Learn to spot ED violence before it hits
Look around—chances are you have one of these potentially violent people sitting in your ED

Violent incidents in hospitals, especially in the emergency department where 24/7 operations can expose a facility to all kinds of people, continue to pose one of the biggest challenges to healthcare workers.

As the security expert at your facility, you probably already know this, and maybe part of your daily routine is to take a long walk around and see where the potential hazards are in your ED. The hazards aren’t always easy to see, and the conditions are always changing. But stopping violence from happening may be as easy as taking a closer look at the people sitting in your emergency room and recognizing the signs of trouble brewing.

That closer look may even be what stops your workers from being injured or killed on the job. According to a report last year in Journal of Healthcare Protection Management, there were more than 150 shootings at hospitals across the United States from 2000 to 2011, and more than a third of them occurred in emergency rooms. In the two years since then, at least 47 gun discharges in U.S. hospitals have led to more than 39 deaths and 19 injuries, according to the report.

Consider also that a report last year from the Emergency Care Research Institute (ECRI) found that as many as 80% of all hospital staff have been “physically assaulted at least once during their career,” with nurses “at the greatest risk” for such assaults, and the picture becomes a little clearer.

“Violent individuals appear in the ED at any time of day or night,” writes Lisa Pryse Terry, CHPA, CPP, director of hospital police and transportation at the University of North Carolina Hospitals in Chapel Hill, in the new HCPro book Preventing Emergency Department Violence: Tips, Tools, and Advice to Keep Your Facility Safe. “Although there are some noticeable signs of impending violence among individuals, it can erupt unexpectedly and with no warning.”
What makes the situation worse is that once violence escalates past the verbal point, there is often little healthcare workers can do to stop it or to defend themselves, since the ER is generally a weapons-free environment. Most anti-violence training for healthcare workers centers around de-escalation techniques that focus on recognizing the signs of imminent violence, which could be as easy as reading a person’s body language as they progress through the stages of violent behavior.

“Anyone in the ED has the potential to be violent at any time, because by nature they can be very stressful places,” says Matthew Daniel, security director for ODS Security Solutions at Sampson Regional Medical Center in Clinton, North Carolina. “There are a ton of training programs out there with insight on how to keep a safe environment if an individual becomes violent. A lot of times verbal aggression is what escalated into someone being physically aggressive.”

Let’s take a quick walk through your facility and identify the types of individuals who could pose the biggest risk of violence:

- **The calm but frustrated patient.** This could account for about 90% of the people in your ER waiting room, and let’s face it—we’ve all been there. The ER is filled with people of all ages who are waiting to be seen for ailments ranging from the sniffles to broken bones to chest pain. How quickly they are triaged and seen by a doctor depends on many different factors, including staffing, time of day, and even weather. All it takes is an influx of critical patients—say, from a serious car accident—to turn that wait into hours. Take a waiting room full of anxious people who don’t understand triage protocols, and the next thing you know, there’s an upset parent or spouse yelling at your nurses, wondering why it’s not their turn yet to be seen.

Whether it’s a family member of someone hurt or if they themselves are in pain, they can get aggressive,” says Daniel.

**What to look for:** About 50% to 70% of all communication is non-verbal, according to Terry, so there’s a good chance that if someone is going to get aggressive, you’ll see it in their actions first. In
a busy waiting room, look for the worried parent reaching out for the nurse’s arm for attention, writes Terry. Eyes that dart back and forth, a clearly agitated person walking back and forth across the room, and clenching of jaws and fists can be indicators that a person is under stress and ready to take things to the next level.

**How to handle it:** First, put yourself in the patient’s place. You wouldn’t want to be the one waiting for five hours to get a Band-Aid put on your daughter’s finger. But people are generally reasonable, and keeping them calm could be as simple as just recognizing their frustrations. If it gets busy and waiting times are long, perhaps it’s time to get out and greet people, apologize, explain the reason for the delay, and maybe offer some coffee or pizza for those waiting.

“Responding to nonverbal cues may be as simple as providing a brief update on the status of a loved one or giving a person a reassuring smile and greeting,” Terry writes. “Eye contact can also indicate genuine interest and concern for a person and alleviate anxiety. In an overcrowded ED, speaking to the agitated person and offering to help him find a more comfortable place to wait can defuse anger.”

If that doesn’t work, it’s time to put your security department on alert. Extra patrols from uniformed officers could send the message that violence won’t be tolerated, but you also don’t want to create the illusion of a police state—at the very least, a security officer can help reassure people that the problem is being worked on.

• **The forensic patient (prisoner).** Prisoners are often brought in for treatment by law enforcement personnel, and their presence can add drama to an already stressful environment. Police officers who bring in patients in custody often are anxious to get back to their jobs on the streets, and many prisoners are not happy about being brought into the hospital against their will, whether it be for a psychological exam or to treat a gunshot wound.

“Prisoner patients introduce added stress levels to an already overtaxed ED staff dealing with high patient volumes, crowded conditions, and lifesaving emergency situations,” writes Terry. “Nurses and other staff who are fearful are not able to completely focus on delivering optimal medical care. This not only affects the forensic patient, but all other patients under their care.”

