

# **The Active Shooter in a Healthcare Facility**

## **A Template for Response Procedures**

*Developed by the DC Emergency Healthcare Coalition*

### **Introduction:**

This document has been developed by the DC Emergency Healthcare Coalition in conjunction with DC Metropolitan Police Department (MPD) as a planning guide for any Coalition member healthcare organization wishing to establish response plans for an 'active shooter' incident. An active shooter situation is defined as any individual with a firearm threatening harm or engaged in the process of causing harm in a facility or on a campus (see other definitions below).

An active shooter situation is considered a low probability yet potentially high consequence incident for any healthcare organization. Historically, employee-on-employee violence and incidents of individuals targeting specific patients have been reported in the region and nationally. In addition, recent law enforcement sources suggest that terrorism may also serve as a potential reason for an active shooter incident in a healthcare facility in the National Capital Region (NCR). Finally, it should be considered that many other types of organizations including schools and universities, have implemented and exercise on a regular basis an active shooter response plan due to this potentially universal threat.

Little formal research or experiential evidence is available upon which to base guidance for this type of incident, especially for healthcare facilities. When considering issues such as the healthcare facility's complicated layout, large staff numbers, and fragile, non-ambulatory patient populations, healthcare facilities are more complex than many other types of organizations that have published active shooter procedures. This document presents available guidance in a cogent fashion for consideration by healthcare facilities.<sup>1</sup>

This document is intended as guidance for healthcare facilities to consider in emergency preparedness. It is not intended to dictate to healthcare facilities what their plans should entail nor is it intended to replace internal organizational expertise. Rather, it describes concepts for facilities developing procedures or re-examining existing response plans. The first section of this document presents several

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<sup>1</sup> Much of the information in this guidance is adapted for healthcare situations from: Active Shooter How to Respond (October 2008). U.S. Department of Homeland Security, Washington DC.  
DC EHC Active Shooter Template Response Plan  
For Healthcare Organizations  
6-2014

preparedness considerations that the organization may wish to include when developing and implementing its plans. The second, lengthier section provides a template structure for documenting response procedures. Healthcare facilities may wish to develop response plans based on these concepts, but their actual guidance for personnel should be considerably shorter.

### **Preparing for the “Active Shooter Incident:”**

As with any potential hazard, it is recommended that the response procedures for an ‘Active Shooter Incident’ be developed within the context of a broader, all hazards emergency management program. This encompassing term means many things but most importantly:

- It means that “Active Shooter” response procedures should exist within a broader emergency management construct (e.g. as a incident specific annex to an Emergency Operations Plan or EOP)
- It therefore builds upon common procedures outlined in an organization’s Emergency Operations Plan (EOP)
- It dictates that any procedures developed must be accompanied by the requisite training to ensure effectiveness
- Some effort should be made to evaluate the procedures once implemented (e.g. are response actions as outlined in the plan adequate? Has training been effective?)

One of the best protections for an active shooter incident is to prevent one from ever occurring. This necessitates that every facility review its current day-to-day security procedures (e.g. secure access to facilities). In addition, healthcare organizations are encouraged to develop and implement a “Work Place Violence Prevention” program. As a part of that program, all employees should understand how to identify concerning or threatening behavior in a co-worker, family members, and visitors, and how to report these issues. Though these activities are not directly in the purview of most emergency management programs, they should receive attention from a facility’s administration.

DC Metropolitan Police have actively encouraged healthcare organizations to work with their Special Operations Division in the development of their response procedures. Law enforcement is a critical part of the response to one of these incidents. They have therefore requested that healthcare facilities make their floor plans available to them. Procedures for prospectively sharing plans have been developed by DCEHC in

conjunction with DC MPD and DC Fire and EMS (DC FEMS).<sup>2</sup> In addition, all healthcare facilities are encouraged to have a hard copy of their floor plans stored in a readily accessible site. If any incident were to occur in the facility necessitating public safety response, these plans should be prioritized for delivery to responding units. Pre-planning could also include a walk-through of the facility by law enforcement.

Additional preparedness actions are listed in the following section discussing response.

