Summary of Lessons Learned in Planning and Conducting a Full Scale Exercise on Violent Threats

I. Planning and Coordinating the Exercise
   a. Exercise partners: multiagency coalition inclusive of Law Enforcement, Fire, EMS, Dispatch, Multi-Jurisdictional, community health care partners, local EMS, CDPH, and California Emergency Medical Services Authority (EMSA)
   b. Objectives and goals of exercise
      i. All agencies agreed to set agency specific objectives, with coordinated overarching goals
      ii. All agencies agreed on date and timeline
      iii. Exercise goals
         1. A map and plan for location, coordination and collaboration with Police/Fire/EMS Agency Command Centers
         2. A map and plan for Hospital Command Center
         3. Establish effective work environment with multiple agencies under one incident command structure
         4. Establish hospital liaison within Unified Command structure
         5. Connect hospital liaison with Hospital Command Center information effectively
         6. Identify leadership roles and capability in clinical areas during event
         7. Identify leadership roles and capability from command center during event
         8. Monitor communications capability
         9. Monitor patient and staff safety (especially during evacuation) and reaction/response to stress with active shooter
         10. Monitor evacuation triggers, leadership roles, authority of hospital and Law Enforcement, staff capability, Law Enforcement capability and restrictions placed on hospital staff
         11. Monitor response to codes for violent person, unarmed and armed, code triage, evacuation
   c. Hospital Coordination
      i. 150 Volunteers
         1. Patients consisted of managers, directors and above (all areas of organization)
      ii. Department staff roles
         1. Emergency Department staff
         2. ICU/Medical Surgical staff
      iii. Event Safety Officer Team
      iv. Senior Leader escorts for VIP observers, evaluators and controllers
      v. Senior Leader evaluators: Directors of ERs, ICUs, Medical Surgical Units, Urgent Care, Chief of ER, Chief of Clinics, Chief of Trauma
      vi. Vest Colors: indicate patients, staff, controllers, evaluators and observer
vii. **Critical for Law Enforcement — who was in play and out play — and safety from event perspective**

d. All hospital participants were pre-screened for history of stress-related issues with this type of scenario  

e. Employee Assistance (psychologists) available during and after the event to provide counseling for all participants if requested  

II. **Artificialities in Exercise Become Real Issues**

a. The location of the alternate care site and the Unified Command post in the hospital parking lot was based on exercise restrictions — do you have a large area that could support command vehicles and agency trucks within close proximity? Can you also isolate media vehicles?  

b. Setup tents the day before (usually takes one hour); where would you place patients for a holding area with a rapid evacuation response?  

c. Medical Response Team: setup and available — would usually take at least one hour for team to deploy to a local site. Who would be available immediately?  

III. **Unified Command**

a. The Unified Command was physically located in parking lot of hospital due to restrictions of exercise  

b. You should plan for staging of multi-agency response with large command vehicles for this type of event within a half-mile radius  

c. HICS: two hospital Liaison Officers were embedded into the Unified Command center — one available to rove if needed leaving one always available in the center  

d. The hospital Liaison Officer represented the Hospital Incident Commander who made decisions in collaborations with Law Enforcement when required — majority of the communications were handled by phone  

e. The Liaison Officer offered key information regarding facilities information (gases, utilities), human resources, information technology, phone systems, lockdown capabilities, floor plans and roof access  

f. EMS/Fire objectives

i. Coordinated management of all unified communications for transportation and dispatch communications through county Fire/EMS dispatch  

ii. Dispatch communications included scripted call to 911 to initiate Law Enforcement/EMS/Fire response  

iii. Managed event coordination of radio frequencies  

iv. Track triage, EMS stabilization and transport time of all event victims  

v. Monitor radio communications for multi-agency response  

g. **Law Enforcement objectives**

i. Deploy Contact Teams, SWAT agencies  

ii. Position Unified Command  

iii. Conduct entry into ER
iv. Clear ER of any potential threats/suspects
v. Provide security for second floor evacuations of victims, staff and patients to triage area
vi. Negotiate surrender of suspect and rescue of hostage

IV. Law Enforcement Information Request
a. Required information for planning, requested through Unified Command
   i. Internal phone capability with phone numbers
   ii. Use of a similar room layout
   iii. Video film availability
   iv. Use of roof access for adjoining and perimeter buildings
   v. Ice Box contents: master keys, facility blue prints, facility radio
   vi. Access management type: manual vs. electronic system — card readers, master keys?
   vii. Facility, utility plans that include location of medical gases and capability for shutoff