It’s also important to remember that these patients are always at risk for an escape attempt, so it’s a good idea to make sure there are plenty of staff watching them.

“These individuals have the potential to escalate a situation, but luckily they are usually escorted by an officer,” says Daniel.

“Anyone in the ED has the potential to be violent at any time, because by nature they can be very stressful places.”

—Matthew Daniel

**What to look for:** The good news is that most hospitals do (or should!) have in place protocols that help them handle forensic patients, and those protocols usually start with making sure that the police or sheriff’s department gives the security department a heads up about who is coming through the doors. In addition to the usual signs of impending violence, it’s a good idea to check the patient for signs of intoxication and weapons—there have been many instances where a patient introduced a knife or gun into the ER that a police officer never found.

“Maintaining a safe environment even in the absence of prisoners requires vigilance and planning on the part of healthcare security professionals and hospital administration,” Terry writes. “Add prisoner patients to the mix, and the potential for violence just escalated.”

**How to handle it:** The trick here is advance notice. If you don’t already have a good working relationship with the local police department, now is a good time to meet with the police chief and work on protocols that will encourage them to contact your facility ahead of time and let them know if you have a patient prone to violence coming in.

Next, you don’t want weapons to be a surprise to caregivers. You should have a protocol in place to check for weapons before a patient ever gets to the
treatment areas—some security departments pat down patients, while others employ high-tech tools such as metal detectors.

“Law enforcement, company police, and armed security professionals may carry department-issued firearms while on duty admitting and guarding a patient prisoner,” writes Terry. “These weapons must be holstered and not accessible by prisoner patients. Officers must ensure their weapons are not vulnerable in the event of a violent outburst.”

Lastly, it’s important to remember that prisoners are people too; they are just as entitled to healthcare as anyone else. This means HIPAA privacy laws must be adhered to—hospital staff should never divulge information about the patient’s crimes, and security protocols need to be worked out if a physician needs to have a private consultation with the patient.

“This creates a particularly high-risk situation for the doctor, staff, and others, unless the patient is effectively secured,” Terry says. “Handcuffs, ankle restraints, and other methods of security can be used. Officers may choose to ensure a safe and secure environment by deploying multiple law enforcement officers to guard the patient room, depending on their professional assessment of risk.”

- **The intoxicated/behavioral health patient.** These patients are either those who show up at the hospital drunk and looking for a place to sleep it off, or those who are looking for a hit of their favorite drug—usually painkillers—and are posing as a patient to get it.

“It could be someone who is currently on drugs/alcohol, or someone who is detoxing,” says Daniel. “Chances are they are about to get to that stage where they are detoxing. If they are not offered the drugs they want, they have a potential to become aggressive very fast.”

Substance abuse—particularly of heroin and other opiates—has become such a problem in some states that hospitals have started to form in-hospital “intervention teams” that are designed to rapidly identify substance abuse problems in patients and get them to treatment quicker.

**What to look for:** Although it’s not always easy to spot someone who is addicted to drugs, there are plenty of signs to look for when spotting someone who is intoxicated. First of all, many people under the influence get brought in through the ambulance bays, and returning patients may already be known to hospital staff to have an addiction. Look for people who are either combative or withdrawn and have trouble focusing, standing, or sitting up straight. You may also detect an odor of alcohol, or slurring of speech. Also, patients who are insisting on being prescribed a certain drug—e.g., OxyContin—may be there just in the hopes of getting a fix.

**How to handle it:** Think de-escalation and isolation. It’s often impossible to reason with an intoxicated individual, so if you approach the individual in a threatening way, it can escalate the situation.

“A crowded ED, long wait times, depression, and anxiety can cause patients to become violent,” writes Terry. “Best practice in the ED is to establish a room or area within the ED, separate from other patients, for treatment of behavioral health patients. The area should be clearly visible to staff, including security. All items that could be used as potential weapons should be removed or carefully secured. This includes any items that could be used as weapons against others, or for self-injury.”

Training for staff members includes learning verbal de-escalation tactics, and providing staff members with reminders about small things like never letting a potentially violent patient get between them and a door to ensure they have an escape route from the situation. As with forensic patients, behavioral health patients have a right to fair treatment; they should never be made to feel like they are being discriminated against, and their privacy should be respected.
Sample forensic patient policy

[Facility Name]
[Facility Address]
Emergency Department

Policy:
Clarify the policy of the facility regarding care for forensics patients. The following Policy from UNC Health Care is an example of a comprehensive forensics policy statement.

The U.N.C. Hospitals Police Department working in conjunction with the N.C. Department of Corrections as well as other Law Enforcement agencies has established this policy and procedure to assure that every reasonable effort is being made to make sure that proper and timely medical treatment is given to patients who are injured or ill and either in the custody of law enforcement officers for alleged criminal activities or in the custody of agents of the Department of Corrections as the result of a conviction for a crime. At the same time, it is important that safeguards are in place to assure the security of these patients as well as the safety and well being of all other patients, visitors and hospital employees in the hospital environment.

Regulation:
Site the regulations supporting the policy. Include IAHSS, TJC, and other regulatory agencies.

