actual geographical location, area, and parameters of the post, while the Post Orders express the policy of the Security Department with respect to security functions such as control of entrances, and movement of pedestrian and vehicle traffic; patrol of buildings and perimeters; special assignments and inspection of safety, security and fire conditions.

Post orders represent a summary of all the required security duties and also provide each facility the opportunity to uniquely respond to institutional-specific needs. The officer is given greater direction and investment in role responsibility, forestalling word-of-mouth transmission of duties to be performed. This impacts in a positive manner upon on-the-job task familiarization as a means of supplemental Special Officer training and instruction.

o Factor 10 - Concomitant Functions

Measured under this factor are the special security department responsibilities requiring the performance of additional activities and tasks. Beginning with the function rated as having the highest measure of importance with each subsequent function in a descending order of priority, list for your facility the additional security programs performed by officers which are the responsibility of the Department but have not been included in the previous staffing Factors. Use the illustration shown below as a guide. Representative programs may include but would not necessarilly be restricted to:

a) I.D. Card Processing/Control
b) Parking permit processing/control
c) Investigation/Detective Unit
d) Key control
e) Locksmithing
g) Money Control
h) Toll booth
i) Flag Protocol
j) Crime Prevention
f) Training (other than roll-call)

Col. 1 Program Name Activity or Description	Col. 2 Level of Service	Col. 3 Manpower time allocation
Locksmithing	Mon. to Fri. 10 am to 6 pm	37:30 hr. per week
Parking Permit Processing & Control	430 Permits issued per year	104:00 hr. per year
Flag Protocol	raise and lower two flags each day	1:00 hr. per day
Crime Prevention	Perform (8) loss pervention surveys and conduct (6) crime prevention training sessions per year	412 hr. per year

Col. 1: Program description

Col. 2: Amount of Service the program renders and/or days and hours service is available.

Col. 3: Enter the amount of time spent by the officer(s) in the performance of the program or activity. Time spent should reflect the total hours and/or minutes needed to achieve the level of service given in Col. 2.

o Factor 11 - Special Situations

Unique security situations such as an unusual event requiring the assignment of a special post (s) for a period of time are measured by this factor. Please list for your facility and separately for each satellite the extraordinary but temporary responsibilities of the Security-Police Department necessitating the assignment of additional Special Officers over an extended period of time which will cause a considerable drain on your available staffing pool. Consider such events as special posts created in response to a period of major construction; unusual environmental hazards; unique social conditions or concerns present in the contiguous community; or identifiable events that occur on a regular cyclical basis. Show the level of service, manpower requirement in terms of hours manned per week and the anticipated completion date for each temporary responsibility listed. Security managers are encouraged to maintain a month by month calendar of activities journal. Maintained over several years the journal provides historical data that enables the manager to forecast and control management problems more effectively.

Upon completion of the foregoing staffing factors, facilities can determine their approximate staffing requirements by applying the Workload to Manpower Conversion Formula (appendix S). This outcome indicates staffing needs in terms of the facilities' defined security mission.

This study was undertaken to determine the feasibility of a standard hospital security police staffing formula. We have attempted to eliminate inequities in the application of our formula which we have titled "Hospital Security Police Staffing Factors", but realize that different managers are applying the criteria, and managers tend to see that which is attractive to them given their perception of their own managerial needs. Problems and obstacles toward a standard universal application exist and probably more will surface as we move forward into the quantification phase of this valuable, albeit necessarily incremental effort.

NOTE:

For the convenience of the reader, we have developed a condensed reference manual, which immediately follows this section. This manual contains many of the key items of interest located in the various appendices necessary for the approximation of staffing needs.

END

CONDENSED REFERENCE MANUAL

Staffing Factor #1

CRIMINAL OFFENSE INDICE

Total hospital facility and satellite(s) crime activity, encompassing felonies, misdemeanors, and violations.

Please enter the total number of criminal offenses which have been reported to the Security - Police during the last twelve months for each category shown below.

OFFENSES	ARRESTS*
Violations_____	_____
Misdemeanors_____	_____
Felonies_____	_____

*Include all appearance tickets and summonses (except traffic "A") in this total.

Staffing Factor #2

MAINTENANCE OF ORDER

Total non-criminal incidents, occurring at your facility and sattelite(s) that are responded to by Special Officers in their peace keeping service role.

Please enter the total number of all recorded non-criminal offense incidents which generated calls for service that have been responded to by the Security-Police during the last twelve months.

Total_____

Note that each incident must be recorded or logged, and required a significant action be taken or activity engaged in by a Special Officer(s). Consider only those functions and activities which were actually being performed by officers in a specific situational environment. Representative activities should include but would not necessarily be restricted to:

a) Fire - alarm or drill
b) Accident - investigation
c) Disturbance
d) Dispute
e) Disaster
f) Disorderly person
g) Unusal occurrence
h) Safety inspection - Report
i) Burglar - panic - door - alarm
j) Vandalism
k) Missing - recovered property
l) Open door - investigation
m) Traffic control
n) Visitor control
o) Parking Control
p) Staff - patient - motorist assist
q) Escort

Staffing Factor #3

SECURITY POSTS

- Total number of security posts; fixed, roving and other.
- Total number of hours that these security posts require manning.

Utilizing the following guidelines list for your facility and and separately for your satellite(s) each Hospital Security Post as per the example shown below. Beginning with the post rated as having the highest measure of importance and list each subsequent post in a descending order of priority coverage. Designate each post as a fixed (F), or roving patrol (R), and give the total number of hours that the post is manned for each calendar week. A Post Description and Post Orders should be furnished for each post which is listed.

Example post list

POST (PRIORITIZED)	TYPE	HOURS MANNED PER WEEK
3	F	168:00
1	R	40:00
4	F	84:00
5	F	56:50
2	R	16:15

Guidelines for Staffing Factor Number 3

A security Post is defined operationally as any location or area at which an activity or combination of activities occurrs which necessitates the presence of a trained security police officer(s). This includes coverage of "Fixed" and "Roving Patrol" post requirements. This definition indicates that a security-police officer's capabilities, characteristics or reactions are required on or at the post in question.

The following kinds of functions, activities or needs while not all inclusive, should be considered when designating an area or location as a post: Security Control at facility entrances and exits; lobbies and elevators; trauma and special treatment centers such as emergency rooms and metadone clinics; vehicle traffic and parking. Security Patrol of buildings, grounds and perimeters; crime prone and safety hazard locations. Security Inspection of fire, safety, accident and security conditions and/or equipment.

Note that the post definition requires a security-police officers capabilities, characteristics or reactions are considered necessary at the post. This means that, if the real application of the capabilities or qualities is at some location other than the proposed post (for example, where a C.C.T.V camera and audio transcriber would permit personal recognition for access-control purposes to be accomplished), then the proposed location may not require security-police staffing.

Having judged a post necessary under the suggested criteria, a determination must be made as to the precise periods during which it must function. For example, an access-control post for monitoring an out patient clinic which operates 0900 to 1700 hours Monday through Friday only, is evidently not needed between 1700 and the following 0900 daily, or on weekends. The techniques for determination of post hours involves charting actual events and activities occurring at or through the post, over a 24 hour, seven day time frame. For example, if personnel access is the activity, flow counts over various time intervals such as 30 or 60 minutes, or longer, will indicate the level or density of movement and occupancy. If it appears that these variables are very heavy for brief periods or peaks, and are light or absent for longer intermediate periods, it is clear that an economy is possible if the post is manned only for the peak density of movement or occupancy and the security-police officer rotated to another interim assignment during the off-peak period(s). This same technique should be followed for posts which control vehicular movement, visitor control and other time-related activities.

Having determined the operational need for a security post, and the days and hours at which that need exists, you will know the number of hours in each of the conventional three shifts during which the post must be staffed.

.../

Post Orders and Descriptions are the most important written instructions for the Security-Police Force. The Post Description describes in detail the actual geographical location, area, and parameters of the post while the Post Orders express the policy of the Security Department with respect to security functions such as control of entrances, and movement of pedestrian and vehicle traffic; patrol of buildings and perimeters; special assignments and inspection of safety, security and fire conditions.

Post Orders represent a summary of all the required security duties and also provide each facility the opportunity to uniquely respond to institutional specific needs. The officer is given greater direction and investment in role responsibility, forestalling work-of-mouth transmission of duties to be performed. This impacts in a positive manner upon on-the-job task familiarization as a means of supplemental Special Officer training and instruction.

CONCOMITANT FUNCTIONS

- Special Security Department Responsibilities requiring the performance of additional activities and tasks.

Please list for your facility, and separately where applicable for each satellite, the additional security programs performed by officers which are the responsibility of the Department but have not been included in the Special Officer Staffing Factor No. 3. Use the illustration shown below as a guide. Representative programs may include but would not necessarily be restricted to:

a) I.D. card processing/control
b) Parking permit processing/control
c) Investigation/Detective unit
d) Key control
e) Locksmithing
f) Training (other than roll-call)
g) Money control
h) Fire/safety equipment inspection
i) Cash escorts
j) Toll booth
k) Flag Protocol
l) Crime Prevention

Col. 1 Program Name Activity or Description	Col. 2 Level of Service	Col. 3 Man power Allocation
Locksmithing	Mon. to Fri. 10 AM to 6 PM	S.O. 37:30 hr. per week
Parking permit Processing & Control	430 permits issued per year	Sen. Sp. 104:00 hr. per year
Flag Protocol	raise and lower two flags each day	S.O. 1:00 hr. per day
Crime Prevention	Perform (8) loss prevention surveys and conduct (6) crime prevention training sessions per year.	S.O. 412 hr. per year

Col. 1: Program description
Col. 2: Amount of service the program renders and/or days and hours service is available.
Col. 3: Enter the rank of the officer(s) assigned and the amount of time spent by the officer(s) in the performance of the program or activity. Time spent should reflect the total hours and/or minutes needed tc achieve the level of service given in Col. 2.

Staffing Factor #5

SPECIAL SITUATIONS

- Unique security situations such as an unusual event requiring the assignment of a special post(s) for a period of time, e.g. construction.

Please list for your facility and separately for each satellite the extraordinary but temporary responsibilities of the Security-Police Department necessitating the assignment of additional Special Officers over an extended period of time which will cause a considerable drain on your available staffing pool. Consider such events as special posts created in response to a period of major construction; unusual environmental hazards; unique conditions or concerns present in the contiguous community; identifiable events that occur on a regular cyclical basis. Show the level of service, man power requirement and the anticipated completion date for each temporary responsibility listed.

Staffing Factor #6

POPULATION PROFILE

- Patient population and makeup (permanent and transient) e.g. Psychiatric ward, Methadone clinic, Alcoholic clinic, Emergency room.

- List the in-patient services provided by your facility and each satellite(s) giving the bed capacity for each service listed.

- List the out-patient services provided by your facility and satellites (including the Emergency Room, if any). Show the days and hours of operation and the total no. of patient visits during the last twelve months for each service.

Staffing Factor #7

NON-PATIENT PROFILE

- Total non-patient population present at the facility (daily average by tour).

Please give the average non-patient population present in each building of your facility and satellites for which you have security responsibility during:

Weekdays Tour 1 _____ Tour 2 _____ Tour 3 _____

Weekends Tour 1 _____ Tour 2 _____ Tour 3 _____

VEHICLE PARKING

o Parking Lot(s) concessioned and non-concessioned.

Please list for your facility and each satellite the average number of vehicles parked in each non-concessioned parking lot during:

Weekdays	Tour 1 _____		Tour 2 _____		Tour 3 _____
Weekends	Tour 1 _____		Tour 2 _____		Tour 3 _____

a) Summarize the security problems associated with these parking lots.

b) Summarize any security problems that you feel should be addressed for parking lots that are concessioned.

c) If "on street" parking is permitted within the campus of your facility or satellite(s) summarize any security problems associated with this practice.

Staffing Factor 9

o Total geographic area of responsibility.

---

a) What is the total area in square miles of your Facility?

b) What is the location and total area in square miles or sq.ft. of each satellite?

(Answer b only if the satellite(s) is located off your campus and you have responsibility to provide security).

Staffing Factor #10

BUILDING SECURITY PATROL PROFILE

o Description and total square footage of each building.

List each building located within your facility and those at each satellite for which you have the responsibility to provide security, giving:

a) Total square footage
b) No. of floors
c) Main occupancy or use of each *building

*Include unoccupied/unused buildings if they require patrol coverage.

Staffing Factor #11

ENVIRONMENTAL PROFILE

- Environmental setting of the facility.

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FACILITY SECURITY OPERATIONS
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

AUDIT REPORT NYC-36-80

Division of Audits and Accounts
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DEPARTMENT OF AUDIT AND CONTROL
DIVISION OF AUDITS AND ACCOUNTS.
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NEW YORK CITY HEALTH AND
HOSPITALS CORPORATION

MANAGERIAL SUMMARY

Scope of Audit

We reviewed the security operations at various NYC Health and Hospitals Corporation (HHC) facilities for the period January 1, 1979 through September 30, 1980. On-site reviews were made at Lincoln, Bellevue and Queens Hospitals, and at the Office of the Director of Security-Corporate.

Background

Security of persons and property at the 17 HHC hospitals, related health care facilities and central administrative offices is a major concern. Protective services were provided by a security force of 887 men and women, a force larger than that of the cities of Miami or Minneapolis and in fact larger than the police departments of many cities in the United States. Security salaries and associated fringe benefits exceeded $15 million annually.

HHC has never had a comprehensive evaluation of its security operation made by the New York City Police Department or any other major law enforcement entity.

A program was initiated in 1978 to designate HHC special officers as "Special Patrolmen," with peace officer status and the right to bear arms and enjoy certain immunities under the State Criminal Procedure Law. To date, about 60 percent of the special officers have been deputized.

The Unified Peace Officer Law mandated that all special officers be deputized by November 1, 1980. Consequently, HHC developed a series of new and higher security standards, especially in the areas of training, recordkeeping and reporting of crime statistics, field investigations, administration and supervision.

Major Observations and Conclusions

The full extent of crime in the municipal hospitals is unknown. There is no comprehensive reporting and compilation of data on criminal activity. Available partial reporting for calendar year 1979 indicated that just property theft losses, both HHC and personal, exceeded $700,000. We expect that actual dollar losses from theft and misappropration involves millions of dollars annually based in part on an HHC Inspector General's estimate that annual property losses exceeded $22 million. An example of the need for improvement in HHC's security operations was a United Hospital Fund of New York report in March 1979 that Lincoln Hospital was experiencing a shortage of wheelchairs because "more than 90 percent of the original wheelchairs had been stolen or lost."

We identified certain factors hindering HHC's ability to control crime which could be overcome through better managerial practices: incomplete reporting of criminal activity (for example, many consecutive months with no incidents reported by a number of hospitals); inadequate training; the absence of clearly defined lines of authority, direction and responsibility; and disparities in staffing patterns (Section B).

Neither the hospitals we visited nor Central Security prepared any consolidated statistical crime report or detailed analysis of the extent of crime at HHC institutions. Facilities did not always file a "Theft and Incident Report" with Central Security when required. We found this to be the case with at least 11 of the 17 hospitals. Hospital officials were confused as to which incidents needed to be reported. They felt that the reporting criteria were vague and that specific guidelines were needed. But Central Security alleged that hospitals' Executive Directors were reluctant to accurately report crime, fearing that it would reflect badly on them and their institutions. Reports were often illegible or failed to identify the crime victim. The Unified Peace Officer Law mandates that accurate statistical and other crime related data must be furnished periodically to the New York State Division of Criminal Justice Services. Therefore, action is necessary to assure that officials comply with prescribed reporting requirements and standards.

Accordingly, Central Security needs to clarify its incident reporting directive, periodically compile and analyze crime statistics, and furnish timely reports to the hospitals. This will permit them to identify high risk problems and better deploy their security forces (Section C).

About 25 percent of HHC's officers had not participated in Central Security training before being assigned to a hospital. Compliance with the Unified Peace Officer Law requires a substantial increase in training hours for all levels of security personnel. A proposal by the Director of Corporation Security has been made for achieving the equipment and staffing needs mandated by the Law (Section D).

At some hospitals, employee thefts were dealt with leniently--suspensions without pay for three to four weeks. At other times, the involved employees were terminated. The lenient treatment, according to Security and Personnel officials, only worsened the situation. We found no mention of encouraging prosecution of offenders.

The relationship between hospital size and number of security staff varied considerably, ranging from 2,856 to 32,182 square feet per security officer. While other factors may have a significant bearing in staffing the security function, we suggest these inconsistencies exist because each hospital budgets for its own security with varying levels of priority in relation to patient care activities. We found that personal service cost for security ranged between .9 and 2.6 percent of total hospital personal service cost. Also, that as the number of security officers at the hospitals decreased, generally as a result of budget constraints, premium paid overtime increased, lessening the expected savings. For example, between fiscal years 1978 and 1980, HHC's security force decreased by 14 percent (1,033 to 887 officers); however, paid overtime more than doubled.