V. Staff Response
a. Emergency Department
   i. Staff immediately responded to gunshot wound victims to provide treatment with no obvious regard to personal safety — assumed someone was managing security
   ii. Leadership evolution: ER physician took control of collecting the ER assessment of patients, Charge Nurse and other other nurse assisted in directing the clinical team to move patients
   iii. EMS triage: paramedic took lead with triage of gunshot wound victims in department
   iv. Began moving acute patients onto gurneys moving stable patients out of rooms
   v. Staff moved patients into safe spaces in back areas of the department
   vi. Primary objective: assess status of critical patients
   vii. Initially began evacuating ambulatory patients outside until “someone” identified it “unsafe” and called a “lockdown” until police arrival
   viii. Staff not aware of who called for lockdown — this is policy in the organization
b. Emergency Department staff assumptions
   i. Staff safety: assumed security was barricading and observing for shooter
   ii. Staff did not stop to gather and plan team approach with other pods in department — assumed someone was doing this
   iii. Staff did not delegate someone to communicate outside of ER other than to page a code — thought someone was doing this
   iv. Evolution of leadership roles: leadership was not initially clearly defined
   v. Definitions of lockdown assumed no one in or out — term not clearly defined. Policy states “lock down the unit,” but does this allow staff to leave if safe?
   vi. Staff indicated 911 called — staff assumed that meant police but call was made for ambulance support
c. Medical Surgical Unit
   i. Staff responded to codes paged overhead, closing all doors on floors but unaware of active shooter event or location progression
   ii. On suspect arrival to floor, staff sheltered in place: all staff took shelter in patient rooms, under desks and in bathrooms
   iii. Staff seen attempting to make calls from under desks and in closets to security and house supervisor for help
   iv. There were no sounds coming from the floor other than patient room alarm
   v. Gunshot wound victims calling for help, hostage and suspect yelling in background — staff did not respond and treat victims
   vi. Staff indicated they felt unsafe with shooter nearby
   vii. Another common response was the inability to treat without appropriate supplies or skillset
   viii. Victims were in line of fire
   ix. Obvious difference: shooter known to be on floor with hostage
   x. Common response: unsafe environment — needed to wait for police protection
   xi. Stark difference from Emergency Department Response
   xii. Once force protection arrived, Law Enforcement directed safe to move — staff elected without direction to evacuate entire floor
   xiii. Law Enforcement approved and assisted with evacuation of patients and escorted staff outside of building to holding area
   xiv. The planned evacuation written in the exercise was for a bomb threat, which staff would be alerted and ordered to evacuate
   xv. Staff indicated in evaluation they felt the security risk so high they elected to evacuate all patients immediately in a rapid fashion
   xvi. Evacuation was complete in 40 minutes upon arrival of force protection
   xvii. 60-bed unit, all beds occupied with patients; Evacush, Stair Chairs and wheelchairs were used to evacuate all patients

VI. Response Consideration
   a. Based on the different responses in the Emergency Department and the Medical Surgical Unit, should we consider a department-specific educational approach?
   b. Should we focus our educational efforts on department culture rather than a one-type-fits-all program?
   c. Should there be specific focus on the initial 10-minute survival plan before help arrives?

VII. Incident Alert and Notification:
   a. Use plain language: visitors unaware of what to do and what was happening
   b. Staff must have script with instructions on what to say
   c. Must give updates on current status and location of suspect if possible
   d. Who is responsible to let a central contact know any updated information on location or status of situation?
i. Should anyone that is in a safe situation inform or make other aware?
ii. In this event, clinical staff were too busy to call after shooter left the area
iii. What is security staff’s role?

 e. Example of best practice message used by health care organizations:
   i. Page Overhead Announcement in plain language (public address system), avoiding
      codes or jargon that only staff understand
      1. Dangerous event in specific location
      2. Please move away if not take shelter
      3. Take immediate steps to protect self and patient
      4. Give description of suspect if available