Objective:
To maintain patient, employee and visitor safety in the presence of hospitalized patients who are in the legal custody of law enforcement officers or in the custody of the department of corrections as the results of conviction of a crime.

Procedure:
Outline, step-by-step, the policy and procedures for handling forensics patients. UNC Health Care’s Forensic Patient Procedures and Policy provides a comprehensive outline for managing prisoner patients. Their procedures include the following components:

- Initial Notification of Inmate Admission
- Arrival/Parking/Transportation of Inmates within UNC Hospitals
- Inmate Wheelchair Transport
- Radiation Oncology Inmate Appointments
- Roster of Inpatient Inmates Assigned to Outside Medical Facilities
- Prisoner Risk Assessment
- DOC Inmate Admission to Outside Hospital
- Inmate Custody Classification
- Restraints
- Specific Regulations Concerning Police/Corrections Officers and the Care of Forensic Patients
- Rules and Guidelines for Visitation with Forensic Patients
- Special Procedures
- Security of an Inmate Attended by Multiple Officers
- Discharge/Next Appointment Planning
- Death of Inmate
- Definitions

A detailed list of expectations and requirements should be included for each of the high-level bullet points above.

Source: UNC Health Care. With permission from Lisa Pryse Terry, CHPA, CPP, director of hospital police and transportation.
Guest column: The origins of hospital emergency management

Editor’s note: Paul Penn is a former hospital environmental health and safety manager who has run a consultancy focusing on healthcare emergency management and hazardous materials emergency response for the past decade. In Part 1 of this two-part guest column, Penn discusses the advent of modern hospital emergency management and how the money trail influences its effectiveness from top management down.

More than a decade since 9/11, hundreds of millions of dollars, innumerable software programs, mounds of equipment, and radios that can talk to “the man in the moon”—no matter how much progress we seem to make, the same scene gets played over and over.

The images are periodic but impactful. A flood, tornado, active shooter, hurricane, earthquake, fire, or other hazard strikes a community, and within the hospital its personnel immerse themselves in tasks for which they were not trained and have not exercised. The airwaves are saturated with tales of evacuating preemies, ICU patients, and moms in labor down darkened stairwells; chaos with no one in

“It’s important to respect behavioral health patients without bias toward their personal issues,” writes Terry. “They should be treated as considerately and politely as any other patient is treated.”

• The wild card. These are the violent people you generally can’t see coming into your ER, and they represent the most dangerous threats to your facility—and highest profile, if they succeed.

What to look for: Specifically, these people may not even be patients. They may be the active shooters who just want to harm a lot of people. They could be disgruntled former employees or spouses at the end of their rope. Or they could be gang members looking to inflict harm on one or more of your patients.

How to handle it: Drills, hypervigilance, and better ER design. It’s up to you as the security professional—along with help and support, hopefully—to decide what your facility’s response will look like should a shooting or other violent incident occur. It’s also up to you to help decide whether your hospital’s security team will be able to use weapons.

“As a security professional, uniformed official, or manager, people are more likely to turn to you for direction and protection,” Terry writes. “It’s important to remain calm and authoritative in the midst of chaos and fear.”

Many hospitals have begun holding regular active shooter drills that test not only the response of staff members, but also the coordination of outside responses from police departments and other agencies. Others have been testing arming their security forces with less-lethal solutions, such as Tasers, to help end a violent situation.

In an actual active shooter situation, the typical attempt to de-escalate a crisis has failed, and the response must turn to survival. “No one can be taught exactly what to do in an active shooter situation, because situations are always different,” Terry writes. “Training can mean the difference between life and death—literally. A lack of planning and not testing the plan with well-trained security personnel before an incident occurs can have disastrous consequences if an event occurs.”

Because of this, many healthcare security experts recommend a series of steps, starting with a comprehensive assessment of threats to the facility, periodic lifelike exercises, and upgrades to the facility’s response plan. Such upgrades include lockdown policies, access restrictions to certain areas of the hospital, and even simple changes to the way nurses’ stations and patient treatment areas are designed to make it more difficult for a perpetrator to jump over the counter or break down a door.
charge; surgery conducted by flashlight; and harried hospital staff bemoaning that they didn’t know what to do. A media conference is held and the CEO, a physician-looking person in a white lab coat, and the public information officer describe how harrowing the event was, but reiterate that the staff pulled through and showed their mettle.

Now imagine a different scene: It’s Monday morning in the hospital board (or executive conference) room, and senior leadership is contemplating budgets for next year. The VP in charge of facilities, EH&S, security, and EVS has a laundry list—as does the director in charge of quality, compliance, and infection control/prevention. Somewhere in the mix the executive whose responsibility includes emergency management has a request for planning, training, and/or exercising, as do other departments. As the deliberations go on, the following questions are articulated:

• “Will this generate revenue or enhance our public profile?”
• “Do we have to do this for The Joint Commission?”
• “Isn’t there some federal funding for these activities/equipment?”
• “What are the chances that something bad will happen?”

