

Case Study: Adapting the IAHSST curriculum in Thailand

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In late 2007 Corporate Protective Solutions (CPS), an independent security consulting company that specialises in healthcare security, approached the IAHSST concerning the adaptation of the Basic Training Manual and Study Guide for Healthcare Security Officers for one of their clients. In this article, CPS' Managing Director for Asia Pacific, Richard Goss CPP, outlines the challenges of this project from which other international healthcare Security Managers can learn to replicate the process for their own facilities.

BACKGROUND

At the end of 2006 Corporate Protective Solutions (CPS) was retained by one of Thailand's largest hospitals to provide security consultancy to help them achieve accreditation by Joint Commission International (JCI). Our scope of work began with a Threat and Risk Assessment (TRA) of the entire campus, during which we also assessed the hospital's prevailing compliance with the Elements of Performance within Standard EC 2.10.

After completing the TRA we submitted a report documenting our findings along with detailed recommendations. Given the amount of data gleaned from a survey of such a large campus, the recommendations were prioritised into a Security Improvement Action Plan that became the hospital's "Bible" over the 6 months before the JCI Audit. During this time CPS continued to support the hospital, undertaking a number of priority projects ranging from physical/technical design and specification to security operations and administration.

SECURITY OFFICER TRAINING

After successfully achieving JCI accreditation at the end of June 2007, one key project yet to start concerned the development of a formal security training structure within the hospital. A number of options were available but it was quickly apparent that the hospital's Training Department, already over-stretched both before and after JCI, did not have the time or motivation to add the development of security training to their portfolio. This meant that we were going to have to undertake this as a project within the Security and Safety Department itself.

WHY IAHSST?

The IAHSST curriculum was one of the options that I had presented to the hospital's management, as I had been familiar with the IAHSST for a number of years and had previously added the complete set of healthcare security training courses to my reference library. The IAHSST course met the hospital's needs in every way, from its content, style, and thoroughness to its recognition as a world-class, industry-leading curriculum, something that is very important in the local business culture.

Fortuitously, at the time that we were discussing options with the hospital, I attended a presentation conducted by Isaac Luten, Principal Consultant at HSS, and Tony York, President of IAHSST, at ASIS International's 53rd Annual Seminars and Exhibits in Las Vegas in September 2007. The presentation entitled "*Top 10 Things Every Healthcare Security Director Must Get Right*" hit on several key points that were still under discussion with our client, including Standardised Security Staff Training.

In the final months of 2007 I finally convinced the hospital that the IAHS curriculum fitted perfectly with our needs, and sought Tony's written approval to adapt the course accordingly.

COURSE IMPLEMENTATION/METHODOLOGY

The training development projects got underway in early 2008. Given the amount of information that would need to be extracted if the entire curriculum was to be amended, I advised the hospital to launch a pilot project using only the *Basic Training Manual and Study Guide for Healthcare Security Officers*. This would not only make the project more manageable but was also the most practical solution given that the course adaptation had to be done quickly whilst the necessary internal changes and improvements were implemented.

The first step was to identify which items were "U.S.-Centric" and which did not reflect the role placed on security officers at this hospital. A total of 4 modules were omitted from our project, namely Interview and Investigation, Judicial Process/Courtroom Procedure/Testimony, Public Safety Interactions/Liaison, and Criminal and Civil Law. The second step was to thoroughly review all remaining modules to highlight which parts would need to be kept in their entirety, which would need to be adapted and by how much, and what internal changes or additions to current security practices the hospital would be required to make so as to ensure they and the course material matched. As will be noted below, one crucial change we needed was to create a partnership between Security and the Customer Service staff, who manned information and reception desks, and provided customer meet and greet services.

The process turned out to be relatively straightforward, however there were several challenges and difficulties that had to be overcome in order for this project to be completed successfully.

Client buy-in. Hospital Management buy-in to all the security improvement projects was excellent, however mid-way through this IAHS project we encountered some pushback from the Customer Service, and Training Departments. There were 2 key obstacles that had to be resolved:

- Who would be responsible for delivering the training? The hospital Training Department, which had the responsibility for all non-medical procedure training courses conducted in the hospital, felt their territory was being encroached on whilst admitting they did not have time for this extra workload;
- Why were Customer Service staff going to have to participate in the training and be given security roles and responsibilities? Departmental management were concerned that their staff were not 'security people' and should not be put in harm's way;

I took the position that the Security Department should be the ones to take ownership of all security-related training because it contained the necessary domain expertise and work experience. Given that the Security Department was already responsible for the management, deployment, briefing, performance and discipline of security officers, and that this basic course was focussed only on them, no-one was treading on anyone's toes. I also argued that if the Training Department was already stretched then this project would never get off the ground if added to their existing heavy workload. My third argument stressed that other hospital departments should see themselves as 'Customers' of the Security Department, with the latter providing a centralised consultancy, including staff security awareness training, as part of that relationship. Finally, the Customer Service staff needed the training as they were

based throughout the hospital and could be additional eyes and ears to assist with overall security protection of the facility. In so doing they would need to have an understanding of security and be able to identify and report suspicious behaviour and incidents before such might lead to a major crisis.