VIII. Team Communications
a. The ER team began to plan for full evacuation when Force Protection arrived
b. Nursing and MD leaders collaborated on assessment and evacuation plans
c. Physician planned and directed department physicians by requesting status assessment of all
   patients
d. Electronic medical records, bed tracking system not used
e. Leaders elected to use paper during the initial first 20 minutes
f. Staff indicated they did not have the time or the ability to communicate to or receive updates
   from Hospital Command Center
g. In the debrief, leaders were encouraged to stop and delegate tasks, identifying this as a critical
   element to survival within the first 15 minutes of the event prior to force protection arrival
h. Staff was not aware of current status of active shooter — they indicated their focus was to
   treat the critically injured and evacuate
i. Once the shooter left the area, security risk was not a priority
j. The common theme in the survey was the assumption that someone else was covering
   security of the department

IX. Patient communications
a. Staff felt uncomfortable and hesitant to be transparent with patients on the situation
b. Even though most patients saw the event, staff did not feel comfortable in discussing the
   event and only comforted the patients
c. This was an unexpected area of need identified — staff have identified a need to script
   messaging

X. Staff Response to Law Enforcement Arrival
a. First Law Enforcement team “came in quiet” and did not identify themselves
b. The first diamond team arrived with mission to find and stop the aggressor; they moved
   directly through the department after given direction of where the shooter went
c. Second diamond team flashed a badge and whistle but also came in quiet, silently moving
   through the emergency department to assess all spaces, movement and people
d. Primary mission of second diamond team was to clear and control the ER — secondary
   mission to provide protection detail for ER evacuation
e. Law Enforcement was not loud or chaotic
f. Staff expressed stress with having guns drawn and pointed at them
g. Law Enforcement instructions to ED staff for staff protection only did not direct instructions regarding patients or treatment

XI. **Evacuation under Force Protection**
   a. Legal considerations
      i. The Emergency Department is no longer an emergency receiving facility when an event occurs: internal disaster is initiated
      ii. The hospital becomes the incident: a crime scene and a closed receiving facility
      iii. Consider what notifications should occur in your community — county EMS, Licensing, Fire/EMS
      iv. Who is in charge at this point? Command and Control is taking place outside in Unified Command and Hospital Command Center
      v. Inside the hospital, Law Enforcement is communicating with the Unified Commander — initially the ER clinical leadership was not taking direction from Hospital Command Center
   b. Evacuating the ED under forced protection
      i. ED evacuated under forced protection and direction of Law Enforcement
      ii. No discussion by ED staff on where to evacuate — Law Enforcement directed staff to evacuate to department parking lot and EMS triage area
      iii. EMS triage set up for transport of gunshot wound victims from the event — EMS transport not directed to transport evacuation of hospital patients
      iv. A planned holding area for evacuated patients located behind hospital — Law Enforcement diamond teams not aware of plan
      v. Separate holding area, transfer, staging and transportation coordination required for evacuated hospital patients, including emergency department patients
      vi. Coordination of evacuation required County DOC support and management for transfer of evacuated patients to community hospitals

XII. **Multi Casualty Event EMS Triage**
   a. Triage mats created excellent organization and structure, but kept blowing in the wind before victims were placed — consider sandbags
   b. Make sure you separate “victims” from “evacuated patients” at the triage and alternate care area
      i. Only relevant in a hospital/clinical setting where both populations will exist
      ii. Any other venue will only produce “victims”
   c. Keeping an accurate count of victims and their locations, especially once hospital staff and Law Enforcement began removing victims, was a challenge
   d. Triage tag Just In Time training was excellent — nurses are trained but seldom use tags, require refresher information. Use a Sharpie Pen... Pens do not work!
e. Make sure that the victim evacuation location and the patient evacuation location are known to decrease confusion — could this have been accomplished with someone delegated to give this information at the door? Unified Command and Hospital Command Center information
f. If personnel are added to any component (EMT from ER added to treatment area) make sure they are accounted for
g. Make sure to triage patients using START triage algorithm and not the mechanism of injury
h. In an MCI scenario, a gunshot wound to the chest may be a “delayed” patient, whereas an everyday gunshot wound would be treated as an immediate
   i. It all comes down to resource availability and patient acuity
   ii. Remember that patients should be continually monitored once in the treatment/transport area and can be re-triaged to a higher or lower level if necessary
   iii. Continuity of Care is critical for all involved.