The executive responsible for emergency management has 10 other priorities that he or she considers to be important. Meanwhile, the chief of a medical specialty department is desirous to offer a new procedure that requires a specialized piece of equipment, and the “return on investment” briefing submitted indicates enhanced revenues and standing in the community. After the meeting, the person responsible for emergency management is told that there just was not any discretionary funding available.

Why is this? It comes down to commitment on the part of the organization and community to develop, implement, sustain, and enhance a comprehensive and substantive emergency management program. It takes a commitment for the long view, not the next quarter or annual report. It takes a commitment to staff, patients, visitors, and community. Commitment takes many forms.

As the Lindy Boggs Medical Center and Charity Hospital during Katrina and the NYU Langhorne Center during Sandy became hurricane poster hospitals, the efforts spent on mitigation and preparedness were not commensurate with the hazards faced. Why? Hospital administrators face daunting challenges in today’s world, and as long as their facilities are dry, with power, and not shaking, emergency management is not a top priority—until those conditions change for the worse. It can be safely stated that there are a number of healthcare executives who have needed to brush off their resumes because they had no facility to return to; that the lack of preparedness ended their career at that location.

In the short run, emergency management may not look good on paper to the finance people (unless it benefits the organization’s normal operations), but it looms large following a major event. One of the key considerations in contemplating the how and why of healthcare emergency management is to recognize, unlike many other industries, that when the facility is impacted by an event is the same time that the community needs it the most. What is important to the financial future of an organization is its ability to function immediately following the incident. If the hospital, or nursing home, or clinic is not able to serve its clientele, that organization will be at a competitive disadvantage versus the other facilities in its community. For those organizations in smaller communities where they are the only healthcare provider, the community is at a greater risk due to the lack of healthcare capability and capacity.

“All politics is local [and so are disasters]”

The quote made famous by Tip O’Neill also holds true in emergency management. Emergencies almost always start and end locally. During the event and immediately thereafter, there may be an influx of personnel and resources from outside the community, but eventually that support goes away.

The events of September 11, 2001, skewed our approach to emergency management. Back in the nascent days of emergency management, single hazards predominated (e.g., earthquakes on the west coast, hurricanes in Florida). The most emphasized but least beneficial was the primacy of nuclear war (aka World War III) imposed by FEMA and its predecessors. In the latter part of the 1980s and into the 1990s, emergency management was
evolving toward an “all-hazard” approach. This methodology established a common manner of managing all emergencies so that no matter what occurred, the activities would be toward managing that emergency, not figuring out “who’s who and what’s what.”

“Make no mistake. There are enemies, foreign and domestic, that have malice aforethought and mean us harm. To be effective, it is imperative that hospitals depoliticize how terrorism impacts their organization.”

—Paul Penn

After 9/11, while still giving lip service to “all-hazard” emergency management, foreign terrorism (aka World War IV) clearly rose to the top. Emergency management became ever more politicized. One of the factors that culminated in the fiasco that was the response to Hurricane Katrina in 2005 (there were many factors, some that started more than 100 years ago) was the sharp shift away from natural hazards in the mindset of emergency management’s policymakers, especially at the federal level.

Make no mistake. There are enemies, foreign and domestic, that have malice aforethought and mean us harm. To be effective, it is imperative that hospitals depoliticize how terrorism impacts their organization. Better to recalibrate the “weapons of mass destruction” mentality thusly: A “chemical terrorism” event is a hazardous materials incident, a “bioterrorism” event is an infectious disease outbreak, and a “bombing” is a mass casualty trauma and burn incident. This allows the healthcare organization to address all of these hazards by focusing on the impact rather than the intent. Yes, there are some added components to an incident with intentional violence (e.g., law enforcement presence; heightened concern among patients, staff, media, and visitors; and the possibility of perpetrators among victims and the hospital as a potential secondary target), but the broader approach has greater benefit.

Money, money, money

When the Hospital Preparedness Program was initiated in 2002 by the U.S. Department of Health and Human Services (HHS), it became focused following the events of late 2001 (World Trade Center, anthrax) on the bugaboo of terrorism with a sole emphasis on bioterrorism (spurred by the anthrax events). At around the same time, The Joint Commission transformed its Emergency “Preparedness” standards to Emergency “Management” standards. And while accreditation is supposed to be about quality, it is often about money.

Thus, the metaphorical floodgates opened. Money poured in. Compliance managers and surveyors took heed. National paranoia was focused. “September 12th experts” appeared. Equipment showed up.

Clearly some organizations took on the challenge of hospital and healthcare emergency management and have made the commitment to build truly robust, sustainable, “all-hazard” capabilities and capacity. Others have not, have done so minimally or under duress, or are under the impression that their organizations are prepared. Still others view emergency preparedness as a distraction or drain on resources with little return on investment.

On the surface, it makes sense that funding for hospital preparedness from the federal government should trickle down from HHS to state health departments to hospitals (sometimes via hospital associations or regional organizations). What became evident early on was that hospitals and public health are not wired the same way. Hospitals can be characterized as mission-driven and, at times, impulsive (i.e., earthlings). Public health is known for its collegial approach to problem solving and interpersonal skills honed for fellow scientists (i.e., Vulcans).