### **Responding to an “Active Shooter Incident:”**

The following material may be considered for inclusion in a healthcare facility’s response procedures. The headers used in the following material can be extrapolated to organize the actual response procedures (for example, in an annex to a facility’s EOP). The actual document for a facility should be much shorter as the following text discusses options and other preparedness issues for organizations to consider when documenting their plan. Finally, very succinct guidance should be provided to building occupants for response and training purposes. Examples of these can be found in the attachments. Attachment B, “Building Occupant Guidance for an Active Shooter Incident,” is an example of incident specific guidance that may sit with service units. Attachment C, “Briefing for Active Shooter Incidents,” is an example of material that could be utilized during training of facility staff.

The response procedures may be organized as follows:

#### Purpose:

The purpose of the response procedures should be clearly articulated and their relationship to the overarching emergency operations plan (EOP) elucidated. Though there are many potential violent incidents that can occur within a healthcare facility (e.g. violent patient, individual armed with knife, discovery of weapon on a patient), it is recommended that a facility develop and maintain an individual procedure for the “Active Shooter.” These potential incidents are so unique and can unfold rapidly requiring a response that is tailored to the specific situation. As an example, a facility may have a separate “code strong” or similar response procedures for the patient that is acting violent but appears unarmed.

The active shooter procedure is designed for response to an individual possessing a firearm that is threatening harm or is in the process of discharging their firearm harming

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<sup>2</sup> “DC EHC Sharing of Healthcare Facility Schematic Drawings with Public Safety Agencies Annex, February 2011” See Attachment A to this document.

individuals. This distinction must be made clear to employees during plan implementation.

Hospitals in particular, often utilize a color coded system to designate specific emergency types (e.g. Code Blue – resuscitation). Though this practice is common, it can complicate responses if individuals are not familiar with a particular color code designation (especially for active shooter which is predicted to be utilized infrequently). If a facility chooses to color code the active shooter procedures, it is critical that staff members are adequately educated in an on-going fashion as to the significance of the particular color associated with the active shooter. For example, a briefing on active shooter response procedures could be included in employee orientation and in yearly educational efforts. For organizations that utilize several color coded responses, it is a good practice for employees to have these defined on a wallet sized card that they can wear with their employee ID (and thus have constant access to). If a color code will be utilized, the Coalition would recommend using “Code Silver” for consistency.

#### Definitions:

It may be helpful to list specific definitions to assist individuals in interpreting the response procedures. Example definitions for inclusion in the documented response procedures include:

- Active shooter: An individual(s) possessing a firearm(s) who is present on the facility’s campus threatening harm or in the process of harming people.
- Firearm: A combustible weapon that fires a projectile(s). Examples include handguns, rifles, and shotguns.
- Cover: A location that provides some level of protection from shots being fired. Examples of cover include being behind brick or cement walls, behind automobiles, and behind heavy furniture.
- Concealment: A location that provides the ability to hide from view but it may or may not protect from projectiles fired in that direction. Examples of concealment are behind cubicle partitions, drawn room curtains, and bed linens pulled over body.
- Self-protective actions: Efforts of an individual to seek cover and concealment.
- Code XXX: Facilities may wish to list the color code assigned to the active shooter incident if one is designated. Code Silver is recommended for the coalition.

Facilities may wish to include in the list of definitions other 'code' designations for violent situations that are separate and distinct from the active shooter procedures (e.g. "Code Strong") in an effort to distinguish these situations from an active shooter incident.

### Assumptions:

Assumptions relevant to the active shooter incident should be listed. These help provide the context for the incident and put response procedures in perspective. Examples of assumptions that can be listed include:

- Various reasons are proposed for the active shooter scenario (e.g. terrorism, worker on worker violence, revenge/targeting of an individual such as a patient or co-worker)
- Active shooter incidents tend to unfold very rapidly and are usually over within 10-15 minutes (per the US Department of Homeland Security)
- In contrast, hostage situations may be quite prolonged and lead to lengthy stand-offs
- Initially, the active shooter situation typically carries great uncertainty over the exact location of the threat within the facility and its exact nature.
- Some active shooter incidents unfold in a stationary fashion while others can move rapidly and unpredictably throughout a facility.
- Rapid self-protective actions are emphasized initially with other actions to follow once the threat is better characterized.
- Intervention by DC Metropolitan Police Department (MPD) and potentially other law enforcement agencies will be required to end most potentially envisioned incidents.
- Rapid liaison with responding law enforcement agencies by healthcare facility personnel can expedite termination of the incident.
- Even without injury to staff, patients, and visitors, such incidents can be a significant source of tremendous stress and organizational actions will be necessary after the termination of such an incident.