We recommended that HHC consider centralizing the security function as a single budget item, with authority in Central Security to assign the force to the 17 facilities based on more uniform criteria of each hospital's security needs. The cost benefit of reduced crime, including lessening of the loss of Corporation-hospital property from increasing the security staff, should be explored as an alternative to premium pay overtime (Section E).

We believe that the decentralized nature of the security function with each hospital independently determining its own security needs and services, partially cause some of the deficiencies cited herein. Assigning a greater role to Central Security as a supervising and coordinating authority might effectively correct this situation (Section F).

Our observations at Queens, Bellevue and Lincoln Hospitals disclosed a lack of control over keys, monitoring of identification cards used for access within the hospital, and unexplained inventory discrepancies. We also found improvements were needed in performing package inspection and small item identification (Section G).

* * * *

The Corporation President responded to the draft report stating:

> "The report identifies serious problem areas and raises important issues that require careful attention. I have shared the report with Police Commissioner McGuire, who has appointed a team to help us conduct a comprehensive review of our security system over the next few months and come up with specific recommendations on how we can improve it."

The President's statement indicates a serious intent to effectively implement our recommendation to have a survey of Corporation security operations made by the New York City Police Department.

NEW YORK CITY POLICE DEPARTMENT

Executive Summary

Hospital Security Police

On-site surveys at all H.H.C. facilities indicate that each hospital security unit is essentially autonomous and is managed under the direct control of the hospital's executive director. This type of decentralization was determined to have a negative impact on performance, greatly affecting the security police role within the facility, enforcement policies, training, communications, procedures, and uniform appearance.

To improve the operational effectiveness of hospital security units, a single security philosophy should prevail throughout the entire corporation. Serious consideration should be given to increased centralization, under the direction and control of the Corporate Security Director. Under a more centralized organizational concept, the authority of the Corporate Security Director should be increased to enable him to more effectively interact with executive directors and assistant directors.

Task force members were particularly impressed by the caliber of personnel hired or selected to fill hospital security director positions. Many are former police officers or supervisors from city police agencies. Others were promoted

through the ranks of the Hospital Security Police. As a group, they appeared to be highly concerned with the security problems of their institutions, and are interested in finding more effective solutions. Some have developed innovative strategies, procedures or crime prevention techniques which should be emulated in other hospitals. Most indicated they manage their security units under severe constraints regarding personnel, equipment, and budgetary resources. Most expressed dissatisfaction with the existing security organization, and with the levels of training and support services received from the Corporate Security Office. Security directors were hopeful that the organization and its operating procedures could be improved as a result of this management study.

The special officer's role, including enforcement policy, training, equipment, procedures, and uniform appearance should be improved and standardized. Under the existing system, special officers are basically employed as security guards, with restricted enforcement powers. Their primary role is to deter crime and maintain order by providing a uniformed presence. Since administrators want to maintain an harmonious environment, most security attention is directed at members of the public. Special officers are not presently effective in policing their fellow employees, or members of the administrative and professional staff. Some staff members, as well as many members of the public, openly disregard criminal laws and hospital

regulations with relative impunity. Several hospitals have potentially dangerous or crime prone areas which are usually avoided by security personnel. Security efforts should be increased to include attention to all persons present in all areas of the facility, including staff members. After proper training, special officers should be permitted wider enforcement latitude, to enable them to exert increased control over lawbreakers. Essentially, the role of a special officer should be expanded through job enlargement, to include crime prevention, intelligence reporting, and the detection of crime and arrest of all offenders, in addition to existing security duties. These recommended changes should be introduced after suggested revisions to improve the organization, hiring standards, training, and security procedures are implemented.

The functions of the Corporate Security Office should be expanded to provide a multilateral attack on hospital crime. A crime prevention function, staffed by an experienced specialist(s) should be created to coordinate a target hardening program to reduce the opportunities for crime. An Inspector General's intelligence gathering capability should be established to covertly gather information about ongoing criminal activities, such as significant inventory shortages, employee theft, and drug activities. A crime analysis capability should be developed to obtain information about crime patterns and formulate appropriate crime response stragegies.

An inspections funotion should be created to improve security management and voluntary compliance with corporate security procedures.

Observations and record sampling techniques were used at many city hospitals to determine the need for additional security training. Most hospitals do not currently have in-service security training programs. Where training programs do exist, they were found to need improvement in both length and content. The most critical areas of training which should be addressed, include knowledge of the Penal Law, Criminal Procedure Law, Use of Force, Handling of Emotionally Disturbed Persons, and Report Writing. Since there is currently no standardized in-service training program, the Corporate Security Office should develop and coordinate a program designed to reach all security personnel.

The security director at each hospital purchases communications and other types of security hardware independently, therefore, equipment differs from one hospital to another. The disadvantages of this system include the inability to borrow or loan portable radios, since they are not interchangeable, inability to communicate between facilities via radio, inability to cannibalize or salvage parts, and inability to have radio repairs made inhouse. There is also little sharing of information about the advantages and disadvantages of various

types of security hardware, such as alarm systems, closed circuit television systems, locking systems, etc.. There are several facilities where costly security systems such as closed circuit television, communications, and card access systems were purchased but are now abandoned. Corporate standards should be developed for the purchase and use of all security related equipment. Volume purchase and maintenance discounts should be obtained where possible. Guidelines should be developed to ensure that security equipment is prudently purchased, with prior consideration given to operating cost, maintenance, and training.

Some hospitals do not currently have a sufficient number of portable radios to equip all security personnel. For the safety of special officers, this condition should be corrected as soon as possible. At several hospitals there are serious radio reception problems which should be remedied by the installation of signal boosters. There is also a need for improved standards for safeguarding communications equipment. When not in use, portable radios should be secured within a locked cabinet located in an area not accessible to the general public.

Each hospital security unit currently uses its own set of regulations and procedures. While there are many similarities, there are also many variations. Hospital security units should be managed using uniform procedures and forms. The Corporate

Security Office should develop a standard Manual of Procedure for use at all facilities and should standardize security forms and reports.

Uniform appearance is an important aspect of the deterrent effect of the police, and may be even more important to the performance of an unarmed security force. In many hospitals, as many as five different types of uniforms are worn by special officers. Therefore, it is recommended that a "Uniform of the Day" regulation be adopted and enforced. This should include a provision regarding the required or optional wearing of hats.

A comprehensive rationale for the recommendations made in this study is explained in the appropriate sections of the report. Summarized below are the major findings and recommendations reached during the course of the project. Included in this summary are areas thought to have the greatest impact on the administrative and operational functions of the H.H.C. security force.

Centralization

The Corporate Security Director should have direct control over the operational and administrative functions of the entire security structure. Command responsibility and accountability are requisites for a well managed organization. The present de-

centralized organization inhibits tne efficient management of resources and provides little coordination, since each security chief remains loyal to his executive director. Executive directors, left to allocate their own budget, tend to place security in a low priority category and disburse funds accordingly. As a result, the deployment of manpower is contingent upon a subjective decision rather than demonstrated need. Hospitals that have experienced an increase in crime or other security related problems must rely upon their executive director to recognize the condition and increase the security allotment. Unfortunately, money must usually be diverted from another function more closely related to the hospital mission such as nursing care. The executive director is not likely to make this kind of financial adjustment. Concentrating the authority for the security budget in the Corporate Security Director's office would be an important first step in correcting this problem. Furthermore, centralizing the budget allocation process is necessary for the eventual control of otner managerial functions such as internal inspections and personnel allocation. An allocation plan, wherein security officers are deployed based on a formula reflecting need, can best be established within a centralized organization. Budget and personnel adjustments could subsequently be made based upon the current needs in each facility. By consolidating direction and control of security operations in the Corporate Security Director's office, efficiency and productivity should improve. Expanding the

authority of the Corporate Security Director in this manner is crucial to better management.

Standardization of procedural and training guidelines can also be accomplished by centralizing the security organization. The present fragmented practice of permitting hospitals to develop their own procedures and training guidelines results in a distortion of corporate security goals and substantial differences in the quality of security. Uniform procedures, emanating from the corporate office, would tend to foster greater efficiency and effectiveness

Training

The H.H.C. security force is comprised of special officers with peace officer status who are authorized to effect arrests and issue summonses. To carry out this responsibility in an effective and prudent manner, they must have a thorough knowledge of the penal law, the laws governing the conduct of law enforcement officers, and organizational rules and procedures. Sufficient entry level and in-service training courses are indispensable to achieving a high level of performance. Attendance at training sessions by all special officers should be mandatory. The present security training program is deficient in both the curriculum content and the method for recording and controlling attendance.

The Municipal Police Training Council of the New York State Bureau for Municipal Police monitors compliance with state standards for a peace officer training curriculum. These standards must be met by public and private employers of peace officers. State officials from that agency annually review existing programs for conformance with these requirements. Review of the existing training program by the Police Task Force revealed certain shortcomings that should be corrected. Additionally, some of the subjects covered in the entry level training program may not be directly relevant to the actual duties of a special officer. Others are verbatim reproductions of statutes or reference material that may be difficult to comprehend. A new training curriculum should be written in clear, concise language that is presented in a logical manner. Methods are suggested for improving the security training program that would meet the standards prescribed by the state and make it more meaningful to the student officers.

Maintaining a proper training curriculum is not sufficient unless the attendance of all security officers is mandated by the Corporate Security Office. Since hospital security police are authorized to use force in making arrests, they should be retrained periodically in the proper utilization of this power. It has been the practice to hold training sessions at the Corporate Security Office and rely upon the hospitals to

direct security personnel to attend. Since the hospitals have limited manpower resources, training sessions were poorly attended. A procedure should be established whereby a record is kept of the courses attended by each officer. To compensate for temporary manpower shortages experienced due to training requirements, the Corporate Security Director should arrange for necessary coverage.

Training must be coordinated from the Corporate Office to be most effective. De-centralized training, although appropriate for local issues, does not meet organizational needs for a coordinated and standardized training program.

Manpower Allocation

As previously noted, the size of each hospital security force is currently determined by the executive director. He reaches this decision after estimating the cost of mandated medical services and allocates funds for security from what remains. Inevitably, security receives a lower priority than most other hospital functions. Since the first priority of a hospital is to provide adequate medical care, the judgement of hospital administrators should not be questioned in this area. However, the resulting disparity ir the number of security officers in each facility should be corrected. For example, Harlem Hospital with 11% of the total security force experienced

8% of the total crime reported for the period 1979-1981. Conversely, Coney Island Hospital with 4% of the total security staff, experienced 21% of the crime reported to the New York City Police Department during the same time period.

Although reported crime is not the only indicator generating a need for security officers, it definitely should be a major determinant. Since it is difficult to estimate the number of actual unreported crimes, manpower must be allocated partially on the basis of those that are reported to the authorities by hospitals. Another factor to be considered in judging manpower needs is the number of non-crime incidents, e.g. disputes, disorderly persons, that are resolved by special officers in their peace keeping role.

In order to improve the present deployment method, the allocation of manpower should be contingent upon an objective estimate of the individual security needs in each facility. For the past eight years, the New York City Police Department has utilized a formula based on operational criteria in allocating manpower to its 73 precincts. In this study of H.H.C. security, it was determined that a similar method could apply. Consequently, a personnel allocation model is proposed as a means for adopting this concept to the hospital police system. Briefly, the formula is based upon the assignment of a weighting factor to each operational indicator, e.g. arrests, incidents,

and is periodically activated to determine each facility's share of the total officer pool. The final step in this process would involve a review of the recommended staffing by the Corporate Security Director and the Hospital Executive Director. This conferral would make allowance for any special condition existing in the hospital that would not surface in the formula. Obviously, this proposal is predicated upon centralized control over the assignment and deployment of manpower. Without a central pool of security officers, an allocation formula would not be viable.

Crime Reporting

The Corporate Security Office has the difficult task of compiling statistics that reflect crime conditions in all 27 facilities. Some hospitals may be reluctant to report all incidents of crime because a high level may reflect negatively on the hospital administration. In many instances, minor crimes, e.g. larcenies from patients, are recorded internally as minor incidents or lost property. The practice of non-reporting seems to permeate the H.H.C. system, resulting in an inaccurate impression of crime. As a result, the hospital with the highest actual incidence of crime may appear statistically to be a relatively safe facility.

In assessing security requirements and determining staffing

levels, management must have pertinent information. Statistical data provides management with a logical basis for making sound decisions. A good working knowledge of crime statistics is of paramount importance in this process. Without the proper data, the deployment of resources becomes a reaction to gut feelings about crime. Consequently, resources may be misallocated or improperly employed.

An allocation plan, contingent upon the full reporting of actual crime, is recommended. An extensively modified crime reporting system, predicated on the submission of a daily summary of crime incidents, is proposed for the H.H.C. security force. Hospitals with the most crime would receive consideration for a greater allotment of officers. This would act as an incentive to fuller reporting. To further facilitate this objective, the New York City Police Department has proposed to modify its Complaint Report to insure notification to H.H.C. of each crime occurring on hospital property. Under the current practice, a victim could report a crime directly to the precinct and bypass the hospital security force.

SECURITY STAFFING
APPENDIX "C"

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
HOSPITAL POLICE
CRIME AND INCIDENT REPORT

Facility											
Pct. Occurrence			NYPD Compl. #			Boro					
Control #			Headquarters File #								
Military Time and Date of This Report	Time	Date	Occurrence On or From	Time	Date	Day Of Week		Occurrence Through		Time	Date
Person Reporting			Position/Relationship			Address, City, State, Apt. #			Home Telephone / Business Telephone		
Victim's Name			Address, City, State, Apt. #						Home Telephone / Business Telephone		

Victim	Age	Victim's Race	Can Identify?	Will Prosecute?	How Was Complaint Received?
☐ Male ☐ Female ☐ Corporation ☐ State		☐ White ☐ Oriental ☐ Black ☐ Hispanic ☐ American Indian ☐ Other:	☐ No — If YES, answer below ☐ Patient ☐ Employee ☐ Visitor ☐ Other: _____	☐ Yes ☐ No	☐ Radio ☐ Phone ☐ Walk-in ☐ Pick-up

Offense(s) or Incident(s)	Was Entry Forced?	Weapon	Type
	☐ Yes ☐ No ☐ Attempted	☐ Used ☐ Possessed	

Address/Location of Occurrence	Location (Be Specific)	Post	Visible by Patrol Assigned
			☐ Yes ☐ No

Pct. of Arrest	Arrest Number(s)	Type of Evidence	NYPD Property Voucher #	Court Docket #

PROPERTY INFORMATION ☐ Lost ☐ Stolen ☐ Corporation ☐ Patient ☐ Employee ☐ Visitor
If Corporation property, was item marked for identification? ☐ Yes ☐ No

PROPERTY INFORMATION (Itemized)				PROPERTY SUMMARY	VALUE STOLEN	VALUE REC'D.
Quantity	Article	Description, Model & Serial #	Item Value			
				CORPORATE PROPERTY Typewriter		
				Currency		
				Calculator		
				Radio/Walkie Talkie		
				Other Hospital Equipment		
				Other Office Equipment		
				Vehicle		
				Miscellaneous		
				OTHER THAN CORP. PROPERTY Currency		
				Auto		
				Jewelery		
				Furs, Clothing		
				TV's, Radios, Cameras		
				Miscellaneous		
				WEAPONS Firearms		
				Other		

ARRESTED PERSONS INFORMATION (Include persons wanted)

Name, Last, First MI	Wanted	Arrested	Address, City, State, Apt. #	Home Telephone / Business Telephone
ie, Last, First, MI	Wanted	Arrested	Address, City, State, Apt. #	Home Telephone / Business Telephone

No	Sex	Race	Age	Date of Birth	Height	Weight	Hair Color	Clothing	Wanted Alarm

DETAILS, INCLUDE WITNESS AND ADDITIONAL ARRESTS AND VICTIMS

Report/Invest Officer's Rank, Signature	Tour	Name Printed	Shield #
Supervisor's Signature	Rank	Director's Signature	

1-White - Headquarters - Records Division Hospital Police 2- Yellow - Institution Copy 3- Blue - Complainant Copy 4- Pink - Reporting Officer

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION
125 WORTH STREET, NEW YORK, N.Y. 10013
Telephone: (212) 566-8038

JOHN J. McLAUGHLIN
(ACTING, PRESIDENT

M E M O R A N D U M

June 6, 1984

TO: EXECUTIVE DIRECTORS
NFCC ADMINISTRATORS

FROM: John J. McLaughlin

SUBJECT: ROLE OF CORPORATE SECURITY

Since he came on board in June 1983, Charles Connolly, Assistant Vice President for Corporate Security, has met with you and your Security Directors to assess the specific security needs of your facility and to formulate a plan of action to make security operations more effective Corporatewide. In large part, his efforts to reorganize and improve the quality of our security force reflect the recommendations made in a number of internal and external studies, notably the New York State Comptroller's Audit and a study of security operations by the New York City Police Department.