Both are meaningful disciplines that do good work but tend to approach life, projects, and processes differently. Here are two examples, the first paraphrased from one senior vice president of a major state hospital association:

When the program first started, we were summoned to the state public health department for a meeting. They lectured us for three hours. Then for six hours. The next time, they lectured us for eight hours. I stopped going.
Second, at the Defending Your Front Lines conference, a national event for hospital-based first responders in 2005 sponsored by OSHA and The Joint Commission, the only spontaneous applause from the audience was in response to a regional hospital association representative from Pennsylvania expressing his frustration in working with public health.

“It comes down to commitment on the part of the organization and community to develop, implement, sustain, and enhance a comprehensive and substantive emergency management program. It takes a commitment for the long view, not the next quarter or annual report.”
— Paul Penn

It is important to note that these circumstances are not the fault of any discipline. Public health was generally not a large player in the world of emergency management until October 2001 and has been chronically underfunded. At the local level, public health generally did not have a seat at the emergency management table, although nearly all emergencies have a public health aspect. The reasons are many. In general, public health itself (with the exception of components of epidemiology) was not comfortable in emergency management settings and ill at ease among fire, law, and EMS. Public health was even more uncomfortable having a command role for disease outbreaks as designated in some communities.

The massive challenges early in the program of ensuring that the millions of dollars ended up in the right place were exacerbated by the staffing of public health throughout the spectrum. Already strapped, many of those public health personnel assigned to manage the programs had no experience in emergency management or working directly with hospitals. The disconnect was evidenced by the large number of public health workers who found themselves transferred to the Hospital Preparedness Program (including those from the Public Health Service) because funding at HIV/AIDS programs was diminishing at the same time that emergency preparedness was gearing up. State hospital coordinators would reflect with amusement and frustration on the revolving door of project managers coming in from DC that required primers on hospitals and emergency management.

It is significant to look back on the relationship between public health and hospitals prior to 2001. In the mind’s eye of the public, there is little distinction between the two. In practice, the linkages between hospitals and public health were primarily via the infection control practitioner and some licensing requirements. Otherwise, the two entities coexisted in their separate worlds.

2014 BHS index

Emergency management
Drill checklist. Sept., p. 5.
Guest column: Continuity of operations planning. Sept., p. 11.
Guest column: How to develop and use your facility’s hazard vulnerability assessment. Dec., p. 11.
Training put into action. March, p. 6.

Facility maintenance/safety
Florida health system takes a comprehensive approach to visitor management. June insert.
Indiana hospitals create police departments following recent legislation. July insert.
Preparing for a power outage. Feb., p. 8.
Spaulding Hospital’s winning new design.
   Nov., p. 7.

Healthcare hazards
Drug epidemics in the ER. Sept., p. 8.
Errors lead to change in San Francisco. April, p. 11.
Failing grades for emergency care. April, p. 8.
How to get rid of 600,000 alarms a week. March, p. 1.
Suicide incident in Houston VA Medical Center highlights national concerns. Jan. insert.

Hospital violence
Brigham and Women’s Hospital creates active shooter video for site-specific training. March insert.
Data on weapons discharges in hospitals helps put shooting incidents in perspective. April insert.
ER violence. May, p. 7.
Safety tips from Minnesota. April, p. 6.

Infection control
Keeping the laundry safe. Sept., p. 7.

Joint Commission/CMS/OSHA
OSHA unveils new worker safety tools. April, p. 1.

Security
Arming the ER: One expert’s view. Oct., p. 11.
Assessing hospital liability when it comes to security breaches. May insert.
Book excerpt: Proper security training is a must for ED staff. Dec., p. 8.
Crossing the line: What to do when community crime leaks onto the hospital campus. Dec. insert.
Designing your security plan. May, p. 10.

Expert Q&A: One hospital’s case for arming security officers. May insert.
Lessons learned from San Francisco. Jan., p. 6.
Q&A: Infant abductions. June, p. 11.
UCSF Medical Center releases independent security recommendations for SF General. June insert.
Weapons in the ER. Oct., p. 9.

Weather events/natural disasters
California hospitals struggle their way to earthquake compliance. Jan., p. 1.
Keeping the floodwaters out. Aug., p. 4.

Worker safety
The battle for worker safety. Aug., p. 11.
Developing a culture of safety. Nov., p. 11.
Worker fatigue. Sept., p. 10.