Local culture. There were a number of constraints related to local and corporate culture to which we needed to be sensitive. The JCI accreditation had resulted in a significant amount of additional ongoing work for many hospital staff, who had other priorities. There was a general perception that their contracted guard company should be providing this training to their staff, for which the hospital should not have to pay, yet the hospital was paying the cheapest rates for their security officer services. We had to change the local mindset and attitudes towards security guards, who are frequently looked down upon and for whom security is not seen as a career but as something people do when they cannot do anything else. Finally, we had to be sensitive as to how we discussed the IAHS Course to avoid perceptions of staff that they were being preached to by foreigners.

Internal organization. As already noted the JCI Project had stretched the workloads of many staff to the limit, and there was still a period of adjustment going on. Security at that time was responsible for transportation, fleet management, and parking. The Security Manager reported to the Engineering Department Head instead of directly to the CEO, meaning that there was a risk of important information and advice not reaching the stakeholders who would have a vested interest in receiving the same. Although not resolved by the time we concluded this project, I continually stressed the importance of the Security Department being a standalone unit, reporting to hospital stakeholders, and acting as internal consultants to the rest of the hospital.

Existing practices. In Thailand there is still the perception that security is achieved simply by throwing many dozens of cameras and guards at a site. There are no laws that really regulate and improve the industry such as we find elsewhere in Asia, such as in Hong Kong and Singapore, or in the US and UK. This means that almost anyone can open a security company, anyone can become a security guard, quality comes at the expense of price, there are no performance standards, and no companies provide true expertise in any particular field, such as healthcare. Companies that provide security guards for hospitals do not provide the sort of healthcare-specific security training that is required, and certainly little that is covered even in the IAHS Basic Course. Still price is the determining factor for awarding contracts, yet clients impose penalties on their contractors when things go wrong, without understanding that their own decisions have contributed to the lack of quality. In any industry staff who are paid a bare minimum wage are hardly going to be motivated to perform to a high standard. Educating our client on these issues was essential to achieving the buy-in to this project but was perhaps more critical in laying the foundations for better service in the future. Demonstrating how empowering security guards, providing them with proper tools, and deploying them more intelligently and strategically could improve the bottom line, reduce risk exposure and enhance customer service, was critical.

Language and Content. The IAHS course was written for a more mature and educated audience, security officers who see their jobs as a career and not as something they have been stuck with because they cannot do anything else. The course was written for people interested in self-development and career progression, people dedicated to playing their part to improve the environment of care for patients, people who realise that in so doing the patients benefit, the doctors and caregivers benefit, and the hospital remains financially healthy able to

continue investing in up-to-date equipment, treatments and facilities. It was essential to maintain the original style and messages within the IAHS course as they provide the motivation, encouragement and the reasoning as to why this job is important and the benefits of self-development.

The course first had to be adapted from international-level English to a more simplified level of English, whilst preserving the intent and structure of the original. This simplified English was required as a precursor to the course being translated since, like many old Asian languages, it is not possible to translate English into Thai verbatim and get the same meaning. To get the meaning across it is necessary to create a mental image and build the listener's understanding using simple statements, ideas and concepts. Also, many technical terms cannot be translated and have to remain in English which behoves the trainers to have a suitable understanding of English in order for them to pass on the training to security personnel, of whom 98% will not have any knowledge of English.

Conclusion

The *Basic Training Manual and Study Guide for Healthcare Security Officers* provides an excellent foundation for the development of a world-class security department and training program in any healthcare facility. The careful repetition and development of key themes focussed on the Environment of Care cause trainees to think more about *why* and *how* they do things and not just *what* they have to do. Internationally, the course transcends cultural, social and other boundaries because at its core are the principals of providing service, understanding the feelings and stresses of patients and their families, and upholding the basic rights of everyone to respect, compassion and kindness. Our client is the first hospital in Thailand to adopt the IAHS course as its standard – and I hope others will follow their example.

(Richard J. Goss is Managing Director, Asia Pacific, Corporate Protective Solutions, Bangkok, Thailand. He is a member of IAHS. For more information, contact Goss at richard@corpprotect.com or refer to the company's website (www.corpprotect.com). See the Winter 2008 issue (Vol. 24 Number 1) of the *Journal of Healthcare Protection Management* for the article version of "The Top 10 Things Every Healthcare Security Director Must Get Right.")