XIII. Evacuation to the Alternate Care Site
a. Tracking staff is as critical as tracking patients — we underestimated the need to track staff
   i. Required 2-3 people to register staff as they came down with patients
   ii. Tracked staff for safety purposes, accountability, ability to redirect physicians and staff to treatment areas or continued evacuation
b. Patient tracking/medical records: with rapid evacuation what is your capability to obtain records? Paper tracking and documentation until electronic system available?
c. Patient transfer: consult with physicians, Law Enforcement, Unified Command and ask the question: how long will the units remain closed? Can a certain area of the hospital open vs. remain a crime scene? Can the existing hospital manage inpatient needs? What is the Licensing Department’s response? All this becomes a coordinated effort — the primary goal is to keep patients safe without transport if possible
d. Staff who are assigned to patients in the hospital should make every effort to every stay with the patients in their evacuated location and continue care — best practice for continuity of care
e. Some staff will have to reenter the hospital to assist with existing in-house patients, but reentry back into the building must to be under Law Enforcement escort, coordination and protection
   i. This is coordinated through the Hospital Command Center and Unified Command for approval
f. All movement in and out of the hospital is under escort of Law Enforcement
g. Patients moved outside of the hospital environment into an austere environment while waiting for transfer to another facility create a high risk
h. After the patients are evacuated to the alternate care site, what support is needed?
   i. Power, environmental protection, supplies and equipment must be considered

XIV. Our Mission as Teachers is to Maximize Survival
a. Understand the different personalities and the unique cultures within the health care environment
b. Understand that the initial reaction and decision each person makes under duress is based on instinctual response to the life threatening situation

c. Ensure the critical choices staff makes are the right choices to maximize survival — we must teach to that

XV. Studies Show Most Cases, Shooters use a Firearm and Have no Pattern or Method for Selection of Their Victims

a. CHA policy recognizes the average of 10–15 minutes for a Code Silver event

b. Contact/diamond teams arrive in 10 minutes on average

c. Thus, should our teaching plan be “10 Minutes to Survival,” which for various groups implies Run, Hide or Fight?

d. Our staff have told us they need education to help them decide what to do within that first 10 minutes

XVI. An “Ah Ha” Moment

a. In our drill, we witnessed different personality types responded differently to scenarios

b. Response difference based on personality, training and culture (ER culture vs. Medical Surgical Culture)

c. Response difference based on department environment with glass rooms, areas to hide, evacuation capability, location within the building

XVII. Our Final Conclusion

a. Different personalities may require different teaching methods based on response reactions

b. “Policy vs. Instinct” research shows a real difference in the reaction of people that have been trained to face life threatening situations and those who have not

c. Those who are trained:
   i. Develop a survival mindset
   ii. Commit to action based on the survival mindset — they will identify options, make a choice and act
   iii. Have a mental plan rehearsed in their mind on what they would do in this type of event

d. A rehearsed plan includes:
   i. Exit paths you might take
   ii. Actions that will reduce the amount of time needed to make a decision on what to do
Ten Minutes to Survival

Can we save lives by teaching simple a basic response for the first 10 minutes until help arrives?

I. 5 simple things to remember — analyze risk (situational awareness) before you react:
   1. Is it Safe? Look around, listen: what is being said, what is your rehearsed plan?
   2. Can I Protect Myself: what are the immediate steps to protect self and if possible the patient?
   3. I Must Alert Security, Warn others: call for help when safe and ask who is guarding the unit?
   4. Communicate with the Team: make a plan — never assume
   5. Make a Decision to Act

II. What choices do I make?
   1. Should I Run
      a. Run where: is the escape exit clear?
      b. Leave belongings behind
      c. Remain calm
      d. Move outside and look for cover
   2. Should I Hide
      a. Shelter and await anticipated help knowing 10 minutes may be needed
      b. Guide others to shelter if you can
      c. Maintain situational awareness — looking, listening to overhead communications, any sounds indicating shooter location
      d. Lock and block door, turn off lights, close blinds and curtains
      e. Instruct others to not make noise, silence all devices
      f. Instruct everyone to stay out of view
      g. Do not open door until notified by Law Enforcement or hospital leadership
      h. Communicate with team: did someone call for help? If in a safe location call for help, notify someone, update status, leave line open
      i. Who is observing or guarding unit?
   3. Should I Fight
      a. A last resort when your life is at risk and there are no other alternatives

In a Perfect World

In our Hospitals
Everyone is responsible for
Security, Communications
Situational Awareness & Risk Evaluation

Our exercise staff had a common theme to the question: Why did you respond the way you did?

I thought I would run away, but found myself compelled to help my coworkers.
I could not leave my friends behind.