### Concept of operations:

The Concept of Operations should encompass specific activities that must be addressed by organizational leaders across all phases of incident response as well as

guidance for building occupants. By dissecting the response in this fashion, substantive response actions can be elucidated and defined appropriately.

- Incident recognition:

It is expected that any active shooter situation will be first noted by a staff member or visitor/patient who notifies staff of the actual or perceived threat. The threat must be clearly defined as an individual with a firearm with intent to harm or in the process of harming individuals. As noted above, the active shooter response procedures are best distinguished from other types of violence in the work place due to some of the unique characteristics. Therefore, staff should receive preparedness training that indicates other types of violence are dealt with other response mechanisms (e.g. patient acting out, individual with knife on premises, etc.). Only the individual armed with a firearm should prompt use of these types of response procedures.

- Activation/initial notification:

The facility procedures should clearly designate the position(s) with the authority to activate an active shooter response. There are two main options with pros and cons associated with each.

1. One option is to permit the individual staff member, whoever they might be, identifying the threat to activate the response by calling a central location (i.e. page operator) or initiating the notification themselves. The announcement can then be immediately disseminated as an alert in the form of a code (e.g. see Attachment B). The advantage with this approach is that a more rapid response can be generated and individuals can initiate self-protective actions more quickly.
2. Another option might be for staff to notify a 24/7 position (e.g. security) who then holds the responsibility of verifying the threat and then activating a response. Though this option may prevent inappropriate activation of the active shooter procedures, it could potentially cause delay in notifications with resultant second guessing and potential media scrutiny.

Regardless of approach, the methodology should be well articulated to staff.

In addition, the methodology for notifications internal and external to the organization should be outlined. Initial notification internally should provide clear warning that an active shooter incident is in process. For example, larger facilities may utilize overhead paging systems to broadcast that an incident is occurring. Other methods include voice communications, text messaging through page groups, other personal device technologies, or utilization of fire alarm speaker systems.

The second important consideration for internal notifications is what to actually broadcast. If a color coded system is to be utilized then this may be announced in the notification. In addition, the location of the active shooter (as specific as possible) should be included in the initial notification. A pre-scripted example might be: “CODE SILVER, LOCATION 4<sup>TH</sup> FLOOR ROOM 421, THIS IS NOT A DRILL.” Organizations may wish to consider providing more actionable guidance in their notifications. It should be noted that overhead, verbal notifications are typically best received and understood if they are short and concise. This then places more emphasis on training such that staff understands what a particular code announcement indicates.

Updates to the shooters location, if they are mobile, may be provided in a similar fashion to building occupants.

External notifications are almost always initially to 911. Specific positions within the facility should be designated to initiate contact to 911. Reported information should include as much of the following information as possible:

- Number and description of assailants
- Last known location
- Type of weapon
- Door closest to location of assailant(s)

Larger healthcare organizations may wish to list other important external notifications that should be made if possible. Examples include:

- DC Emergency Healthcare Coalition
  - Parent corporation to the healthcare facility
  - Staff not on-site
  - Other campus facilities
- Mobilization:

There are several activities that should occur rapidly in any facility. Important considerations include:

- The individual leading the healthcare organization’s response should be rapidly identified. For larger facilities, this will often follow procedures outlined in the respective emergency operations plan. Smaller facilities may wish to consider specific positions that are available 24/7 to assume this role.

- The facility's leadership should be mobilized in a safe location ( i.e. Command Center or EOC), even if it is a temporary gathering at the secure perimeter.
- A liaison should be immediately identified to be dispatched to interface with responding law enforcement. This would normally be a security representative in a large healthcare facility. The liaison should meet with the law enforcement in a pre-established location (set up during preparedness planning) if possible to facilitate early interaction.
- A hard copy of current facility floor plans should be immediately secured for incident planning and for use by arriving law enforcement responders. Having a Engineering Department/Facility Management Supervisor available to advise law enforcement on facility details is also recommended. Controlling elevator access, restricting power, turning off TVs should be expected to be law enforcement priorities.