To date, the focus of Central Office Security's reorganization initiatives has been improving the quality of training to raise the skill level and image of security personnel. The first step in this process is the agreement we've negotiated with John Jay College of Criminal Justice for both entry-level and in-service training for our Special Officers. Another initiative under way is the Executive Development Seminar Program for our Directors of Security. Coupled with this focus on top security management will be the introduction shortly of a monthly newsletter, which will highlight timely and useful security administration and management information.

Supplementing the John Jay College training will be the development of regional mini-training sessions and hospitals staff security instructors. For instance, the Corporation recently benefited from a one-week Crime Prevention Course sponsored by the New York City Police Department, and each of the seven attendees are expected to put their learning experiences to good use in their home facilities.

Under the direction of the Vice President, Corporate Affairs, and with the full support of my office, the Office of Corporate Security will be assuming a more participatory role in the security management within our facilities. I recognize that accountability in security in each facility rests with the Executive Director; in our decentralized system, it could not be otherwise. Consistent with our need to develop a more meaningful security structure within our system, however, I've charged Mr. Connolly with the responsibility for providing direction and support, and for monitoring security performance and budgets Corporatewide.

To this end, we are establishing three bureaus within the Office of Corporate Security (see attached organization chart):

- Security Operations Bureau
- Loss Prevention Bureau
- Support Services Bureau

The following is a brief overview of the responsibilities of each of these areas:

Security Operations Bureau

Presently, Corporate Security is responsible for security operations of sites that fall under Central Office jurisdiction (125 Worth Street, 346 Broadway, 41st Street, Lower Washington Heights, and the Brooklyn Central Laundry). This will not change. Two additional functions, however, will support the Executive Directors' role of accountability in security at their institutions: Corporate Investigations and Inspectional Services. The investigative section will be divided into three zones by borough: I - Manhattan; II - Bronx, Queens; III - Brooklyn, Staten Island. At the present time, we are updating our crime and incident reporting system so that we

will have not only timely information, but an overall view of asset losses within the Corporation. The recommendations made by outside agencies and consultants support the belief that, in addition to the Inspector General's role, an investigative ability must be in place on a Corporatewide basis. This should provide not only a psychological deterrent to those engaged in illegal activities within the Corporation, but will also enable the Corporation to make more meaningful investigations beyond those currently performed by the local security directors. This security measure will go a long way in removing the perception that the property of HHC facilities -- and of its clients and employees -- is fair game.

The Inspectional Services Section is being set up to provide the President of HHC and the individuals in charge of each of our facilities with feedback based on a centralized system of Corporate Security observations and performance audits. This section will monitor the performance of our security personnel on a 24-hour, seven-day-a-week basis. In addition, they will visit and audit facilities to insure that security operating procedures, new and old, are being complied with.

Loss Prevention Bureau

HHC already has a number of accountability centers to review and evaluate Corporate operations and performance and to take remedial measures to insure the Corporation's integrity. Among these cost centers are the Inspector General, Internal Audits, Hospital Operations and Management Review, and to the extent possible, Procurement. In a system as large and extensive as ours, however, there appears to be an additional need for a loss prevention operation similar to those of other large corporations. Specifically, we need to develop a base of information on the latest state-of-the-art prevention techniques to reduce in general the opportunity for and likelihood of criminal acts, larceny, and the diversion of Corporate assets. The Loss Prevention Section will establish a program that offers both expertise and a communications network to support management units dealing with crime prevention, substance abuse, and contract compliance.

In addition, the Technical Skills/Special Services Section will be responsible for developing standards for the technical equipment to be used, for providing assistance in crime prevention surveys and public safety lectures, and for facilitating whatever training is necessary in the areas of physical security, fire prevention, and enforcement of OSHA regulations.

Support Services Bureau

Records management, crime analyses, quality control and budget monitoring, training coordination, and operating procedures will be centralized within this bureau.

Finally, the Office of Corporate Security will be establishing a staffing pattern formula to meet the needs of the facilities as closely as possible. Therefore, all requests for additional personnel, endorsed by the Executive Director, must be forwarded to Mr. Connolly for approval before any commitments to hire are made. Similarly, all personnel reductions and all major purchases of security equipment - -surveillance cameras, computer access doors, radios, vehicles, etc. -- must be approved ahead of time by Corporate Security.

As in the past, I'm sure I can count on your full cooperation in implementing these innovative efforts to improve security Corporatwide. Mr. Connolly will be in touch with you as the process unfolds, and, if you have any comments or suggestions, please feel free to contact him at 566-8675.

Thank you.

JMcL/pah
cc: Carlotta A. Brantley

SECURITY STAFFING
APPENDIX "E"

THE METROPOLITAN HOSPITAL SECURITY DIRECTORS ASSOCIATION, INC.

THE PULSE

A PERIODICAL ISSUED FOR MEMBERS OF MHSDA

June, 1985

Volume 2 - Issue 1

REPORT OF

SECURITY LABOR DISTRIBUTION SURVEY

BY

DAVID W. SACKMAN

F O R E W O R D

This is a report of the survey conducted last month concerning the division of work within a health care Security Department. It is a repeat of a survey conducted in 1977. Forty-eight Security Directors were canvassed and twenty-five answers were received.

Some of those who did not send in answers have expressed their regrets for their lack of response. It is sincerely believed that a pooled resource of information is a strong aid to professionalization.

Others should conduct their own studies as this type of information can be useful. Thanks to those of you who promptly cooperated and who thereby made this modest effort possible.

David W. Sackman

David W. Sackman
Director of Safety & Security
St. Vincent's Hospital and
Medical Center of New York

SECURITY REPORT OF DIVISION OF WORK WITHIN A HEALTH CARE SECURITY DEPARTMENT

The objective of this survey was to obtain the answers to questions as follows:

1. With reference to the usual performance of duties by health care Security Officers, what is the average assignment of Security Department manpower to specific functions? If possible to answer, are there recognizable differences that prompt a radical variance of assigned hours to those respective functions?

2. Is there any acceptable mathematical formula that can evaluate the Security hazards of a health care facility based on standard criteria? The purpose of such a formula would not be to establish a rigid basis for Security staff members. It would rather act as a "rule of thumb" which Administrators could refine in accordance with the unique needs of their own institutions and which have not been considered in this tabulation.

3. Can we provide a list of duties performed by Security Officers which are not within the survey's consideration as "usual duties"?

The report is not intended as the final answer to the above questions but hopefully represents a comparison effort to nail down some specifics relating to Security staff needs. The comparison is with an identical survey made in 1977. Further studies will surely be made by others to profit institutions in the planning of Security budgets which are responsive to their needs rather than a reaction to situational crises.

The methodology of the survey was to send out a questionnaire on 2 sides of one page to the Security Directors of 48 health care facilities in Metropolitan New York. Responses were received from 25 which is slightly more than 50%. Careful study of the responses revealed the following observations:

1. Everyone of the 25 responses identified themselves despite the letter stating "there is no need for identification of your return." This indicated to me a tremendous interest of participation by those responding. It is also testimony that there is a solid core of professional Security Directors who are interested in establishing "pools of Security knowledge resources".

2. Further studies might separate long-term care facilities from acute care hospitals. This would affect statistics.

3. The questions were occasionally answered in a fashion that registered doubt in my mind as to whether the question was clearly understood. Future questionnaires should contain clear intent instructions for each question. The frequency of this type response was not such as to seriously affect the conclusions but does represent an inaccurate area.

4. In rare instances, a question was not answered at all and it sometimes posed difficulty for me to determine whether it was not applicable or was inadvertently omitted. These occasions might affect the completeness of results. Additional endeavors should contain instructions to answer all questions (i.e. N/A when not applicable).

Observations were madefor all questions. You may not agree with the observations as specific circumstances do vary from the average. The format of the report that follows is to list each question after the caption "QUESTION" and follow each by the average statistical results and personal comment. The statistical results and personal comment will be preceded by the caption "RESULTS". This should serve to accomplish Objective #1.

Following questions and results, the possibilities of a mathematical hazard formula will be discussed in an effort to attain Objective #2. Finally, a list will be provided in the results of Question #20 which represents attempts to achieve the goal of Objective #3.

QUESTION 1.

Relative to the location of your hospital and the assessment of crime in the area, is it an area of HIGH HAZARD ☐ AVERAGE HAZARD ☐ LOW HAZARD ☐ ?
Do you have perimeter patrol on outside of hospital? YES NO
If yes, the number of hours of such patrol per week is _____.

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
NUMBER OF FACILITIES	7	9	9
HAS PERIMETER PATROL	4	6	4
AVERAGE WEEKLY HOURS	35	73	42

As compared with 1977, the percentage of institutions having perimeter patrol and the number of weekly hours devoted to that duty, has increased. This would suggest a progressive attitude by hospitals with a view to "community involvement" and the extension of protection for employees and visitors.

QUESTION 2.

The number of beds in the hospital is approximately _____.
Do you have Detex Clock Rounds and/or Nursing floor rounds? YES ☐ NO ☐
Number of total hours of these rounds each week is _____.

RESULTS:

	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
AVERAGE NO. OF BEDS	469	732	452
HAS DETEX OR NURSING ROUNDS	5 of 7	8 of 9	8 of 9
HOURS OF SUCH ROUNDS	74	51	55

The overall average number of beds is 557. In 1977, ALL reporting hospitals had clock rounds. This report would suggest some institutions are either not making these rounds or reducing the hours for such duty. It is hoped that this duty is not being dramatically curtailed or eliminated as an economic measure. Be aware of the New York City Fire Department regulation requiring such rounds for safety (Fire Dept. Dir. 1-58, Jan. 30th, 1958).

QUESTION 3.

The number of open entrances for ordinary entrance and exit are:
8A-4P tour____(The # of guard hours per day at these fixed posts is ___
4P-12M tour____(The # of guard hours per day at these fixed posts is ___
12M-8A tour____(The # of guard hours per day at these fixed posts is ___

RESULTS:

	High Hazard Averages		Average Hazard Averages		Low Hazard Averages	
Tour	Daily Entrances	Daily Hours	Daily Entrances	Daily Hours	Daily Entrances	Daily Hours
8A-4P	5	24	6	22	6	22
4P-12M	4	18	5	22	5	22
12M-8A	2.5	14	2	17	1.8	17
Totals	11.5	56	13	61	12.8	61

The obvious is that there are less entrances open at night than in daytime. There is a general increase in the number of entrances open at all times in each hospital category as compared with 1977. The trend makes security a more difficult job. The relative number of man hours compared to entrances open has decreased since 1977 and may indicate a need for review of these assignments by some institutions.

QUESTION 4.

Do you have Psychiatry facilities? (There may be 2 checks needed for "in" and "out").
NONE ☐
IN-PATIENT ☐
OUTPATIENT ☐ The total number of guard hours per week is ____.

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Has Psychiatric facilities	4 of 7	6 of 9	5 of 9
Average number weekly hours	63	80	22

With two exceptions, all facilities reporting Psychiatric units indicated both out-patient and in-patient facilties. Since 1977 there has been a dramatic increase in the number of Security man hours allocated to this duty. It indicates a recognition of the need for Security to supplement and integrate with the efforts of professional staff in this area.

QUESTION 5.

Do you have Emergency Room facilities?

NONE ☐
Under 10 patients ☐
10-25 patients ☐
Over 25 patient ☐

If yes, is there a fixed post thereat?
YES ☐ Number of guard hours per week is _____.
NO ☐

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
NONE	1	1	2
Under 10 patients	1	0	2
10-25 patients	1	3	1
Over 25 patient	4	5	4

While the E.R. presence in the High Hazard and Average Hazard hospitals did not change appreciably, the Low Hazard hospitals showed increases in both the sizes and number of E.R. facilities available. The average weekly Security hours devoted to this duty remained constant from 1977. (Average of 200 hours per week).

QUESTION 6.

Is there an outside Receiving Dock?

YES ☐
NO ☐

If yes, do you have a fixed post thereat?
YES ☐ Number of guard hours per week is ____.
NO ☐

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Has Outside Receiving Dock	6 of 8	7 of 9	7 of 9
Coverage # of weekly hours	24	30	20

An apparent deficiency in the number of man hours devoted to this duty in 1977 with respect to Average Hazard institutions has apparently been corrected at present (30 hours as compared with 12 in 1977). The surprise in this survey is the low number of hours devoted in the High Hazard hospitals. This may need some review.

QUESTION 7.

Do you have responsibility for residences? If yes, the # of weekly guard hours is:

NONE ☐
NURSES ☐ _____
DOCTORS ☐ _____
OTHERS ☐ _____

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
NONE	1 of 7	2 of 9	6 of 9
NURSES	4 of 7	4 of 9	3 of 9
DOCTORS	4 of 7	4 of 9	None
OTHERS	1 of 7	1 of 9	None

The totals in this category may exceed the number of reporting hospitals as more than one type of residence is guarded by some forces. The average number of average hours for High and Average areas is 168 hours per week whereas the Low Hazard area has NO assignments to residences. This was a predictable result.

QUESTION 8.

Do you have responsibility for parking facility? If yes, the # of weekly guard hours is:

NONE ☐
Under 50 cars ☐ _____
50 - 150 cars ☐ _____
Over 150 cars ☐ _____

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
NONE	4	2	0
Under 50 cars	1(12 hrs.wkly)	0	0
50 - 150 cars	0	4(ave.63hrs.wkly)	1(98hrs.wkly)
Over 150 cars	2(ave.110hrs.wkly)	3(ave.22hrs.wkly)	8(ave.103hrs.wkly)

As compared with 1977, some of these figures are startling! High Hazard hospitals seem to be abandoning parking facilities. They may more largely depend on public transportation for sources of clientele. While Average Hazard institutions possess a similar number of facilities, they are staffing the parking areas with heavier manpower. The Low Hazard hospitals have involved themselves greatly in large parking places since 1977 and have expended large number of Security hours to this type duty. This was predictable as these hospitals are frequently in suburban areas with motorcars as the most frequent method of transportation.

QUESTION 9.

Do you have responsibility for Safety? If yes, approx. how many weekly hours are assigned _____.

YES ☐ NO ☐

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Have Safety Responsibility	5 of 7	4 of 9	4 of 9
Average weekly hours	72	28	10

The proportion of Security Departments with Safety responsibility is largely the same as 1977. However, in High Hazard hospitals, the average weekly hours increased greatly.

QUESTION 10.

Are there clinic(s) for out-patient service? If yes, the # of weekly guard hours is_____.
YES☐ NO☐

RESULTS:

	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Have Clinics	6 of 7	8 of 9	6 of 9
Average Weekly Hours	50	72	160

While the number of hospitals having out-patient clinic service largely remained the same as 1977, the Security hours devoted to that facility increased greatly in the Average and Low Hazard institutions.

QUESTION 11.

Are there Medical and/or Nursing Schools? If yes the # of weekly guard hours is _____.
YES☐ NO☐

RESULTS:

FACT	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Have Schools	2 of 7	3 of 9	3 of 9
Average Weekly Hours	66	160	0

The significant comparison with 1977 are the decrease of schools in the High Hazard and Average Hazard areas and the increase of average weekly hours in the same areas.

QUESTION 12.

Is there a CCTV system and/or a multiple Alarm system? If so, the total # of weekly guard hours to monitor the system is ____.
YES☐ NO☐

RESULTS:

	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Has TV and/or alarm	2 of 7	9 of 9	8 of 9
Average weekly hours	86	140	150

(Results 12)
There is a great increase from 1977 in Average and Low Hazard areas relative to both the use of CCTV and alarms and the weekly guard guard hours devoted to monitoring the system. Apparently, the High Hazard areas find manpower rather than electrical or mechanical deterrants as most effective.

QUESTION 13.

Is there construction under way at present?

YES ☐ NO ☐

If yes, the total # of weekly guard hours assigned exclusively to this area is _____.

RESULTS:	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Has construction	6 of 7	6 of 9	5 of 9
Average Weekly hours	67	17	58

This responsibility is a changing one and hours depend upon the policy of the respective hospital administrators relative to Security accountability (i.e. construction company or hospital security).

QUESTION 14.

Do you have guards assigned specifically to meal and personal relief?
YES ☐ NO ☐

The weekly # of guard hours so assigned is:_____

RESULTS:	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Has meal and relief guards	3 of 7	7 of 9	2 of 9
Average Weekly Hours	130	120	85

While the High Hazard hospitals remain the same as 1977statistically, it is noteworthy that Average and Low Hazard hospitals have increased both the number of relief guards and consequently the average weekly relief hours. Doubling up posts for relief may have seriously detracted from Security in this respect.

