Lessons Learned: Enhancing Security in a Critical Access Hospital

YORK GENERAL HOSPITAL
YORK, NE

YORK GENERAL

Process of Identifying Need

- Incident that occurred on December 10, 2016
- Incident involved a man with a knife
- Man was subsequently shot by law enforcement near the Nurse Station
- The man died as a result of the gun shot

Process Improvement Methods

During:

- Safety of other patients, visitors, and staff was ensured
- Law enforcement was contacted immediately
- Attempted to diffuse the situation
- Notification of the Administrator on call of a situation occurring

Immediately following and up to three hours after:

- Staff documented events
- Patients moved from the hallway in which the scene had been secured so care could be continued
- All staff and patients accounted for
- Staff collaborated with law enforcement in their investigation
- Hospital went on ambulance diversion status
- Surrounding facilities notified of diversion status
- Local dispatch notified of diversion status
- Information systems staff came in to facilitate review and securing of video surveillance of event
- ED patients cared for and dismissed
- Cooperated with law enforcement in their investigation
- Asked staff to call their families to let them know they were okay, in case their families heard about the shooting
- Called in additional staff
- Documentation of staff names and contact numbers provided to Nebraska State Patrol
- Debriefing of all staff involved in situation

Process Improvement Methods

Post event (four to eight hours after)

- Planned and executed communication plan for oncoming staff
- Planned and executed communication plan for notification of medical staff
- Chairman of the Board of Directors and Sr. VP/DON called all Board of Directors to inform them of the event
- Deferred any media calls until appropriate statements were available
- Plant Operations staff removed the carpeting with the blood stain

Next day:

- Went off of ambulance diversion status at about 1000
- Deferred media calls until CEO was available
- Marketing developed a news release
- Media was contacted to inform them of a statement time
- CEO was interviewed for the media

Process Improvement Methods

Next working day:

- Notified Nebraska Department of Health and Human Services of the incident and filed a report
- Continued to cooperate with law enforcement in the investigation
- Planned additional debriefing session

Next weeks and months:

- Evaluation of contracted armed security guard companies
- Evaluation of the use of armed versus unarmed security guards
- Communication of status of security enhancements
- Placement of contracted armed security guards starting on March 1, 2017 for 12 hour night shifts, seven days a week
- Analysis and implementation of security recommendation enhancements from staff.
- Evaluation of building and campus security

Results

- Armed Security Guards
- Crisis Prevention Intervention Training
- Locking doors to limit access to buildings, yet allowing visitor, staff and patient access
- Enhanced lighting by employee entrance doors
- Installation of additional panic buttons
- Enhanced communication with local law enforcement

Results

- Replaced keypads and doors
- Evaluation of technology during construction
- Utilization of the security guards to escort staff to their vehicles
- Placement of additional security cameras
- Ability for security guards to observe all security cameras on monitors in ED
- Routine testing of panic buttons

Lessons Learned

- Evaluate how individuals gain entrance into the buildings on your campuses
- Incorporate technology into your security plan
- Be proactive in your approach to safety and security
- Listen to your staff- they are here 24/7 in all areas
- Develop strong relationships with law enforcement