Miscellaneous
ACEP poll underscores safety and security concerns with psychiatric patients. Aug. insert.
Code calls. May, p. 4.
A day in the life of a safety officer. June, p. 4.
How this year will affect next year’s safety. Dec., p. 1.
Putting the IRCA to good use. March, p. 10.
Washington Supreme Court ruling bars psychiatric boarding. Nov. insert.
What keeps the safety folks awake? July, p. 5.
Identify, Isolate, Inform: Emergency Department Evaluation and Management of Patients with Possible Ebola Virus Disease

1. Identify exposure history:
   - Has patient lived in or traveled to a country with widespread Ebola transmission or had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days?
     - NO: Continue with usual triage and assessment
     - YES: Identify signs and symptoms:

2. Identify signs and symptoms:
   - Fever (subjective or >100.4°F or 38.0°C) or Ebola-compatible symptoms: headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage
     - NO: Continue with usual triage and assessment
     - YES: Isolate and determine personal protective equipment (PPE) needed

3. Isolate and determine personal protective equipment (PPE) needed:
   - Place patient in private room or separate enclosed area with private bathroom or covered, bedside commode. Only essential personnel with designated roles should evaluate patient and provide care to minimize transmission risk. The use of PPE should be determined based on the patient’s clinical status:
     - Is the patient exhibiting obvious bleeding, vomiting, copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (e.g., intubation, suctioning, active resuscitation)?
       - NO: For clinically stable patients, healthcare worker should at a minimum wear:
         - Face shield & surgical face mask
         - Impermeable gown
         - 2 pairs of gloves
         - If patient’s condition changes, reevaluate PPE
       - YES: Use PPE designated for the care of hospitalized patients
         - http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html
         - If the patient requires active resuscitation, this should be done in a pre-designated area using pre-designated equipment.

4. Inform
   - A. IMMEDIATELY notify the hospital infection control program and other appropriate staff
   - B. IMMEDIATELY report to the health department

5. Further evaluation and management
   - A. Complete history and physical examination; decision to test for Ebola should be made in consultation with relevant health department
   - B. Perform routine interventions (e.g., placement of peripheral IV, phlebotomy for diagnosis) as indicated by clinical status
   - C. Evaluate patient with dedicated equipment (e.g., stethoscope)

Source: CDC.
Healthcare facility preparedness checklist for Ebola virus disease (EVD)

All U.S. healthcare facilities need to be prepared for managing patients with infectious diseases such as Ebola virus disease (EVD). Facilities should review infection control policies and procedures and incorporate plans for administrative, environmental, and communication measures. Facilities should also define the individual work practices that will be required to detect the introduction of a patient with EVD or other emerging infectious disease, prevent spread, and manage the impact on patients, the facility, and staff.

The following checklist highlights some key areas for healthcare facilities to review in preparation for a person with EVD arriving for medical care. The checklist format is not intended to set forth mandatory requirements or establish national standards. In this checklist, healthcare personnel (HCP) refers to all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP include, but are not limited to, physicians, nurses, nursing assistants, therapists, technicians, laboratory personnel, autopsy personnel, students and trainees, contractual personnel, and persons not directly involved in patient care (e.g., housekeeping, laundry, volunteers).

- Monitor the situation at CDC’s EVD website: www.cdc.gov/vhf/ebola/index.html.
- Assess and ensure availability of appropriate personal protective equipment (PPE) and other infection control supplies (e.g., hand hygiene supplies) to all HCP.
- Review facility infection control policies for consistency with the Centers for Disease Control and Prevention’s Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected EVD in U.S. Hospitals (www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html).
- Review environmental cleaning procedures and provide education/refresher training for cleaning staff (www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html).
- Begin education and refresher training for HCP on EVD signs and symptoms, diagnosis, how to obtain specimens for testing, appropriate PPE use (including putting on and taking off PPE), triage procedures (including patient placement), HCP sick leave policies, how and to whom EVD cases should be reported, and procedures to take following unprotected exposures (i.e., not wearing recommended PPE) to suspected EVD patients at the facility.
- Review triage procedures and ensure relevant questions (e.g., exposure to case, travel within 21 days from affected country) are asked during the triage process for patients arriving with compatible illnesses (www.cdc.gov/vhf/ebola/hcp/case-definition.html).
- Ensure laboratories review procedures for appropriate specimen collection, transport, and testing of specimens from patients who are suspected to be infected with Ebola virus (www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html).
- Review policies and procedures for screening and work restrictions for exposed or ill HCP, and ensure that HCP have ready access to medical consultation, including via telephone.
- Designate points of contact within the facility responsible for communicating with public health officials and providing internal updates for HCP and volunteers.
- Confirm the local or state health department contacts for reporting EVD cases. EVD is a nationally notifiable disease and must be reported to local, state, and federal public health authorities.

Source: CDC.
Identifying security’s role in managing a potential Ebola patient

Officers are crucial for screening potentially infected patients, controlling access to the hospital, and managing possible quarantines

Ever since September 25, 2014, when the first Ebola patient in the United States arrived at Texas Health Presbyterian Hospital in Dallas, government officials, public health experts, and health systems around the country have shifted their focus toward preventing a potential epidemic and ensuring healthcare workers are prepared to care for an infected patient.

Much of this focus has naturally revolved around the most pressing issues, namely, how to properly isolate patients, protect healthcare workers, and prevent the spread of the illness to other patients. Although clinicians, infection preventionists, and occupational health experts have been at the center of this health scare, some say hospital security departments have been an afterthought, despite the fact that security officers play an integral role when it comes to access control and patient screening.

“I don’t think security has a gotten as big a role as it should have,” says Caroline Hamilton, CHS-III, risk expert and president of Risk and Security, LLC, in West Palm Beach, Florida. “I have a feeling this has sort of been taken over by the bureaucracy. It’s gone into this other realm where functional, practical things aren’t happening.”