QUESTION 15.

Are guards assigned to Receptionist Duty as well as Guards duty in lobbies?
YES ☐ NO ☐

RESULTS:	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
YES	4	5	5
NO	3	4	4

These figures remain largely the same as 1977.

QUESTION 16.

Total number of guards on force (include part-time or temporary guards by approximating their time as equivalents to 1 full-time guard, i.e. 6 men performing 20 hours weekly each are included as 3 men). _____.

RESULTS:	GUARDS HIGH HAZARD	GUARDS AVERAGE HAZARD	GUARDS LOW HAZARD
100-300 Beds Hospital	25	21	14
300-600 Beds Hospitals	40	38	25
Over 600 Beds Hospital	52	60	42

These figures are averages and they represent a general increase of Security force in almost all categories compared with 1977. The single exception is the size of force in High Hazard over 600 Beds which decreased. This points up a need for increase requests in these institutions.

QUESTIONS 17, 18 19.

Total number of Supervisors _____

Do You have 24 hours Guard Supervisory coverage? YES ☐ NO ☐

Total number of Security Administrators _____Total # of clerical help_____

RESULTS:	HIGH HAZARD	AVERAGE HAZARD	LOW HAZARD
Ave. # of Supervisors	6.6	5.2	3.6
Has 24 hr Superv. coverage	5 of 7	9 of 9	5 of 9
Ave. # of Sec. Adm.	1.4	2.8	1.6
Ave. no. of clerks	1	1.33	.8

The supervision and clerical help indicated by the above average figures is consistent with the high, average and low hazard areas. The only surprise is the absence of 24 hour supervision in 2 of 7 hospitals in the high hazard areas. A plausible explanation is that supervision is

probably strongly present in Administration during 24 hours of each day and at night (12-8); the administrator on duty supervises Security. This is not recommended. The presence of Security supervision for 24 hours in the average and low hazard facilities has 2 possible explanations: 1) the supervisor is a working supervisor in the sense that he mans a guard post and is merely in charge of the force for a period; this reduces his actual supervisory time and while expedient, is not recommended for average hazard facilities; 2) the Security Supervisor absorbs many of the functions of the Night Administrator to supplement the night nursing supervisor in solving problems; this is a desirable organizational arrangement for average hazard facilities. There is an increase from 1977 in almost every aspect of supervision, administration and clerical help. This would indicate the emerging recognition of the importance of Security in patient care. The 24 hours coverage of the coordinating function of Security in hospitals has been advantageously employed by many hospital administrators.

QUESTION 20.

Please include below any other types of guard assignment and weekly hours respectively.

Assignment	Weekly Hours	Assignment	Weekly Hours

RESULTS:

Assignments

Methadone Clinic	Photo ID.s
Driving vehicles	Lockers issued
Valuable pick-ups	Keys issued
Fingerprints	Mortuary Control
Investigations	Locking & unlocking doors
Deceased's Clothing	Employee Orientations
Lost and Found	Monitor switchboard calls at night
Psychiatry Transfers	

The above functions were those reported. It is felt that this question was not fully answered and therefore statistics would be at best, suggestive only. Therefore, weekly hours have been omitted and only a listing of other duties is given. In 1977, the following additional duties were also listed:

Money escort	Home Care escort
Coin collection (parking)	Firewatch
Discarded needle and syringe pick up and disposal	Messenger

MATHEMATICAL FORMULA

The last page of this report will contain a table of basic variables which have been discussed previously. The table will estimate a range of needed number of guards depending upon 2 factors; 1) number of beds and 2) type of hazard area. Naturally, added to the basics in the table should be all of the hours devoted to the list of duties in the "results" to Question 20 of this report. A series of duties which do not seem to vary by size of hospital or type of area are assignments to: 1) psychiatric areas, 2) inclusion of safety responsibilities, 3) schools, 4) monitoring CCTV and/or alarms, 5) construction in progress and 6) receptionist and/or information duty. All of these additional duties should be tabulated as unique needs in YOUR hospital and added to the varying score of the provided table. The total added hours should be divided by 37.5 (or 40) to determine the number of Full Time Equivalent (F.T.E.) guards that should be added to the basic force developed in the table for the variables.

CHART COMMENT

The chart that is given on the last page of this report is very approximate and based on available average statistics. It recognizes the difference in Hazard Areas and also the varying magnitude of problems based on the size of the institution. It does NOT, however, include such duties as appear in the answer to Question 20 or other responsibilities such as Psychiatry, Safety, Schools, CCTV monitoring, Receptionist, construction, etc.. Obviously, the assignment to this type duty (not listed in the chart) should be added to the number of staff required. Listed factors which are not performed by a specific Security Department should, of course, be subtracted in number from required staff.

	HIGH HAZARD AREA			AVERAGE HAZARD AREA			LOW HAZARD AREA		
VARIABLE FACTORS	UNDER 300	300 - 600	OVER 600	UNDER 300	300 - 600	OVER 600	UNDER 300	300 - 600	OVER 600
Perimeter Patrol	1	*** 1.5	1	*	*** 2	*** 2	*** 1	*** 1	*** 2
Detex and/or Nursing Rounds	2	** 1.5	4	*	** 1	3	1	1	*** 3
Entrances (lobbies)	6	** 7	*** 20	*	*** 9	*** 16	*** 8	10	*** 18
Emergency Room	3	*** 9	*** 8	*	*** 9	*** 5	*** 3	6	*** 3
Outside Receiving Dock	1	2	2	*	*** 2	1	*	*	1
Residences	*** 4	*** 4	*** 4	*	*** 2	*** 5	*	*	*
Parking Areas	1	*** 3	** 3	*	1	2	*** 1	3	*** 5
Clinics	*** 2.5	1	*** 3	*	1	*** 2	*	*	1
Meal & Relief	*	** 2	*** 8	*	2	*** 4	*	*	*** 6
BASIC TOTALS	*** 21	*** 31	*** 53	*	*** 29	*** 40	14	21	39

No asterisk(s) indicates same result as 1977

* No response received

** Decrease from 1977

*** Increase from 1977

(THE NUMBER IN THIS TABLE INDICATE FULL TIME GUARDS)

NEW YORK CITY POLICE DEPARTMENT

PROPOSED HOSPITAL SECURITY ALLOCATION PLAN

An equitable allocation of manpower is essential in any security organization. Many police agencies employ a patrol allocation plan to deploy officers effectively. Pre-determined operational and crime criteria are processed through a formula to determine each local unit's fair share of the agency's total number of personnel. In addition to the formula, special conditions in each locality are considered before a final staffing determination is made. The Police Department utilizes an allocation formula for the deployment of police officers and patrol cars, based upon workload indicators such as reported crimes, calls for police services and the time required to complete an assignment. These factors are given a pre-determined weight, based on experience, and become an integral part of the formula. The Patrol Allocation Plan is periodically calculated to determine each precinct's fair share of available manpower. Consultations also take place with local commanders, to determine if there are any special conditions that may justify an adjustment in the suggested allotment.

The present system of allocating security personnel is based upon the discretionary judgement of the individual Hospital Executive Director and the priority he may place on security. This causes a disparity in the size of the security complement in facilities with similar crime experience. Furthermore, some administrators may not recognize the value of security in deterring crime or maintaining order in the public access areas of hospitals. Although this de-emphasis of security may be attributed to personal proclivity or a shortage of funds, the end result is reduced protection.

One of the major objectives of this study is to suggest a metnod for establishing a more equitable level of security in each hospital or facility. The Police Department's Patrol Allocation Plan, because it has proven to be effective, has been used as a model in developing a framework for a proposed security allocation plan. The suggested security allocation plan is an attempt to apply a proven allocation methodology to a system that presently relies on subjective judgement. The key presumption for an allocation model is that all security personnel are centrally controlled. If the centralized control of personnel is adopted, the suggested allocation and deployment model could become a meaningful step toward providing adequate security in all facilities.

FINDING

The number of special officers employed at each hospital is determined by the Executive Director. This decision is based upon a subjective evaluation of security and may not reflect existing conditions.

RECOMMENDATION

Determine deployment of special officers according to a proposed allocation model.

Under the present system, the size of a hospital security force may not reflect prevailing crime conditions or other incidents requiring a security response. A subjective rather than objective estimate of security need may currently be the basis for the allocation of special officers.

For the last decade, the New York City Police Department has employed a "Patrol Allocation Plan" to allocate resources throughout the agency's 73 patrol precincts. The plan is based on a formula that recognizes crime and other workload data and produces a mathematical factor for each precinct. The factor is used to judge each precinct's fair share of the total manpower pool. A similar allocation formula could possibly assist the Corporate Security Director in deploying special officers. There are major differences between policing a New York City patrol

precinct and in providing security for a large municipal hospital. However, by adjusting the model to respond to the type of crime experienced in city hospitals, a viable means of objectively allocating manpower could be established.

Prior to adopting the proposed allocation model, a more complete and accurate crime and incident reporting system must be established. The uniform crime reporting procedures suggested in this study will assist in realizing this objective.

Following is a demonstration of the proposed allocation formula utilizing hypothetical data:

Proposed Formula for Determining Allocation of Special Officers

Formula:

$$\frac{\text{Total Hospital Crime (Indoor)}}{\text{Total Crime All Facilities (Indoor)}} \times .50 + \frac{\text{Total Hospital Crime (Outdoor)}}{\text{Total Crime All Facilities (Outdoor)}} \times .40 + \frac{\text{Total Hospital Non-Crime Incidents}}{\text{Total Non-Crime Incidents All Facilities}} \times .10 = \text{Allocation Factor}$$

Definitions:

Crime	A felony or misdemeanor offense as defined in the state penal law.
Crime (Indoor)	A complaint of a felony or misdemeanor offense which occurs within the interior portion of any hospital building or other HHC facility, including abandoned buildings, tunnels, entrances, roofs, terraces, and loading docks.
Crime (Outdoor)	A complaint of a felony or misdemeanor offense which occurs on the exterior portion of hospital grounds or on the contiguous street(s) or portion thereof surrounding the facility, including on and off-site HHC parking facilities.
Non-Crime Incident	A non-crime incident recorded on an Incident Report, such as a dispute, disorderly conduct, report of lost property, etc., which requires the response of a special officer.
Allocation Factor	A numerical result determined by calculating the products of crime and incident data through the allocation formula. An allocation factor should be found for each hospital.
Sample Time Record	An appropriate period of time large enough to offer a representative sample of crimes and incidents. The samples for the individual hospital and for the total of all facilities should be taken during the same time period. For the purpose of this example a theoretical six month time period is used.
Weighting Factor	A percentage factor determined by the Corporate Security Director to allow for the differential weighting of crimes and incidents.

	Weighting Factor
Indoor Crime	.50
Outdoor Crime	.40
Non-Crime Incident	.10

Unique Situation	A strike, series of demonstrations, or similar unique event requiring the assignment of a detail of special officers for a period of time.
Fixed Post	A high priority post, i.e. Emergency Room, which must be manned on a permanent basis for at least one tour of duty each day. Fixed posts will be established by consultation and agreement with the Corporate Security Director.

Sample Calculation

Time Period = Six Months

	No. For All Facilities	No. For Sample Hospital
Total Special Officers	850	?
Total Fixed Posts	105	15
Total Unique Situations	48	3
Total Crimes (Indoor)	1,620	285
Total Crimes (Outdoor)	500	95
Total Non-Crime Incidents	750	100

1. To determine the allocation factor for the sample hospital, insert the appropriate statistics into the formula:

$$\frac{285 \times .50 + 95 \times .40 + 100 \times .10}{1{,}620 \times .50 + 500 \times .40 + 750 \times .10} = \frac{191}{1{,}085} = .18$$

Sample Hospital Allocation Factor = .18

2. The hospital allocation factor is then applied against the total manpower pool, less the combined total of personnel required for unique situations and fixed posts, as follows:

850	Total Special Officers
-153	Combined Total Unique Situations and Fixed Posts
697	Available Manpower Pool
x.18	Hospital Allocation Factor
125	Recommended Sample Hospital Manpower Share

3. The number of personnel required for fixed posts and unique situations at the sample hospital must then be added:

125	Recommended Manpower Share
+ 15	Hospital Fixed Posts
+ 3	Hospital Unique Situations
143	Recommended Special Officer Allocation

All data used for this sample calculation are for demonstration purposes only and have no present relationship with actual security manpower levels in any particular facility. The weighting factors were determined on the basis of experience with similar calculations for police officer allocation. The weighting factor is greatest for indoor crimes, since they occur within the area under the direct control of special officers. The weighting factor for non-crime incidents is smallest since they are the least serious. Weighting factors may be adjusted by the Corporate Security Director on the basis of actual experience in applying the formula.

The proposed formula represents a "first cut" attempt at an equitable allocation of special officers. Further enhancements may be incorporated based on experience with an improved crime data reporting system. If any hospital or other facility has a special condition not considered by the allocation formula, the Executive Director could obtain additional manpower through consultation and agreement with the Corporate Security Director.

The proposed allocation plan, in addition to providing an objective method of allocating manpower, would also encourage hospitals to report all crimes and other incidents. The incentive for more complete reporting would be the assignment of additional special officers, when appropriate. Because of the

weighting features of the formula, more officers would be directed to hospitals with higher rates of crime than to those with high rates of less serious non-crime incidents.

If a hospital has a special condition that would not be represented in the formula, the Executive Director could, in consultation with the Corporate Security Director, possibly receive additional manpwer. A conference should also be held with all the Hospital Executive and/or Security Directors at which these special conditions are considered.

In addition to providing an objective means of deploying manpower, this allocation model also serves another purpose: encouraging hospitals to report crime. For example, if statistics indicate an upward trend in hospital crime, additional personnel would be assigned. An increase in personnel would also be recommended if an increase in incidents was experienced. Instituting this kind of allocation plan necessitates a centralization of security control. The allocation model could be employed on a trial basis in order to test its feasibility vis-a-vis H.H.C. security conditions. This recommendation is an attempt to improve the current allocation method by suggesting a proven alternative.

PERSONNEL REPORT - SPECIAL OFFICER OCUPATIONAL GROUP *EXHIBIT 3

	HOSPITAL SECURITY OFFICER		SENIOR SPECIAL OFFICER		SPECIAL OFFICER		TOTAL
FACILITY	Perm.	Prov.	Perm.	Prov.	Perm.	Prov.	
Bellevue Hospital	0	0	6	0	59	4	69
Bird S. Coler Hosp.	1	0	6	0	20	0	27
Bronx Municipal Hosp.	1	0	10	1	54	1	67
Central Office	1	0	5	0	34	0	40
City Hospital @ Elmhurst	1	0	7	0	47	1	56
Coney Island Hospital	0	0	8	0	36	0	44
Cumberland Hospital	0	0	6	1	25	0	32
Goldwater Memorial Hosp.	0	0	6	0	13	0	19
Gouverneur Hospital	0	0	5	0	16	2	23
Greenpoint Hospital	1	0	5	0	19	0	25
Harlem Hospital	1	0	14	0	90	0	105
Kings County Hospital	0	0	13	0	103	0	116
East New York NFCC	0	0	2	0	7	0	9
East New York CHCC	0	0	0	0	3	0	3
Lincoln Hospital	1	0	12	0	74	14	101
Segundo Ruiz Belvis	0	0	1	0	7	1	9
Metropolitan Hospital	1	0	11	0	61	0	73
Metropolitan - DEMO	0	0	1	0	3	0	4

	HOSPITAL SECURITY OFFICER		SENIOR SPECIAL OFFICER		SPECIAL OFFICER		TOTAL
FACILITY	Perm.	Prov.	Perm.	Prov.	Perm.	Prov.	
Morrisania NFCC	0	0	2	0	14	0	16
North Central Bronx Hosp.	1	0	7	0	42	0	50
Queens Hospital Center	1	0	6	0	38	1	46
Sea View Hospital	0	0	6	0	10	1	17
Sydenham NFCC	0	0	0	0	22	6	28
Woodhull Hospital					14	12	26
TOTAL	10	0	138	2	811	43	1004

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

M-E-M-O-R-A-N-D-U-M

October 31, 1985

TO: HHC Security Directors

FROM: Charles P. Connolly CPC
Assistant Vice President
Corporate Security Administration

SUBJECT: SECURITY STAFFING PROJECT - POLICE FUNCTION QUESTIONAIRE

As you are all aware the issue of staffing levels has caused an ongoing controversy among Hospital Security Police Managers. This complex problem has to date eluded a solution. Complex formulas have been equally unsatisfactory in providing universal parameters for staffing modern, urban hospitals.

The Health and Hospitals Corporation has directed Corporate Security Administration to establish a Security Staffing Pattern Formula that will meet the needs of the Corporation's institutions and facilities. Our ultimate goal is to create a staffing allocation plan based on a formula reflecting the actual security needs of each institution.

In support of our mission, Corporate Security has obtained a $10,000 grant from the National Institute of Justice. The grant, although not large is the first of its kind ever awarded to a hospital police organization.

The first part of the grant money has been allocated to employ a team of consultants. Internal Control Associates (ICA) have extensive experience in health care facilities and recently participated in the successful Lincoln Hospital Linen Project.

.../

The first step in our project is to determine the full range of our present security responsibilities. Toward that end we have developed a brief questionaire which will provide you with an opportunity to input information at the earliest part of the project. Your help will be essential in this matter if we are to be successful. We solicit your active participation throughout the entire process.

Please return the questionaires to James L. Wegman, Director of The Loss Prevention Bureau at the Corporate Security Office. He will act as coordinator for this phase of the project. We would like to begin analysis of the raw material by December 1, 1985 and would hope to have all completed returns by the last week of November.

Let me thank you in advance for your cooperation in this most important matter.

CPC/ic
cc: Carlotta A. Brantley
Executive Directors

Attachments

RETURN BY 12/1/85

SURVEY OF HHC SECURITY DIRECTORS

RELATIVE TO GENERAL AND NON-SECURITY RELATED FUNCTIONS

PERFOMED BY HOSPITAL SECURITY POLICE

Q1.) Do security police become involved with patient valuables - collection, transportation, storage, return, in-room "safe" procedures?

If yes, to what extent?

Q2.) Do security police render first aid services; C.P.R., transportation of injured, etc.?

Q3.) Are security police assigned any non-patrol duties relative to parking lot operations - collecting fees, operating gates, etc.?

Q4.) Are security police utilized in transportation services of any kind - employee bus service, etc."

.../

Q5.) Is any perimeter patrol performed in areas which are the responsibility of the City Police Department - Roving, R.M.P., Scooter, Street Patrol in the vicinity of the hospital, etc.?

Q6.) Are there any other non-security related duties you can identify - raising and lowering flags, auto or room lockouts, etc.?

GENERAL

Q1.) To what extent do you employ electronic security equipment?

Is it operational?

Is it reducing personnel requirements?

Is it cost effective?

Q2.) How are incidents reported - assaults, missing patients, etc.?

.../

Q3.) How are thefts of hospital property reported?

Q4.) How are thefts of patient and visitor property reported?

Q5.) What investigation is conducted relative to the above if any, and by whom?

Q6.) Is property recovered:

a.) Often

b.) Sometimes

c.) Never

Q7.) Is there any attempt to evaluate loss patterns by area within the hospital?

If yes, what special attention is given to the problem areas identified?

.../

Q8.) Is security in your hospital involved in materials management?

Is security asked to assist in evaluation of internal controls of such areas as general stores, food service, linen service or is security only called to respond <u>after</u> a loss is identified and reported?

Feel free to add additional information or comments, or to answer questions at length on separate sheets of paper by indicating the questions by number and your answers.

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

M-E-M-O-R-A-N-D-U-M

May 8, 1986

C-O-R-R-E-C-T-E-D C-O-P-Y

TO: HHC Security Directors

FROM: Charles P. Connolly CPC
Assistant Vice President
Corporate Security Administration

SUBJECT: SECURITY WORKCHARTS

A number of times in the past, questions have been raised as to the possibility for a City-wide security workchart that can meet the needs of both the employee and management. As I am not an expert on charts, I do not presume that such is an automatic possibility. Yet, I think that it might be appropriate that we attempt to identify some of the issues that continually surface and appear to remain unresolved. Therefore, I would like you to consider the following questions and respond as appropriately as possible.

Q1.) Is your current workchart providing security officers with an every other weekend off situation? If the response is affirmative:

a.) How long has this chart been in effect?

b.) Are there any problems that seem to surface as a result of such including increased overtime costs, etc.?

Q2.) Have you had such a workchart providing every other weekend off and were required to discontinue it? If so, what circumstances prompted the change of scheduling?

.../

Q3.) In your judgment as a manager, are there situations that would lend themselves to the development of a worthwhile chart such as the one indicated in question one. Feel free to comment please.

Q4.) Based on your experience, are there circumstances that negate an every other weekend off possibility? Again, your comments would be appreciated.

Q5.) I believe it is important that we collectively review the most effective scheduling opportunities available. I would ask that you send me a copy or description of your current scheduling chart.

Obviously, even the best run operations have problems. If such problems are encountered in your present chart it would be valuable to identify such.

Q6.) Inasmuch as "no one of us is as smart as all of us" and you feel your background in this area would lend some expertise to a problem solving group, would you volunteer your services to examine this particular issue?

I would appreciate a response not later than May 20th.

CPC/ml
cc: Jo Ivey Boufford, M.D.
Pam Brier
Thomas Doherty
Executive Directors

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

M-E-M-O-R-A-N-D-U-M

September 1, 1986

TO: HHC Directors of Security

FROM: Charles P. Connolly CPC
Assistant Vice President
Corporate Security Administration

SUBJECT: **PARKING LOT SECURITY**

At this time we are attempting to determine the status of parking areas; lots or garages, and security arrangements for each. It is our intention to examine the various types of parking areas, review the security arrangements and report to the Security Directors Council on our findings.

We have been advised that all new contracts negotiated by the Corporation with respect to privately operated parking lots, garages, etc., on Corporation property will contain a section requiring the operator to provide their own security staffing. Some of the contracts in place now call for parking concessionaires to provide security for the areas under their control.

Your prompt return of the enclosed questionnaire will assist our efforts in preparing a report based on an all facility picture, and, perhaps, allow us to report our preliminary findings to you on September 16, 1986 our next Security Directors Council Meeting.

CPC/ic
cc: Executive Directors
Stephen W. Lenhardt
James L. Wegman

Attachment

Parking Lot Security/Questionnaire

1. Briefly describe the parking lot(s) and/or garages which are in any way connected to your facility. Provide the approximate number of spaces, and number of floors if a multi-level garage is involved.

2. Is any of your parking capacity leased, or in any way under the control of a private parking concessionaire.

3. If a concessionaire is involved give company name and briefly describe operation including security provided by the company.

4. If HHC Security resources are being utilized in any fashion in the parking lot or garage describe fully.

ICA
INTERNAL CONTROL ASSOCIATES
Servicing the health care field

November 25, 1985

Mr. Charles P. Connolly
Assistant Vice President
Corporate Security Administration
N.Y.C. Health and Hospitals Corporation
346 Broadway, Room 1120
New York, New York 10013

Dear Mr. Connolly:

Attached hereto is our report relative to the feasibility study conducted at Woodhull and Bronx North Central Hospitals in an attempt to develop a security staffing procedure based on demonstrated need.

We would like to express our thanks to Mr. Wegman of your staff for the assistance he provided us and to thank Ms. Blanchette, Mr. Horne and Mr. Shields for the splendid cooperation we received while at their facilities.

I trust that this report will be of assistance to you in determining your future staffing requirements.

Sincerely,

James A. Ghericich

James A. Ghericich
JAG:cg
Enc.

120 Wall Street • Suite 1044 • New York, N.Y. 10005 • 212-514-6519
9348 Santa Monica Blvd. • Suite 101 • Beverly Hills, Ca 90210 • 213-278-6333

SECURITY STAFFING SURVEY

WOODHULL HOSPITAL

NOVEMBER 1985

ICA was asked to review the staffing requirements at Woodhull Hospital and attempt to develop staffing guidelines based on demonstrated need which would have general applicability throughout the Corporation. Because security requirements vary considerably between hospitals in the Corporation, we were asked to examine security at Bronx North Central Hospital in order that these variations could be observed and considered.

METHODOLOGY:

- Review operations at Woodhull and Bronx North Central Hospitals.
- Interview key personnel.
- Inspect equipment.
- Review records of thefts, incidents, etc.
- Review reports of HHC, NY State Auditors and NYPD Security Surveys.
- Interview Security Directors in selected Veterans Administration and Voluntary Hospitals relative to their staffing.

STAFFING DETERMINATION:

There are various staffing formulas applied in order to determine the manpower need for post coverage, (number of persons required to cover a single post for a specific time period). For the purpose of this report we have elected to use the formula applied by most law enforcement agencies nationwide and which was used by the New York Police Department in their security surveys prepared for the Corporation. This formula is 4.5 officers for a

post manned 24 hours a day, 7 days a week or 1.5 officers per 8 hour day, 7 days a week.

We noted that in a staffing analysis prepared by Woodhull Hospital in July 1984, the formula used was 1 FTE for five days: 1 x 1.7 (2) or 1 FTE for seven days: 1 x 2.4. This formula appears excessive by any comparison and may be an attempt to compensate for an unacceptably high sick rate among officers as identified by the State Auditors and confirmed by ICA. Using the Woodhull formula it would require 7.2 officers to cover a single post 24 hours a day 7 days a week as opposed to the generally accepted 4.5 officers.

The State Auditors recognized that staffing cannot be based solely on the square feet of a facility; nevertheless they give square footage primary consideration. We believe this method of calculating security staffing needs is ineffective. By an extension of this logic the NYPD should have a larger force in Central Park than in a busy Harlem precinct. ICA attempted to estimate staffing requirements based upon the minimum number of entrances required to permit Woodhull to operate in an efficient manner, the maximum use of electronic security devices and the number of security incidents previously reported.

DESIGN AND EQUIPMENT REVIEW:

The design of Woodhull tends to make the most cost effective security measures expensive. There are 23 openings from which

entry to the interior of the complex can be achieved:

- 14 doors to the hospital from street level.
- 6 loading bays
- 2 entrances to the rear yard.
- 1 ramp to the 4th floor parking area.

OBSERVATIONS:

- Most of the doors which were supposed to be locked to prevent access from the outside were not locked. Two of these were broken and could not be secured.
- Five loading bays were open but two of these were not in use.
- The rear yard is not secure. We observed several persons climbing through a broken security booth to gain entry to the rear yard which contains the receiving area.
- The computer alarm is defective. We violated the alarms on three doors and there was no response. Subsequent investigation disclosed that no signal was received by the computer. We were informed by the officers on duty in the Command Center that when alarms are received, only selected alarms are responded to by security because employees are always setting off alarms in certain areas.
- We observed 28 TV monitors and 25 cameras in a storage room. Their condition is not known. At present there are no minitors in operation at Woodhull.
- Base station radio equipment is present but inoperative. The officer on duty in the Command Center was attempting to maintain communications by using two portable radios. He said that sometimes he can hear a call on one radio but not the other, so he uses two radios. He also reports dead spots from which he cannot receive a radio signal.
- We found many Detex boxes without keys and were informed that Detex is seldom performed as required by law as most of the keys are missing. Some Detex boxes are not properly located to provide maximum fire protection.

- Several doors to the interstitial space between floors were found open, giving any intruder access to an entire floor above the ceiling.

- Both side doors to the Main Pharmacy work area were open for the convenience of the staff and access is not controlled.

ICA was not engaged to conduct a security survey of Woodhull. However, a brief review was required in order to establish vulnerability before security staffing could be addressed.

ICA will base its staffing requirements on the assumption that the present inadequacies will be corrected. The technology required to improve security at Woodhull is available and will be more effective and less costly than an increase in personnel. Much of the necessary equipment, wiring, TV cameras and monitors are already available on site.

EXAMINATION OF SECUIRTY REPORTS:

Incident reports are supposed to be filed monthly and numbered consecutively beginning with #1 on January 1st.

Examination of Incident Reports filed for January 1985 disclosed 35 reports in the file. There were 77 report numbers issued from the control log. There are 42 reports missing from the January file folder. We were advised that the State Auditors may have taken some of them. There were 3 reports submitted in February concerning January incidents:

Report Number	Date of Occurrence	Date Reported
7	1- 7-85	2-8-85
78	1-15-85	2-2-85
79	1-25-85	2-2-85

As of June 1, 1985 a new log was started which is intended to more accurately account for report numbers issued and which contains more specific information. This log indicates 41 reports completed in June. A review of the June file discloses only 23 reports; 18 are missing. We concluded that a review of the incident file would not disclose the actual number of reported incidents.

We attempted to establish the number of incidents from the entries in the log book from which numbers are assigned. There were 737 numbers issued between January 1st, 1985 and October 28th, 1985. Since June the new log indicates 55 report numbers issued for which no reports were received by the supervisor. Our review disclosed that many different officers failed to prepare the reports for which they were responsible. The number of missing reports from January 1st through May 31st cannot be determined, as prior to June 1st there was no cross reference. In addition, the master control log discloses that the first number issued in 1985 was 85-31, with numbers 1 through 30 not accounted for.

Supervisors are not ensuring that their subordinates submit required reports, and, when an officer fails to submit a required report no action is taken.

It would appear that many security incidents and crimes which occur at Woodhull are unidentified or unreported. Woodhull reported 136 crimes in the first ten months of 1985. By comparison, Bronx North Central, a much smaller hospital in a less crime prone neighborhood reported 325.

Corporate Security published Operating Procedure No. 220-4 on April 26, 1985 which directs all corporation hospitals to report security incidents in a standard manner. This directive is not being complied with fully at this time.

Having concluded that many incidents at Woodhull go unreported, we had to base our review of "ACTIVITY BY AREA" on this assumption: THAT UNREPORTED INCIDENTS, IF REPORTED, WOULD BE DISTRIBUTED IN A SIMILAR MANNER TO THOSE INCIDENTS WHICH WERE REPORTED.

The following review of serious incidents reported "BY AREA" discloses that 83% of all serious incidents reported took place in 5 locations. Three of these areas, 4th Floor Parking Area, 6th Floor and 9th Floor seldom receive attention under present

post coverage. However, 43% of all reported incidents occurred in these three locations.

AREA	TYPE OF INCIDENT	NUMBER REPORTED	ICA PRIORITY RATING
Emergency Rooms	Disarmed Patient	1	
	Assault on Doctor	1	
	Assault on Patients	4	
	Assault on Officers	3	
	Restrained Patients	2	
	Assault on Staff	2	
	Dis Con	10	
	Larceny	8	
	Possession of Drugs	2	
	Criminal Trespass	2	
	Harassment	5	I
	Intoxicated Patient	1	
	Escaped Patient	1	
	Vandalism	1	
	Arrest - Reason Unknown	2	
	Sub Total	45	
6th Floor	Attempted Kidnapping	1	
	Armed Robbery	1	
	Burglary	4	
	Criminal Trespass	7	II
	Larceny	11	
	Attempted Larceny	1	
	Malicious Mischief	2	
	Dis Con	1	
	Harassement	1	
	Disorderly Patient	1	
	Sub Total	30	
4th Floor	Larceny from Auto	9	
	Criminal Mischief	9	III
	Criminal Trespass	1	
	Sub Total	19	

AREA	TYPE OF INCIDENT	NUMBER REPORTED	ICA PRIORITY RATING
9th Floor	Attempted Arson	1	
	Attempted Suicide	1	
	Attempted Burglary	1	IV
	Larceny	2	
	Criminal Trespass	2	
	Dis Con	1	
	Harassment	1	
	Restrained Patient	1	
	Sub Total	10	
2nd Floor	Burglary	2	
	Dis Con	4	
	Criminal Trespass	1	V
	Altercation	1	
	Criminal Mischief	1	
	Sub Total	9	
3rd Floor	Burglary	1	
	Larceny	1	
	Attempted Larceny	1	
	Criminal Trespass	3	
	Sub Total	6	
5th Floor	Larceny	2	
	Harassment	1	
	Disorderly Patient	1	
	Sub Total	4	
10th Floor	Attempted Arson	1	
	Criminal Trespass	1	
	Larceny	1	
	Sub Total	3	
Cafeteria	Family Dispute	1	
	Larceny	1	
	Sub Total	2	
Team 2A	Larceny	2	
Social Services	Assault	1	
EKG	Larceny	1	
Room 3CD	Larceny	1	
Main Lobby	Intoxicated Person	1	
1st Floor Supply	Burglary	1	
Staff Elevator	Assault on Officer	1	
	Grand Total	136	

As a result of our review we concluded that some of the posts presently covered at Woodhull cannot be supported on the basis of need and others appear overstaffed. We recommend the following:

- That the present staffing of the Emergency Room be reduced from 4 officers around the clock 7 days a week to 3 officers for the same period, as the area configuration permits all 3 Emergency Room Posts to be covered by officers who are in sight of each other.

  Manpower Savings 4.5

- That the post at the Staff Elevators be eliminated as only one incident was reported in 10 months and that was an assault on the officer.

  Manpower Savings 4.5

- That the Main Entrance be closed at the conclusion of visiting hours and the post not be covered during the evening hours.