Security officers frequently serve as de facto utility staff. During any point during a typical day, officers may undertake an array of job duties in addition to traditional security responsibilities.

“It’s kind of like a MacGyver role, so to speak,” says Christopher Sonne, CHEC, assistant director of healthcare emergency management at HSS, Inc., in Denver. “It’s not just physical security; there is a whole lot that falls underneath that umbrella.”

In many cases, security officers may be the first member of the hospital staff to come in contact with a person with symptoms of Ebola; they may also be involved with initially screening patients and visitors as they arrive at the ED. For that reason, hospitals need to develop a plan in conjunction with the security department so officers know how to identify patients potentially infected with Ebola and direct them to the appropriate clinical staff and into isolation, while protecting themselves from transmission. However, because this illness is so closely tied to infection control, security officers are frequently left in the dark.

“In my opinion, security is very heavily involved in the planning for the controlled access screening plan for this kind of situation, and should be involved from the very beginning with infection control, emergency management, and senior leadership,” says Thomas A. Smith, CHPA, CPP, president of Healthcare Security Consultants, Inc., in Chapel Hill, North Carolina.
Although Ebola has been present in relatively few hospitals, the criticism levied against Texas Health Presbyterian Hospital has made it clear that hospitals need to begin planning for this event now, and those plans need to include the hospital security department.

**Developing a plan**

Following the isolated cases of Ebola in the United States, the government identified five international airports as the only means to enter the country from affected countries in West Africa. The federal government also identified hospitals across the country that would be designated to handle the care of an Ebola patient. Although these facilities would be specifically equipped for the presence of Ebola patients, the reality is that a symptomatic patient could walk into any hospital ED or clinic at any time, Sonne says.

“It’s not just for those hospitals in the five primary cities where patients are coming into, it can happen anywhere and it can happen anytime, which is why we push for a good all-hazards approach for this,” he says. “I doubt Texas Presbyterian thought they were going to be on the front line of Ebola. That kind of behooves and strengthens the fact that we need to be prepared because we don’t know when or where the next Ebola patient is going to present.”

But not enough hospitals have a cohesive plan in place to effectively manage this situation, Hamilton says.

“I’d want to have some kind of screening program in place and have a plan so as soon as you know someone is presenting you can put your plan in place,” Hamilton says. “I think that’s the first thing that is missing is people don’t have a plan.”

A multidisciplinary approach is crucial to developing a plan that will be effectively carried out across all units of a health system, Sonne adds.

“Specifically, security should have a role in identifying patients that are exhibiting symptoms of Ebola. Hospitals should be using signage in the parking garages and entrances that instruct patients to alert a staff member if they have been to countries in West Africa, had contact with a person infected with Ebola, and are exhibiting any of the symptoms associated with Ebola.

Depending on the structure of the hospital, security officers may be the first person to come in contact with an Ebola patient. Officers should be trained to gather information about recent travel and symptoms and then appropriately direct those potentially ill patients to the right clinicians.

“Now that we’ve identified someone, what are we going to do with them?” Hamilton says. “We need to have the isolation areas set up before the first person comes in, even if it’s not an isolation area that’s going to be the long-term treatment area.”

Some hospitals may elect to direct patients toward one or two entry points in the hospital to control patient flow and improve the efficacy of the screening process. The security director should be intimately involved in that controlled access plan and designing the most effective pathway for patients presenting to the ED. Additionally, the hospital may elect to go into a full or partial lockdown if an Ebola case is confirmed.
Security officers also need to receive training from infection control staff members on the proper PPE that is required when coming in contact with an Ebola patient, how the illness is transmitted, and the protocols for preventing transmission.

Smith adds that there is no cookie-cutter plan for this scenario since layout, geographical location, and emergency response plans will vary from hospital to hospital.

“Everyone should be familiar with the incident command, and this is most definitely a case where the incident command system would work very well,” Smith says. “It’s hard to do a cookie-cutter plan because everyone’s organization is a little bit different, but the bottom line is you really need to be using these basic tenets of controlling access.”

Three levels of access control

Hospitals can boil down access control for potential Ebola patients into a three-tiered system, Smith says:

- **Level 1:** Appropriate signage in the parking areas and entrances of the hospital. Information should be sent out to physician offices and clinics to make them aware of certain symptoms (e.g., high fever, vomiting, and diarrhea). In some cases, patients may be given a questionnaire over the phone when scheduling appointments with a physician’s office or clinic.

  “It’s basically a passive screening system,” Smith says. “There isn’t someone out there taking your temperature, you are just relying on them to read the signs and self-report.”

- **Level 2:** Restricting access to a few entrances. At this level, the hospital would still rely on employees to self-report, but may be doing slightly more active surveillance for patients and visitors. This may include screening patients and visitors at the door by simply asking them questions as they arrive. Hospitals may jump to this level if there is a confirmed Ebola patient in their county or state.

- **Level 3:** Controlling access to a limited number of doors and actively screening employees, patients, and visitors. This, Smith says, is “a huge, huge task.” Hospitals would escalate to level three if there is an Ebola patient in the facility and it’s necessary to prevent the spread of transmission by actively controlling access in and out of the building.