  Manpower Savings 2.5

STAFFING:

We observed post placement at Manhattan VA, Montifiore, Bronx North Central and Woodhull Hospitals. While variations in security requirements are obvious based on the volume of visitors, patient population, number of psychiatric beds, methadone clinics, etc., we noted that certain similarities exist in every hospital. Each has the same mandated requirement to provide Detex Patrol between the hours of 10:00 PM and 6:00 AM. Each hospital covers what can be described as "essential" post requirements, i.e.; posts at entrances to provide security

for hospital property and to direct patient and visitor traffic, posts at Emergency Rooms and Psychiatric Emergency Rooms to maintain order and prevent patient elopement. The remainder of posts appear to be arbitrarily created by individual directors or placed as a result of some incident which distrubed the professional staff.

Our review of various type hospitals confirmed that security staffing requirements are unique to each institution. We concluded that any precise formula developed on such information as square feet, patient census, bed size, etc., would not have wide applicability.

We recommend that staffing levels be established by analysis of the following criteria:

- The number of personnel required to staff posts mandated by law or Corporation policy, Detex, Crime Prevention, training, investigations, etc.
- The number of personnel required to staff what has been previously described as "essential" positions, entrances, emergency rooms, etc.
- The number of personnel required to provide security based upon a careful evaluation of security related incidents previously experienced.

  (See Appendix A for detailed questions relative to this approach.)

Utilizing this approach, our analysis of Woodhull Hospital's staffing needs are as follows:

LOCATION	NUMBER OF OFFICERS	NUMBER OF TOURS	DAYS OF WEEK	TIMES RATIO	TOTAL FTE REQUIRED
Emergency Rooms	3	3	7	x 4.5	13.5
Command Center	2	3	7	x 4.5	9.0
Detex Patrol	2	2	7	x 1.5	6.0
Front Entrance	1	1	5	x 1.5	1.5
Flushing Gate	1	3	7	x 4.5	4.5
4th Floor	1	3	7	x 4.5	4.5
6th to 9th Floors	1	3	7	x 4.5	4.5
Clinics	1	1	5	x 1.5	1.5
Rear Yard	1	3	7	x 4.5	4.5
Perimeter Patrol	1	3	7	x 4.5	4.5
Crime Prevention	1	Open	5	N/A	1.0
Training and Investigations	1	Open	5	N/A	1.0
				TOTAL	56.0

We are advised that 14 officers are required to staff satallite units at Cumberland NFCC, 960 Manhattan Avenue, 1420 Bushwick Avenue and 150 Maujer Street. Supervision is provided by Woodhull supervisors.

CONCLUSION:

Woodhull is adequately staffed with Police Officers. The present complement is 69 officers. This provides 55 for service at Woodhull and 14 for use at the satallite locations.

SUPERVISORS

RANK	DUTIES	NUMBER REQUIRED
Captains	Total responsibility for one platoon 7 days a week.	3
Lieutenants or Sergeants	Supervise Woodhull security and the satellite units around the clock 7 days a week.	7
	While 5 Sgts. could provide coverage at Woodhull, 2 more are required to provide coverage at satellites and to relieve at Woodhull.	
	TOTAL	10

CONCLUSION:

Woodhull is overstaffed by 5 supervisors. The ratio of one supervisor for every 4.6 officers is too high. Suggested staffing reduces the number of supervisors to one for each 6.9 officers.

BRONX NORTH CENTRAL:

We visited Bronx North Central Hospital on November 1, 1985 and the staffing reported by the Director was as follows:

RANK	NUMBER
Captains	1
Lieutenants	3
Sergeants	4
Officers	37
TOTAL	45

On November 1, 1985, 8 officers were on sick report. This represents 22% of the entire complement. Seven of these officers were on long-term disability and three had been out sick over one year.

The State Auditors reported a sick percentage at Woodhull of over 14%. From the 22% sick rate we observed at Bronx North Central we concluded that this excessive sick rate may be a Corporation wide problem. The post staffing problems reported by the administration of both Bronx North Central and Woodhull appear to be directly connected with excessive absenteeism as opposed to any actual personnel shortage.

OBSERVATIONS:

We observed that two officers are assigned to the Psychiatric Emergency Room, 7 days a week, 24 hours a day. The Psychiatric Emergency Room is not secured. There are three entrances, two of which remain open at all times. Therefore, the two officers cannot control entry or prevent patient elopement and it appears their only function is to provide a sense of security to the professional staff who are especially trained to work with this type of patient.

The assignment of officers to the Psychiatric Emergency Room at Bronx North Central cannot be justified by demonstrated need. There are two posts which are always covered located only a

short distance from the front and rear doors of the Psychiatric Emergency Room and these officers could provide assistance to the staff should the need arise. We calculated the cost of Psychiatric Emergency Room coverage as follows:

2 FTE x 3 Tours x 7 Days = 2 x 4.5 = 9 Officers

Each officer costs approximately $23,000 in wages and fringe benefits bringing the annual cost of this unnecessary staffing to $207,000. We also noted a supervisor relieving an officer on this post and were told that this is common practice. When supervisors' salaries are considered, the cost is even higher.

The Director reports that he does not always perform the mandated Detex patrol, since to provide for this function he would have to uncover fixed posts such as the Psych Emergency Room which are considered more important.

Our review of 525 crimes reported during the first 10 months of 1985 revealed that unlike Woodhull, where the largest number of crimes reported took place in 5 specific locations, the incidents at Bronx North Central were widely separated throughout the hospital.

The elimination of the fixed post in the Psychiatric Emergency Room would provide 9 officers to perform the mandated Detex patrol and to provide for a roving patrol, the need for which is supported by the number of incidents reported and their scattered locations.

CONCLUSION:

Both Woodhull and Bronx North Central are adequately staffed with Police Officers and overstaffed with Supervisors who are sometimes used in place of Police Officers who are unavailable due to excessive absenteeism.

RECOMMENDATIONS:

- Post revisions should be made to more effectively utilize available manpower.
- Problems concerning poor communications, defective alarms, broken doors and the failure to utilize effective elctronic security systems should be addressed.
- The standardized system for reporting security incidents contained in Operating Procedure No. 220-4 should be enforced. A system of periodic inspection by Corporate Security should be instituted to incur compliance.
- The administrative problem concerning excessive sick time should be addressed at the Corporate level.

APPENDIX "A"

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING "MANDATED" MANPOWER NEEDS.

Question	YES	NO
Is there any state law requiring that security be provided in any specific hospital area such as the psychiatric area?		
Are there any city or municipal ordinances requiring a fire watch during evening hours? If there is, consider the number of locations which must be visited, frequency of required visits, distance between locations, single building or multi-building complex, etc., to determine manpower requirements.		
Are there any contractual agreements which require the presence of a security officer or which establish that two officers must be present at any location?		
Has hospital administration elected to provide security for a specific area in order to improve public relations, ensure training of the security staff or to provide investigative services?		

Any affirmative answer will require staffing without further qualification.

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING "ESSENTIAL" MANPOWER NEEDS.

Question	YES	NO
Have the number of entrances left open been reduced to the absolute minimum number required to sustain efficient hospital operations?		
Is electronic security employed to best advantage? Electronic alarms, TV monitors, controlled access door locks, etc., will reduce manpower needs.		
Are officers on post used to perform a dual function where possible, i.e., prevent the removal of hospital property and control visitor traffic, etc.?		
Are communications effective? Can officers be dispatched promptly to required areas? Improved communications can reduce manpower needs.		
Is the perimeter secure and adequately lighted, doors locked, fences in good repair, etc.?		

Any negative response will increase manpower requirements beyond that which can be considered "essential".

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING MANPOWER REQUIREMENTS BASED UPON A "DEMONSTRATED NEED"

	YES	NO
Are many incidents reported from any specific area?		
If a post were established would the officer have good visibility? Can the uniformed presence be expected to reduce these incidents?		
Is the area large enough that it could be more effectively patrolled by scooter or other vehicle?		
During what hours are the incidents experienced?		
Is the value of the loss experienced or the danger to patients, staff or visitors sufficient to justify the manpower commitment?		

The establishment of any post based on previously demonstrated need requires subjective judgement and should be reviewed semi-annually to determine its effectiveness and to ensure that changing conditions have not eliminated the need for it.

There is an extreme reluctance to eliminate a post once it has been established, even though the need for it no longer exists.

SECURITY STAFFING
APPENDIX "K"

New York City Health & Hospitals Corporation QUARTERLY SECURITY PERSONNEL STAFFING REPORT		Facility	Borough			Signature, Director of Security						Date
Name	Residence Address	Social Security No.	Perm.	Prov.	Title	Date of Birth	Shield No.	Tour Assg.	Date App't.	Terminated ? Yes	No	Date

.rtC 8 (Jul 80) Replaces 220-16

NEW YORK
HEALTH AND HOSPITALS CORPORATION
CENTRAL OFFICE SECURITY

MONTHLY REPORT OF OFFENSES, LOSSES AND CALLS FOR SERVICE

SECURITY STAFF
APPENDIX "L"

Date:

TO Assistant Vice President
Corporate Security Administration

FROM _____ *(Security Director)*

SUBJECT **MONTHLY REPORT OF OFFENSES, LOSSES AND CALLS FOR SERVICE**

FACILITY _____

The Statistical Report of Offenses, Losses and Calls for Service for the month of _____ 19 _____.

A. OFFENSES

Misdemeanors		Felonies		Violations		Less "A" Summons Arrests		Injuries		Weapons	
Year to date	Month	Year to date	Month	Year to date	Month	Year to date	Month	Year to date	Month	Year to date	Month

During this month _____ (number), HHC 587 Reports Less "A" Summons were submitted.

B. PROPERTY LOSSES / PERSONAL

Corporate		Patient		Employee		Other	
Reported Value	Cumulative Value	Reported Value	Cumulative Value	Reported Value	Cumulative Value	Reported Value	Cumulative Value

C. CALLS FOR SERVICE

Number of calls current month:

Total Number of calls current year:

SECURITY DIRECTOR

_____
(Signature)

HHC 686 (Apr 85)

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

June 13, 1986

Dear Associate,

In the past I have had the opportunity to address our membership at IAHS seminars. During those meetings I have been impressed with the professional level and developed expertise of the members. You are the leaders and mentors of the hospital security industry. For that reason I ask you to consider one of the more difficult to define issues of a clearcut security staffing formula for health care facilities. Presently many of our colleagues agree that the current utilization of a facility's square footage, as the primary staffing consideration is inadequate. Recently we hired an independent consulting firm to explore the feasibility of developing such a formula. The consultants report, while certainly a viable and workable document could not possibly encompass everything that's needed to be considered. Constraints on both time and resources simply did not allow it. However, it occurred to me that members of the IAHS probably comprise the greatest collective resource of hospital security knowledge today. Therefore, I would like to request your assistance in the development of such a formula.

I am desirous of receiving your thoughts on what issues or related job aspects should be identified which can serve as the basis for the staffing formula. To that purpose we are forwarding herewith the first generation results of our initial steps towards developing this formula. The material includes several staffing factors accompanied with attendant guidelines and additionally, a series of pertinent questions which should serve to assist security managers in determining their manpower needs. Hopefully you can expand, modify, even refute some of our early thoughts on this issue.

I want to thank you for your consideration in this matter. Please direct your response to my Associate, Charles Stettner, Assistant Director Corporate Security, 346 Broadway - Room 1114, New York, New York 10013, or if you have any questions which require immediate clarification please call him at (212) 566-8428.

Sincerely,

Charles P. Connolly, C.P.P.
Assistant Vice President
Corporate Security Administration

See over

CPC/ic

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

M-E-M-O-R-A-N-D-U-M

June 13, 1986

TO: IAHS Members

SUBJECT: SURVEY ASSISTANCE REQUESTED
APPENDIX A

Attached is a draft of a number of staffing factors with appropriate guidelines which HHC Corporate Security Administration will utilize to establish a security staffing formula.

The first four factors in our judgment are considered as being the most important workload indicators for staffing needs and will be the primary basis for the development and application of a weighted allocation formula. Special conditions and/or unique circumstance present at some facilities can be surfaced by the remaining factors and would be considered before a final staffing determination is made.

We ask that you critique these staffing factors and their attendant guidelines. In your comments please feel free to expand, modify or refute the material. With your help we hope to develop a management tool not only adequate but flexible for application by any security manager who may be required to determine proper security staffing levels.

As a security management professional I am sure you will agree that "no one of us is as smart as all of us". Therefore, I urge your cooperation in making this initiative a worthwhile endeavor.

Sincerely,

Charles P Connolly

Charles P. Connolly, C.P.P.
Assistant Vice President
Corporate Security Administration

CPC/ic

Attachments

Save Water

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

M-E-M-O-R-A-N-D-U-M

June 13, 1986

TO: IAHS Members

SUBJECT: SURVEY ASSISTANCE REQUESTED
APPENDIX B

Attached are a series of questions designed to surface proper staffing levels by analysis of the following criteria:

1.) Mandated Assignments

The number of personnel required to staff posts, mandated by law, corporate policy, governmental regulations, etc.

2.) Demonstrated Deployment

The number of personnel required to provide minimal security based upon a careful evaluation of security related incidents previously experienced and a likelihood of re-occurrence - exists.

3.) Essential Staffing Needs

The number of personnel required to staff essential positions, such as entrances, emergency rooms, etc.

We ask for your critique of the following questions which are meant to determine a basis for staffing requirements. Please feel free to expand, modify and even refute the material contained herein. It is our hope that with your help the above mentioned staffing criteria will expand to provide a multi-listing of necessary questions that a security manager will find useful.

.../

Steve Weiler

Such a directory of questions will serve as a resource to the Security Manager in need of operational guidelines that can be applied as a management tool regarding formulation of a staffing level specific to his/her security environment. The number of appropriate questions to be asked are limited only by one's imagination.

I would like the opportunity to express my appreciation for your cooperation in this matter.

Sincerely,

Charles P. Connolly

Charles P. Connolly, C.P.P.
Assistant Vice President
Corporate Security Administration

CPC/ic

Attachment

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING "MANDATED" MANPOWER NEEDS.

Question	YES	NO
Is there any state law requiring that security be provided in any specific hospital area such as the psychiatric area?		
Are there any city or municipal ordinances requiring a fire watch during evening hours? If there is, consider the number of locations which must be visited, frequency of required visits, distance between locations, single building or multi-building complex, etc., to determine manpower requirements.		
Are there any contractual agreements which require the presence of a security officer or which establish that two officers must be present at any location?		
Has hospital administration elected to provide security for a specific area in order to improve public relations, ensure training of the security staff or to provide investigative services?		

Any affirmative answer will require staffing without further qualification.

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING "ESSENTIAL" STAFFING NEEDS.

Question	YES	NO
Have the number of entrances left open been reduced to the absolute minimum number required to sustain efficient hospital operations?		
Is electronic security employed to best advantage? Electronic alarms, TV monitors, controlled access door locks, etc., will reduce manpower needs.		
Are officers on post used to perform a dual function where possible, i.e., prevent the removal of hospital property and control visitor traffic, etc.?		
Are communications effective? Can officers be dispatched promptly to required areas? Improved communications can reduce manpower needs.		
Is the perimeter secure and adequately lighted, doors locked, fences in good repair, etc.?		

Any negative response will increase manpower requirements beyond that which can be considered "essential".

QUESTIONS WHICH MAY ASSIST MANAGEMENT IN DETERMINING MANPOWER REQUIREMENTS BASED UPON A "DEMONSTRATED NEED"

	YES	NO
Are many incidents reported from any specific area?		
If a post were established would the officer have good visibility? Can the uniformed presence be expected to reduce these incidents?		
Is the area large enough that it could be more effectively patrolled by scooter or other vehicle?		
During what hours are the incidents experienced?		
Is the value of the loss experienced or the danger to patients, staff or visitors sufficient to justify the manpower commitment?		

The establishment of any post based on previously demonstrated need requires subjective judgement and should be reviewed semi-annually to determine its effectiveness and to ensure that changing conditions have not eliminated the need for it.

There is an extreme reluctance to eliminate a post once it has been established, even though the need for it no longer exists.

HHC CORPORATE SECURITY ADVISORY BOARD APPENDIX "N"

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M-E-M-O-R-A-N-D-U-M

March 31, 1986

TO:	P. Sladack (Chairman)	Sea View Hospital
	E. Lacerra	Coney Island Hospital
	C. Stettner	Corporate Security
	P. Horne	Woodhull Hospital
	Cpt. E. Godette	Metropolitan Hospital
	Cpt. A. Woodard	Harlem Hospital
	Cpt. T. Moriarity	Bellevue Hospital
	Cpt. L. Olivo	Lincoln Hospital
	Sgt. M. Boone	Queens Hospital

FROM: Charles P. Connolly CPC
Assistant Vice President
Corporate Security Administration

SUBJECT: CORPORATE SECURITY TASK FORCE COMMITTEE ON MANNING OR STAFF LEVELS

I want to take this opportunity to express our appreciation for the interest and dedication shown by your participation. My Staff and I look forward to working with you on this extremely worthwhile project.

As formulated at the Security Director's Council meeting held on Thursday, March 20, 1986, you have been designated as a member of the Corporate Security Task Force Committee on Manning or Staff Levels.

The committee will meet at the call of the Committee Chairman. A draft recommended procedure will be submitted by June 1, 1986.

CPC/ic
cc: Jo Ivey Boufford
Carlotta A. Brantley
James L. Wegman
Vincent R. Roberts
Harry Moldaw

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Internal Memorandum

To: Charles Connolly
Corporate Security

Date: December 19, 1986

From Peter G. Sladack
Associat. Director

Subject: Chairman's Report on
Staffing Committee

Per our recent discussion, I am forwarding my report on the Staffing Committee which I had the honor of chairing.

Please review it and I will call during the week to see if there are any revisions which are required.

The staffing formula now reflects our suggested changes based on past experiences and independent research and in our opinion can be applied system-wide.

PGS/bp
attachment

Chairman's Report on Staffing Committee

The following is a summary report on the Corporate Security Task Force Committee appointed by Charles Connolly, Assistant Vice President, Corporate Security of the New York City Health and Hospitals Corporation.

As the chairperson for this committee, I arranged meeting dates, location and facilitated the discussions. The committee was comprised of nine individuals from eight different hospitals and Corporation's Central Office. Eigh of the nine were regular participants. The designee from Bellevue Hospital was unable to attend any session because of conflicting scheduling or pressing problems in his Institution. He, however, did converse with me at length via the telephone on two separate occasions expressing his opinions openly and candidly and constructively. His ideas were vicariously communicated by me to the group and melded into our findings.

In the body of this report, certain statistics are quoted. While we used the thoughts given to us by Bellevue, the statistics do not reflect their participation.

PERSONNEL COMPOSITE

Four members of the group are managerial employees. Three are Hospital Administrators with latitude for independent judgment and decision making within each respective hospital. The other is a manager in the Central Office Corporate Security Office. Two of the Administrators had multi-faceted departmental jurisdiction in addition to Security. Between these managers exists a 30 year aggregate of diverse administrative/managerial authority. Of this group, two are former New York City Police Officers; one a former Security Officer with the United Nations and the other a Human Resources/Labor Relations specialist.

The rank and file members consisted of three Captains and one Sergeant. Each was personally recommended by his or her Security Director on the basis of integrity, job knowledge, commitment to law enforcement and personnel attributes which singled them out as outstanding officers. These staff members averaged nearly 15 years of security/safety experience each.

The groups ethnicity was one Black female; three Black males; one male of Hispanic origin, and three male Caucasions. This represented a good cross current of the racial mix of both Corporate employees as well as the patients/clients dealt with through hospital care and service.

All of the members were minimally high school graduates with nearly a two year average of advanced studies. All were participants in one way or another in special courses or seminars offered outside the Corporation in the private sector. As all were supervisors on various levels each was familiar with addressing groups and none was restricted or reticient in cogently expressing his or her viewpoint. A high degree of insight and concern was exemplified at each session and active participation was the norm rather than the exception.

GEOGRAPHICAL REPRESENTATION

The participants represented the five boroughs of New York City ranging from Harlem Hospital in an inner-city predominantly black neighborhood to Sea View, a Staten Island Nursing Home located in a nearly White area, to the Central Office in the downtown Manhattan Civic Center.

Some of the hospitals are situated on main City blocks adjacent to subways/bus stops heavily travelled by pedestrian traffic,

to one hospital -- the nursing home -- located an eighth of a mile off a secondary road and nestled in 400 wooded acres. Of the 42,000 employees working for the Corporation, the nation's largest municipal health care system, forty-four percent were represented by the committee.

Excluding the Nursing Home, each of the other five hospitals has a psychiatric unit as well as alcoholic/detoxification units. Three are medical centers and combined all five handle over three quarters of a million emergency room cases per year. Any type of approved medical care is given by at least one of these acute care facilities running the gamut of care from world reknowned burn center, to micro surgery groups to nuclear medicine, to geriatric specialization, etc.

OVERVIEW

The above statistics are given as a montage to demonstrate the diversity and broad spectrum of situations which may be encountered by Security, i.e., a situation might be so trivial as a child who won't stop crying, to a belligerent teenager on angel dust, to the homeless, to dealing with the exigencies, difficulties and attending complications arising out of a plane crash. Co-lateral with each of these are distraught family members or friends demanding instaneous treatment. Numerous cases are complicated by patients speaking esoteric languages, or at least languages that are not common among the polyglot languages spoken in New York, e.g., Serbo-Croation-Yugoslavia.

The Special Officers certified to administer hospital Security are trained professionals with New York State Peace Officer status.

They are cognizant of the State penal code with on-going training and education given through John Jay College of Criminal Justice. Many of these officers reside in the district in which they work. The hospitals give specialized training in handling psychiatric patients and by extension this spills over into dealing with and controlling unruly visitors and friends of patients.

Many of the Hospitals have the latest technology offered by Security such as closed circuitry TV, electronic door locks, motion and sensor detectors as well as patrol vehicles, hand held radios, and computers. The few Institutions which do not have most of these devices will have them in the forseeable future. Most have investigators among their ranks trained to undercover and surveillance techniques and interogation.

COMMENTS

I have deliberately avoided commenting on particulars discussed by the committee as a colleague in the group is elucidating on these and it would be superfluous to delineate on it.

However, the most salient feature collectively adduced was that each location exemplified a unique personality, and staffing needs at each was different from location to location. Lobby control imperative in one hospital was not an apparent problem in another prioritized posts in one setting were only a secondary consideration elsewhere.

Other than petite larceny the various Security Departments exercised great guardianship of their respective Institutions, but it is an unending up-hill struggle with no allowance for relaxation. It appears that the challenge offered by such a

huge and diversified system is being met with an equally responsible affirmative and enlightened approach in dealing with New Yorkers and the socio/psychological environmental setting.

The committee met on three different days (June 17, July 17 and August 25, 1986) and each session lasted about four hours. The group literally talked itself out so that at the closing there was no topic left untouched or unturned. Each member came well prepared having done independent research. There was little critical disparaging of others remarks because all could associate by past experience with events related. This immediate case agreement mitigated the necessity for debate and expedited the meetings allowing development of isolated incidents permitting us to venture into nearly every perceptible security situation conceivable.

The formula has been adjusted as per our input and the committee has unanimously signified their acceptance of the product as a reliable staffing formula which can be uniformly applied.

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
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M-E-M-O-R-A-N-D-U-M

January 14, 1987

TO: Charles P. Connolly
Assistant Vice President
Corporate Security Administration

FROM: Charles Stettner
Assistant Director Technical Services

SUBJECT: CORPORATE SECURITY STAFFING TASK FORCE

The Task Force convened on 6/17, 7/17 and 8/25/86 at Central Office. Present were P. Sladack, E. Lacerra, P. Horne, E. Godette, A. Woodard, L. Olivo, M. Boone and C. Stettner. Discussed were the eleven staffing factors prepared by Corporate Security and the tasks associated with proper completion of the staffing study. The results are:

Factor #1 was accepted intact by the committee.

Factor #2 The committee discussed the language utilized in the factor. The present language was unclear as to whether the information called for was to be taken only from Incident Reports (HHC 587) or was the total also to reflect responses made from calls for service.

Factor #3 The committee suggested that the Guidelines for this factor should be standardized throughout the system. Each committee member agreed to complete factor 3 for their particular facility and forward their response to the chairman.

Factor #4 The committee agreed that fingerprinting of all new facility employees by the security department is a task performed by most present and should be added to the representative list of programs.

Factor #5 The committee suggested that these special situation posts should be required to have both post orders and post descriptions and directions to this effect should be included in the instructions.

Factor #6 was accepted intact by the committee.

Factor #7 The committee felt that the make-up of non-patient population consists of: visitors, staff, vendors. A point was made that some facilities allow coffee shop concessionaires to serve the general public and that the instructions should give direction to the effect that special situations can be listed and explained.

Factor #8 The committee suggested that provision should be made to list the average number of vehicles parked in each concessioned parking lot as several facilities utilize Special Officers to provide security at these sites.

Factor #9 The committee suggested that questions a & b be changed to include the word "land" before area, in order to improve comprehension.

Factor #10 was accepted intact by the committee

Factor #11 The committee felt it would be important for the instructions to specify some external security conditions.

The committee completed its review of the staffing formula requirements as revised by their input and unanimously signified their acceptance of the product as a reliable staffing formula which can be uniformly applied, system-wide.

HOSPITAL SECURITY OFFICER
STAFFING REQUIREMENTS

The protection level of any given healthcare organization is that level assigned, either specifically or tacitly, by the administrative authority of that organization. Thus the protection level is one of individual facility philosophy or priority.

In the way of analogy, two individuals with similar, or exactly the same, circumstances will invariably assign different philosophies to the issue of life insurance. One may have an abundance of protection, while the second may have little or none.

It must also be clearly understood that the protection level provided a healthcare organization cannot be measured in terms of security manpower alone. A protection level is established as a system utilizing many different safeguards such as alarms, fencing, CCTV, locks, in-service education, and security staff applied in varying degrees. The security staff is merely one safeguard. It is, however, imperative that a foundation of security patrol and response capability be established. This capability, especially in smaller organizations, may be performed by persons other than designated security personnel. As example, a Maintenance employee may be assigned a security patrol and response function as part of his maintenance job function in the very small facility.

STAFFING FACTORS

The following major factors should be utilized to determine the security manhours to be applied to a specific healthcare organization:

1. Establish the desired response time for called for services broken down into:

   - Emergency situation (assault, fire situation, disturbance, injury)
   - Non-emergency situation (escorts, motorist assist, patient assist, deliveries, missing property)

2. Establish the desired frequency of patrol inspection of specific areas. (Note, this frequency will vary by time of day.) In order to facilitate planning it is suggested that the following general areas serve as a base for analysis:

   - Parking areas
   - In-patient bed areas
   - Facility public areas
   - Ancillary patient care areas, i.e., lab, x-ray, physical therapy
   - Support areas, i.e., food services, medical records, maintenance, and engineering

   This patrol frequency should be viewed as that required for routine day-to-day patrols and does not allow for an increase in patrol activity of a given area as a tactical response to a new or increased security vulnerability. Assign the time factor required for these patrols for each day of the week.

3. Determine the need (philosophy and priority) of security fixed post assignments and the number of manhours required to fill these posts. Fixed post assignments will reduce the amount of manpower required for both patrol and response time considerations.

4. List all scheduled routine functions (excluding patrol and called for response) performed by security by the hour and day. Assign a time factor that it takes to accomplish this activity. Examples would be scheduled cash escorts, locking/unlocking, picking up parking receipts, bank run, deliveries, putting up and taking down the flag, equipment checks.

5. List all non-scheduled activities but routinely performed by security personnel. Assign an estimated time factor. It may be easier to calculate the time required on each of three workshifts as opposed to the hourly approach as required in calculating the time requirements for scheduled activity. Examples of this category of activity would be preliminary investigation or problem resolution by first response

field officers, handling lost and found, unscheduled locking or unlocking, assisting with patients on an emergency basis, acceptance of emergency shipments, assisting in releasing valuables, acting as a witness, preparing reports, etc. It is not uncommon for this category of activity to take up fifty percent or more of the individual officer's working time.

The end result will be to calculate the manhours required to accomplish the defined security mission. While the manhour requirements will be viewed on an hourly and daily basis, it is suggested that the manhours required be projected to the weekly total. The weekly total provides not only a summation of each of the different days of the week, but allows for easy conversion to an FTE (Full-Time Equivalent) employee basis. It is not uncommon for manpower need to vary with each different weekday. However, such needs generally remain fixed from week-to-week with the exception of special assignments due to planned or unplanned events.

SAMPLE MODEL

One should now be able to develop a model in a manner in which the previously discussed factors can be utilized. While all hospitals will vary, this sample model may very well be applicable to a hospital with the following general profile:

- General medical/surgical facility
- 300 licensed beds located in the inner city
- Medium emergency room patient load pattern
- Basic 20 year old, five story structure with newer additions of less than five floors with property covering six city square blocks
- Six doors with heavy ingress/egress activity. Seven with minor such activity, and an additional fourteen doors designated as fire exits ony
- Parking for 725 vehicles on surface lots scattered around the facility
- 990 full-time equivalent employee count
- Medium crime area

MODEL CATEGORIES

I. Response Time

- Emergency response time defined	3-4 minutes
- Routine response time defined	10 minutes

II. Patrol Frequency

Parking areas	every	30 minutes
In-patient bed areas		
6A - 8P	every	4 hours
8P - 6A	every	2 hours
Auxillary patient care areas		
6A - 6P	every	4 hours
6P - 6A	every	2 hours
Support areas		
6A - 6P		as called
6P - 6A	every	3 hours

III. Fixed Post Assignments

- Emergency room	4P - 8A
- Security operations center	24 hours
- Employee entrance	6A - 6P
- Parking lot one (visitors)	8A - 4P
- Employee parking lot	2P - 4P
	10P - 12M

IV. Scheduled Duties/Activities in Hours

	Days	Swings	Mids
Sunday	1	1	1
Monday	3	2	1
Tuesday	2	2	1
Wednesday	2	2	1
Thursday	2	2	1
Friday	2	2	1
Saturday	1	1	1

V. Non-Scheduled Duties/Activities in Hours

	Days	Swings	Mids
Sunday	12	12	5
Monday	14	18	6
Tuesday	12	15	6
Wednesday	12	15	6
Thursday	12	15	6
Friday	18	20	8
Saturday	12	12	5

PROJECTED SECURITY WORKLOAD IN HOURS

Model Category / Day	Su	M	T	W	Th	F	Sa	Week Total
I	72	72	72	72	72	72	72	504 hours
II	*	*	*	*	*	*	*	
III	64	64	64	64	64	64	64	448
IV	3	6	5	5	5	5	3	32
V	29	38	33	33	33	46	40	252
Totals per Day	168	180	174	174	174	187	179	1,236 hours

* Included in the hours scheduled for Category I.

Notes:

- The above projections do not include an allocation of hours required for fringe benefits (vacation/sick/funeral), training hours, or required additional manpower loading for emergency situations or special events.

- It should be noted that a nominal increase in scheduled or non-scheduled activities will not materially effect emergency response time. An increase in this area of activity will reduce preventive patrol time and generally slow response to non-emergency calls for service.

CONVERSION OF PROJECTED SECURITY MANPOWER NEEDS TO STAFFING

- Projected Workload	1,236 hrs/week ÷ 40 hrs =	31.1 FTE
- Fringe Factor based on 21 days of off time per officer, per year	31 FTE x 168 hrs = 5,208 hrs ÷ 2,080 hrs =	2.5
- Training Time based on average of 5 days per officer, per year	31 FTE x 40 hrs = 1,240 hrs ÷ 2,080 hrs =	.6
- Extra Special Assignment coverage per year is estimated at 452 Hours		.2
		34.4 FTE

CONCLUSION

It would require 34.4 FTE security officers to staff this hypothetical hospital security operation. This number of personnel are working field personnel and does not include supervisory or administrative personnel.

Prepared By:

Russell Colling
Director of Security
Hospital Shared Services of Colorado
333 East Nineteenth Avenue
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July 1986

foreword

The Joint Commission on Accreditation of Hospitals (JCAH) is a not-for-profit organization whose primary purpose is to promote high quality in the provision of health care and related human services. JCAH's member organizations include the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association.

JCAH conducts voluntary accreditation and education programs throughout the United States for general acute care hospitals, adult psychiatric facilities, child and adolescent psychiatric facilities, drug abuse treatment and rehabilitation programs, alcoholism treatment programs, community mental health services, long term care facilities, and ambulatory health care organizations. Approximately 7,400 facilities, services, and programs currently hold JCAH accreditation.

This *Safety Clinic Handbook*, which is used as the text for JCAH's Safety Clinic workshops, provides an overview of life safety for health care facilities. This *Handbook* is a combination of JCAH's *Safety Clinic 1* and *Safety Clinic 2* handbooks, which have been published separately in the past. Both books were slightly revised to make them consistent with current JCAH requirements, and the "Resources" sections were updated to include articles through 1982. The books have been combined into this *Safety Clinic Handbook* to provide hospital staff with one reference source for common life safety questions.