“Normally security people are the first folks that are seen by the patients and visitors; they are asking the questions,” Smith says. “It’s definitely security, valet parking if you have it, and people at the information desks that are at the front line.”

It’s important to be able to quickly and safely execute this plan to avoid transmitting the disease to other frontline employees, or to patients and visitors within the facility.

“Any time there is a threat to the well-being of those in the facility, it behooves security to develop that situational awareness and control access to the facility,” Sonne says. “I’m not saying they are going to restrict people, but just manage the way in which they enter, so if they are symptomatic and need to be isolated right away, we have the ability to do so.”

Hamilton adds that valets are a particularly important and often forgotten consideration, but they are the very first people to come in contact with patients and visitors. Valets and security may work hand in hand in getting potentially infected patients to the appropriately designated area of the hospital.

“If the valet opens the door of the car and the patient throws up all over everything, you need to call someone,” Hamilton says. “You’re not going to call a nurse, you’ll probably call security.”

Managing a quarantine

Already, issues have emerged regarding the quarantine of potentially infected Ebola patients. In late October, controversy erupted in New Jersey when the state opted to quarantine Kaci Hickox, a nurse returning from an assignment with Doctors Without Borders in Sierra Leone. Hickox was quarantined in an isolation tent at University Hospital in Newark despite testing negative in a preliminary test for Ebola. Hickox published a first-person article in the *Dallas Morning News* days later, criticizing her treatment at the airport and at the hospital.

Initially, the hospital indicated Hickox would be quarantined for 21 days, but released her from the hospital three days after she was symptom-free for 24 hours. Hickox hired a civil rights attorney and planned to sue for her release. Upon returning to her home in Maine, the state initially said she must comply with a 21-day quarantine in her house, a protocol she
publically rebuffed. A judge later lifted the mandatory quarantine and Hickox reached a settlement deal with the state of Maine, allowing her to travel freely in public and self-monitor her health.

The incident has raised a number of concerns about mandatory quarantines, all of which could impact hospital security in some way, Smith says. Although the authority for implementing a quarantine falls to the local health department, enforcement could rest on hospital security and/or local police.

“The reality is, the sheriff’s department has very limited resources and they will have to work hand in hand with local police, whether that’s city police or municipal police agency, or local security forces of each healthcare system,” Smith says.

He adds that hospitals should begin thinking about these issues now and connect with local health agencies and police departments to begin planning the management of potential quarantines.

“Sometimes I find people don’t even talk until there is an emergency,” he says. “That’s not the time to be building relationships. The time to build good relationships and communication with local law enforcement is when you don’t have something like this staring you in the face.”

Drawing from SARS and H1N1

Although the panic surrounding an Ebola epidemic has reached a fever pitch, this is not the first time the U.S. healthcare system has faced off against a potentially deadly infection.

During the spring of 2003, a global SARS outbreak that originated in Hong Kong and spread to Toronto put U.S. hospitals on high alert. In 2009, the H1N1 flu pandemic swept through the U.S., with particularly severe outbreaks in Texas, New York, Utah, and California.

“[This is] very similar to SARS, and I think the lessons learned from SARS could be used to help people today,” Smith says.

In November 2003, following the SARS outbreak, the Institute for Bioethics, Health Policy and Law at the University of Louisville School of Medicine published a report to the CDC entitled Quarantine and Isolation: Lessons Learned From SARS. Among the many lessons learned, the authors pointed out that “to implement successful programs of quarantine and isolation, affected countries needed ancillary services and logistical support, including law enforcement and other measures to ensure compliance.”

Sonne says it can be frustrating as an emergency management professional to see how quickly these epidemics are forgotten and discarded, along with the lessons learned. During those outbreaks, Smith adds, security officers played an important role in directing patients to the appropriate part of the hospital, and conducting passive screening by asking pointed questions and recognizing the potential signs and symptoms of the disease.

“It’s hard to look forward without looking back,” Smith says. “SARS, in my mind, that experience and the lessons learned from that are critical to being successful now with Ebola. If we don’t pay attention to those lessons learned for SARS, it’s hard to move forward and make sure we’re as successful as we can be with an Ebola outbreak.”

Webcast: Preparing for Ebola

On November 17, 2014, HCPro hosted a webinar addressing some of the most pressing issues surrounding Ebola preparation. Hosts Marge McFarlane, PhD, MT (ASCP), CHSP, CHFM, HEM, MEP, CHEP, principal of Superior Performance, LLC, in Eau Claire, Wisconsin, and Thomas A. Smith, CHPA, CPP, president of Healthcare Security Consultants, Inc., in Chapel Hill, North Carolina, cleared up misconceptions surrounding the Ebola outbreak and outlined an effective response plan that addresses security control issues, access control, staff training, communications, and support for a variety of frontline staff that may encounter an Ebola patient.

Listeners walked away with an understanding of PPE and isolation requirements along with the tools needed to maintain a safe and secure hospital environment while effectively triaging patients.

Visit http://hcmarketplace.com/ebola-how-to-prepare-your-facility to order this webcast on demand.