Module	Security
Category	Facility Policy
Capsule Statement	Specific guidelines must be established for the direction, responsibilities, and authority of the security program. In addition, policies and procedures must be established for security personnel to follow.
Questions' Responses	1. *Why does JCAH require hospitals to maintain a security program?* JCAH requires all hospitals to establish a security program to protect patients, personnel, and the public. Security programs vary depending on the size, location, and population of the hospital. Security services should be designed to protect individuals within the hospital and must stay within guidelines set by the governing board and local laws. 2. *What is the difference between a private and a contract security force?* A private security force is composed of persons hired and paid by the institution. A contract force uses personnel provided by an agency or company on a fee-for-service basis. When a contract force is used, the agency or company recruits, trains, and supervises security personnel; however, the hospital must establish its responsibilities.

3. *What is a statement of authority?*

A statement of authority documents the institution's support of its security force. Such a statement demonstrates that the administration gives its full support to the security force provided the security force's actions are within the security policy guidelines. The statement gives security personnel the authority to carry out their responsibilities.

4. *What should be included in security contingency plans?*

Contingency plans should include policies and procedures to be followed during employee strikes (including strikes by security personnel), civil disturbances on hospital premises, bomb threats, and other internal disasters. The plans should also define the security force's role during natural disasters, such as severe weather or fire, and when requests for assistance from other hospitals or from the community are received.

5. *Can safety and security programs be combined?*

A hospital can meet the standards in any way that is effective for that particular institution. Some facilities designate one person or department to be responsible for both functions. Other facilities divide the responsibilities.

Module	Security
Category	Patient, Personnel, and Visitor Security
Capsule Statement	All patients have a right to personal security, and facilities have a responsibility to take reasonable steps to provide a secure environment. A proper and effective security program will also help ensure the safety of visitors and employees as well as protect the facility. This can be achieved through an employee identification system and strict exit and entry control. Only when security abuses are discouraged can a facility provide a functional and secure health care environment.
Questions/ Responses	1. *What are some measures that could be implemented to provide security?* Several measures may help provide security, including the following: • Every facility should have exit and entry control. Many organizations limit the number of entry points to the building, both for employees and visitors. (Remember that exits may be locked against entry; however, they must not be locked or obstructed in such a way that rapid escape in an emergency is prevented.) An exit search policy, if utilized, should be well defined, approved by the facility, uniformly applied, and meet current legal guidelines. • Every visitor, whether visiting a patient or an employee, should carry a visitor pass. All passes should be dated and should state whom the visitor wants to see and where that individual can be found. Visitors should be required to return passes.

- One of the most common methods of providing security is the use of a closed-circuit television system. Cameras can be mounted in waiting areas, stairwells, and various potential trouble spots. The units should be monitored at a central communication point and controlled by a security officer.

- One of the best ways to provide patient security is with a well-trained security staff. All the cameras, alarms, or visitor passes will be ineffective unless they are controlled by a well-trained staff.

- The education of facility personnel in the importance of patient and facility security can create an atmosphere of vigilance that prevents and deters many security problems.

- Incident reports should be reviewed because they can indicate problem areas that need corrective actions.

- Provide lighting for exterior walkways, entry/exit areas, and secluded areas.

- Conduct routine inspections, especially during low-use hours and when areas are unoccupied.

2. *Why is exit and entry control important?*

Many institutions require both visitors and employees to enter and leave the facility at designated locations. This allows the facility to control who enters and leaves the premises. All employees should have an identification badge. Visitor passes should be available for visitors, salespeople, and other persons not employed by the facility.

3. *Because employee identification badges can be stolen or duplicated, can they really be considered an effective part of the security system?*

The most widely used employee identification system is an identification badge with a picture of the employee. It is extremely difficult to use a stolen photo ID badge unless it is designed in such a way that the picture can easily be replaced. Frequent updating of photo badges will help make an identification program even more effective.

4. *What instructions should patients receive?*

Patients should be made aware of pertinent hospital policies, such as security programs and emergency procedures. This information can be part of the admitting information or can be distributed by a patient representative or volunteer.

Module	Security
Category	Staff Training
Capsule Statement	Facility security should provide safety and control without compromising convenience or effectiveness of service. Although security is an important part of patient care, it should not be so rigid that it detracts from that care.
Questions, Responses	1. *What should be included in employee training?* Employees should not be trained to function as a police force, rather they should be the eyes and ears of security. Employees should receive training in procedures to summon assistance to deal with undesirable or uncontrollable visitors or patients. Each employee should be aware of the special security measures in his or her work area and of actions to take if those measures are violated. 2. *Who should be responsible for this training?* A qualified member of the security department or someone responsible for employee training can instruct employees in security policy and procedures. This material should be reviewed and updated annually.

- Bulk storage of concentrated acid shall be located near the floor level, and the storage area appropriately identified.
- There shall be a written plan of action for personnel to implement in the event of a serious accident in the laboratory. The provisions of the plan shall be made known periodically to all laboratory personnel as a part of the continuing education program relating to safety.
- A fire blanket and self-contained breathing apparatus are recommended for the clinical laboratory.

*Smoking** Because smoking has been acknowledged to be both a fire and health hazard, a continuous effort shall be made to reduce its presence in the hospital. Written regulations governing smoking shall be adopted, and shall be conspicuously posted and made known to all hospital personnel, patients, and the public. These regulations shall include at least the following provisions:

- Smoking shall be prohibited in any area of the hospital where flammable liquids or gases, or oxygen, are in use or stored. These areas shall be identified with "No Smoking" signs. Where indicated, the signs shall be multilingual or shall make use of symbols.
- Ambulatory patients shall not be permitted to smoke in bed.
- Patients who are confined to bed should be discouraged from smoking.
- Unsupervised smoking by patients classified as not mentally or physically responsible for their actions shall be prohibited. This includes patients so affected by medications.
- Wastebaskets shall be made of noncombustible materials and shall not be used as ashtrays. Ashtrays shall be noncombustible.
- Smoking shall be prohibited in areas where combustible supplies or materials are stored.
- Smoking by personnel using the surgical and obstetrical suites shall be limited to dressing rooms and lounges; doors leading to the suites shall be kept closed.

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.

*Used, with permission, from Chapter 6, NFPA 56B, *Respiratory Therapy*, Copyright 1973; Chapter 17, NFPA 101, *Life Safety Code*, Copyright 1973.

†Used, with permission, from Chapters 10 and 17 NFPA 101, *Life Safety Code*, Copyright 1973.

- Use of surveillance equipment such as visual monitors (mirrors and closed-circuit television) and alarm systems.
- Management of prisoner-patients as required.

Standard III **The hospital shall have written plans for the timely care of casualties arising from both external and internal disasters, and shall document the rehearsal of these plans.**

INTERPRETATION *External Disaster Plan** To meet its responsibilities for the care of emergency casualties at the time of disaster, the hospital shall develop a disaster plan based on its capabilities. A hospital's capabilities may range from providing simple first aid or preparing casualties for transfer elsewhere to administering definitive care.

The disaster plan should be developed in conjunction with other emergency facilities in the community so that adequate logistical provisions are made for the expansion of the hospital's activities in coordination with the activities of these facilities. Planning should include consultation with local civil authorities and with representatives of other medical agencies in order to establish an effective chain of command and to make appropriate jurisdictional provisions. Such planning should result in disaster-site triage and distribution of patients that ensures the most efficient use of available facilities and services. The hospital has the responsibility for informing the community of its capabilities and its limitations in handling a disaster in the community. The extent of each hospital's capability or resources should be clearly identified for use by local police, rescue squads, and ambulance teams. The plan shall include coordination with law enforcement agencies, as required, to provide a mechanism for physician identification as well as route access and entrance to the hospital when such are compromised by a disaster situation. For disasters involving radioactive contamination, refer also to the Emergency Services, Radiology Services, and Nuclear Medicine Services section of this *Manual*.

The external disaster plan shall be rehearsed at least twice a year. There should be evidence that a concerted effort has been made to use the plan in a coordinated exercise in which other community emergency service agencies participate. Drills should be realistic, and they shall involve the medical staff, as well as administrative, nursing, and other hospital personnel. Actual evacuation of patients during drills is optional. There shall be a written report and evaluation of all drills.

The disaster plan should make provision, within the hospital, for:

- an efficient system of notifying and assigning personnel.
- unified medical command.
- availability of adequate basic utilities and supplies, as well as essential medical and supportive materials. The hospital should be essentially self-sustaining in these areas for a minimum of one week. This may include preestablished mechanisms for immediate supply of certain major critical items such as water, food, and fuel.
- a method of identifying patients who are immediately dischargeable

*Used, with permission, from Chapters 2, 3, and 5, NFPA 3M, *Hospital Emergency Preparedness*, Copyright 1973.

or transferable, and includes provision for their expeditious transportation. A manual method of identification is acceptable.

- conversion of all usable space to provide triage, observation, and treatment areas. In a small facility, the emergency services area is usually not best suited for this, and the size of the disaster may dictate that an area outside the hospital is more realistic, particularly for secondary triage and for accessibility to large numbers of patients simultaneously.
- prompt transfer of patients, when necessary, to the facility most appropriate for rendering definitive care, in accordance with any regional plan in operation.
- the use of a special disaster medical record or medical tag that accompanies the patient at all times and contains specific required information.
- establishment of a centralized public information center with a designated spokesman.
- security, to minimize the presence of unauthorized individuals and vehicles in or near the triage, observation, and immediate care areas. Additional security measures may be required when the casualties have resulted from riots and civil disobedience.
- a preestablished radio communication system for use when telephone communications are out or overtaxed.
- instructions on the use of elevators.

*Internal Disaster Plan** The hospital shall ensure that it has fire protection services either from the local fire department or by providing its own.

Internal disaster plans shall be developed with the assistance of qualified fire, explosion, safety, and other experts as required. These plans should provide for at least:

- notification of emergency services and designated personnel;
- assignment of specific responsibilities to all personnel;
- instructions relative to the use of alarm systems and signals;
- instruction concerning the location and use of fire-fighting equipment, and methods of fire containment;
- an operational plan in case of threat of explosion by bomb or other device, including notification of designated authorities, search procedures, and evacuation of patients and personnel;
- specification of evacuation routes and procedures; and
- management of casualties when the resources of the facility remain functionally intact.

Internal disaster plans shall be made available to all hospital personnel and should be posted on appropriate bulletin boards at nurses' stations and in other areas of the hospital that ensure maximum exposure.

Effective internal disaster, fire, and evacuation drills shall be held at least quarterly for each work shift of hospital personnel (totaling not less than 12 drills per year) in each separate patient-occupied hospital building, and shall be designed to:

- ensure that all personnel are trained to perform assigned tasks;

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NEW YORK CITY HEALTH & HOSPITALS CORPORATION
346 Broadway • New York, New York 10013

December 18,1986

TO: Charles P. Connolly
Assistant Vice President,
Corporate Security Administration

THROUGH: Harry Moldaw
Senior Management Consultant,
Corporate Security Administration

FROM: Doris Gaskins
Detective,
Records & Information Unit

SUBJECT: OFFENSE DATA

Attached is a completed statistical report of all reported offenses compiled from incident reports forwarded to Central Office from the various facilities.

The information shown under each category reflects two totals, one is the amount of activity for the particular month being reported, while the second is the cumulative total of activity from January 1, 1986 of the current year through the last day of the reported month.

HM/DG/db

cc: Roberts
Hankers
Ward

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Internal Memorandum

To: Mr. Charles Connolly
Assistant Vice President

Date: December 18,1986

From: Doris Gaskins
Records &Information Unit

Subject: Monthly Offense report

The statistical report of offenses for the month of November 1986 is as follows;

FELONIES	
YEAR TO DATE	MONTH
1546	128

MISDEMEANORS	
YEAR TO DATE	MONTH
2253	170

VIOLATIONS	
YEAR TO DATE	MONTH
1309	86

ARRESTS	
YEAR TO DATE	MONTH
1008	60

WEAPONS	
YEAR TO DATE	MONTH
179	17

INJURIES	
YEAR TO DATE	MONTH
292	19

16 Arrested

44 Summoned

4 Guns
6 Knives
1 Bat
1 Brick
1 Metal pipe
1 Mop handle
1 Chair
1 Wheel chair arm rest
1 Telephone

8 Officers

CC: C. Stettner
V. Roberts
B. Hankers

CUMULATIVE AND MONTHLY OFFENSE REPORT

NOV. 1986

	FELONY		MISDEMEANOR		VIOLATION		ARREST		WEAPON		INJURY	
	YEAR TO DATE	11/86	YEAR TO DATE	11/86	YEAR TO DATE	11/86	YEAR TO DATE	11/86	YEAR TO DATE	11/86	YEAR TO DATE	11/86
CENTRAL OFFICE 346 BROADWAY	12	1	8	1	1	1						
BROOKLYN LAUNDRY	1											
FINANCE CENTER	3						1					
LOWER WASH. HTS.	13	1	8		5		2		3	1	4	
NFCC EAST NEW YORK	1		10									
BEDFORD STUY. A.T.C.	0		1									
SYDENHAM	3		3	1								
MORRISANIA	16	6	14	2					2			
SEGUNDO BELVIS	8	1	9								1	
CUMBERLAND	1											
NEPONSIT	11	1	12		1		2		1		3	
T O T A L S	1546	128	2253	170	1309	86	1008	60	179	17	292	19
CUMULATIVE THROUGH CURRENT MONTH	1546		2253		1309		1008		179		292	

CUMULATIVE AND MONTHLY OFFENSE REPORT

	FELONY		MISDEMEANOR		VIOLATION		ARREST		WEAPON		INJURY	
	YEAR TO DATE	11/89	YEAR TO DATE	11/89	YEAR TO DATE	11/89	YEAR TO DATE	11/89	YEAR TO DATE	11/89	YEAR TO DATE	11/89
BELLEVUE	130	4	165	5	145	1	216	1	28	1	34	1
B.S. COLER	42	5	101	5	30	5	6	0	15	2	19	3
BRONX MUNICIPAL	126	7	155	18	24	2	15	1	4	1	9	2
CONEY ISLAND	91	6	193	24	220	15	78	5	9	2	22	2
ELMHURST	50	7	66	2	29	2	23	3	5	1	11	2
GOLDWATER	38	1	114	6	27	3	2	0	9	1	17	2
GOUVERNEUR	28	3	72	7	15	2	5	0	2	0	0	0
HARLEM	177	0	224	0	179	0	133	0	15	0	41	0
KINGS COUNTY	117	18	111	7	66	1	81	4	14	0	19	0
LINCOLN	207	12	246	22	275	25	229	25	22	3	42	2
MASPETH (EMS)	14	2	16	1	0	0	2	0	7	1	0	0
METROPOLITAN	145	15	138	7	39	2	32	3	14	2	20	1
NORTH CENTRAL BX	87	13	178	22	70	8	40	3	5	0	18	1
QUEENS	93	12	171	17	29	5	22	4	10	0	8	0
SEAVIEW	9	0	63	4	7	0	1	0	0	0	0	0
WOODHULL	123	13	175	19	147	14	118	11	14	2	24	3

CONVERSION FORMULA
FOR
PROJECTED SECURITY MANPOWER NEEDS
TO
STAFFING REQUIREMENTS

A. - PROJECTED WORKLOAD

The amount of manhours required by a facility to accomplish its defined security mission are determined by totaling the hours shown for Corporate Security Staffing Factors # 9 , Security Posts; # 10, Concomitant Functions; and # 11, Special Situations. Adjust this grand total to reflect manhours required per year.

GRAND TOTAL_____

B. - TIME RESOURCE

Special Officer contract requirements provide for a work week of 37.5 hours, 52 weeks per year, totaling 1,950 hours per officer each year. However each officers availability for duty assignment is affected variously by the considerations listed below. In the column marked "two years experience" please show the total amount of Special Officer manhours expended on each of the categories listed during the last two (2) calander years. This time experience is necessary to allow for a statistically valid sampling.

ACTIVITY	2 YRS. EXPERIENCE
Holiday	
Vacation	
Sick	
Disability (workmans compensation cases)	

Approved leave of absence (maternity, drug or alcohol rehabilitation, etc.)

Heat day

Compassionate leave (death in family)

Terminal Leave

Court supoena (job related)

Jury duty

Training

Absent with out pay

Suspended from duty

Other (explain on separate sheet)

GRAND TOTAL_____

C. - TIME REDUCTION

Reduce the Grand Total shown for "B" by ½ and divide the result by the average number of Special Officers employed during the last two years. For example, if 70 officers were employed in 1985, and 63 were employed in 1986, the average employed during those two years would be 66.5 officers. Divide 66.5 into the reduced (by ½) grand total for "B" and this calculation will indicate the average time expended by each individual officer, each year, due to the considerations listed in paragraph "B".

AVERAGE TIME_____

D. - STAFFING REQUIREMENT

Deduct the average time shown for paragraph "C", from the 1,950 hours each Special Officer is contractually required to

perform each year. Divide the resulting number into the Grand Total (projected facility workload) for paragraph "A". This outcome represents your staffing requirement in terms of your defined security mission.