- Incident Operations:

The guidance in active shooter response procedures will focus at two levels: that for facility leaders (i.e. command and security personnel) and that for building occupants. Both types of guidance may be listed in a response procedures document (e.g. for training purposes) but should be summarized more succinctly in tools such as checklists (see attachment B as an example) for actual use during response.

*Guidance for Organizational Leadership*

The facility may wish to consider pre-determining specific functions (activities) that may need to be addressed during an active shooter incident. For larger facilities with more complex emergency operations plans (EOP), this section should relate which predetermined response functions would be staffed for an active shooter incident. For any type of facility, individuals expected to fulfill specific roles should receive prior instruction as to how to fulfill these responsibilities. Examples of important functions to consider for specific assignment include:

- Announcements/notifications: Once an active shooter situation has been recognized, who is specifically responsible for making the initial and on-going announcements within the facility (e.g. shooter has moved to XX location)? From whom do they take direction? Are clear, pre-scripted messages for this individual rapidly accessible for use during what is expected to be a moment of duress? For larger facilities, a page operator or equivalent can be assigned to broadcast a specific message in an overhead fashion (assuming that the page operator, if within the affected facility, is in an area that can be safely secured) or through



other means (i.e. emails alerts, blast paging etc). For smaller facilities, other means of making notification may be necessary (e.g. floor wardens, notifications to personal devices, utilization of fire alarm speaker systems, etc.).

Consideration should be given to how off-site staff will be notified and given updated instructions on the operational status of the facility. Finally, consideration should be given to how an “all clear” determination will be made and then announced. Someone in a position of responsibility such as incident commander for the facility, security, the administrator on call, and/or law enforcement should make this declaration so that the word can then be announced.

- **Calling 911:** Though persons in the facility may individually contact 911, a position should be assigned the role of formally contacting 911 and providing the nature and location of the incident and other pertinent situation details. Where a facility has a security presence, the security staff should be alerted and is usually best qualified to perform this detailed law enforcement notification.
- **Security:** For facilities that have security staff, specific response roles and guidance for the active shooter incident should be outlined. Many facilities do not arm or protect their security staff (e.g. side arms, tazers, or bullet resistant vests) and hence, it is unreasonable to expect these individuals to actively engage someone discharging a firearm. In these circumstances, tracking the threat through the facility, securing specific areas through specified lock down procedures, establishing safe perimeters, and liaising with arriving police may be more prudent activities to actively pursue. For facilities with armed and protected officers, more aggressive response actions may be outlined. As part of training, staff should understand the expected response actions and limitations of their respective security staff.
- **Law Enforcement Liaison:** The positions assigned to rapidly liaison with arriving law enforcement units should be specifically designated. This would normally be the security staff if they exist at the facility. An important part of this role would be to provide a briefing on the layout of the facility. As mentioned above, rapidly available computer and or/hard copies of facility floor plans are critical. Access to available CCTV, other security monitoring devices, and overhead paging access may be requested by arriving law enforcement personnel.<sup>3</sup> In addition, this position should be capable of providing regular updates of law enforcement

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<sup>3</sup> Note: Some facilities may be able to provide to responding law enforcement the capability to remotely access video monitoring systems. This should be considered during pre-planning.

actions to facility leadership. A facility director may also be requested to provide specific information about facility design or operations.

- **Accountability:** A significant challenge during and after termination of the active shooter incident will be accounting for building occupants. Early in the response, the facility should initiate accountability procedures. For those that are immediately able to evacuate from the building, they should utilize pre-designated evacuation routes (if not compromised by the active shooter), and should be encouraged to congregate in pre-designated rally points clear from any danger. *Documenting these individuals who were able to escape before they leave the premises altogether is extremely important.* Accountability for individuals that remain in the facility is important to address as well (see guidance below- "Clearing the Facility").
- **Addressing injuries that are a direct result of the active shooter incident:** Planning should address the possibility of gradual access to injured individuals versus immediate access. This should include coordination with DC FEMS on issues such as staging personnel and evacuation equipment and readiness to assist in this effort if needed. The level of care given to victim(s) will be commensurate with their location (e.g. still in danger area versus safe location), scene safety, and availability of treatment resources in the facility. Injuries may require transfer to other healthcare organizations for medical, logistical (e.g. facility compromised), or psychological reasons. Tracking of any patient transfers should occur centrally within the facilities incident management team.
- **Media:** What messaging will necessary to deliver to the media? In order to be most effective and consistent, media messaging should be integrated between the healthcare organization and law enforcement PIOs. Should initial, brief messaging be considered while the active shooter incident is still unfolding (e.g. facility is on lock-down, organizational leaders are working with MPD to resolve)? Can the neighborhood and neighboring organizations be rapidly notified (e.g. University affiliated with healthcare facility)? Specific media messaging will definitely be required after all threats have been eliminated. The location for this should be established in conjunction with law enforcement and be remote from any clinical areas, locations of damage, or on-going restorative/investigative activities. The "post-shooter" briefing should highlight actions the organization is taking to address the impact of the active shooter incident and the operational status of the facility. When possible, representatives from security, clinical operations, and executive leadership each may be helpful in conveying messages to the public along with law enforcement. An example briefing might be conducted as follows:

- Security should talk to what happened in the facility with regard to the active shooter.
- The clinical representative (wearing a white coat for televised appearances) should address the injured and behavioral health issues to be addressed.
- Leadership should speak to the overall impact on the facility and the staff.
- Law enforcement could speak to the expected investigation effort.
- Family notification for directly affected staff, patients and visitors: As soon as feasible (during or after the situation is stabilized) any injured or deceased individuals within the facility should be rapidly identified and their families notified by the facility's senior staff. A receiving area for these arriving families should be prepared in a secure and safe location away from the media. The need for escorting them to this location should be considered if needed.
- Other public information: How will patients, patient families and others have their questions answered? Initially, this may be passive (i.e. one way messaging to media) but soon after the ability of processing individual inquiries should be addressed. Messaging to other campus buildings and local neighborhoods may be relevant as well. A hot line should be established for in-coming calls to respond to questions or provide general information. Separate call in lines should be considered for general public and staff members. This effort should maintain victim privacy
- Staff information: Beyond establishing a call-in line as noted above, active messaging should occur to staff throughout the incident. This includes notifications of shooter location, termination of the threat, and facility actions after the threat has been terminated. On and off-site messaging needs to be included.
- Clearing the facility once the threat is eliminated: Individuals in each area of the facility should provide for accountability of occupants (staff, patients, visitors) through a previously established accounting and reporting procedure. Area supervisors should also perform (or oversee) a room to room search to ensure that no one remains in concealment or that no injured individual is unaccounted for.
- Investigations once the threat is eliminated: It is anticipated that any active shooter incident will entail a significant law enforcement investigation. Organizations should address how they will support this investigation as well as

how they will support employees and others who are requested to participate in this investigation. The need for patient/service relocation while the investigation is being done should be anticipated and planned for early in the response and continuously assessed.

- Post-incident debriefing: Any active shooter incident will require evaluation and potentially intervention on the behalf of the expected strong emotional reaction to the incident. Patients, staff, and visitors may require specific services and these should be pre-established. Actual intervention techniques are beyond the scope of this document and may be very specific to each individual organization.

In addition, the organization may wish to describe any facilities utilized in the response for this scenario. For example, alternate emergency operations center or command posts for the facility may be pre-planned for and established during the response to an active shooter. Another facility type to describe and how it would be utilized might be a video control center (area where video or audio surveillance of the facility is monitored or other alarms are controlled). Finally, a location may be pre-designated for the police department to operate from with telephone communications support. These telephones ideally should include a direct dial capability within the facility.

#### Guidance for Building Occupants

Procedures for building occupants should be clearly articulated in an easy to understand format. These are best presented in checklist fashion for review prior to any potential incident (see Attachment B as an example). Concepts that should be addressed include the following:

- ✓ Self-protective measures: When an active shooter has been announced in a healthcare facility, there are two basic choices available to occupants:
  - *Get out.* If individuals are near exits that are not blocked and are easily and safely accessible, persons should immediately leave the building. Ideally, guidance should indicate preferred evacuation routes (if not compromised by the shooter) and rally points distant from the facility. Guidance should also indicate that accountability procedures will be initiated at the rally points so that occupants do not disperse before their presence out of the building is documented.
  - *Seek cover and concealment.* Instructions to individuals not able to exit should address:
    - **Spread out.** avoiding collecting in large numbers if possible.

- **Hide out.** Finding a location that provides concealment and cover. Once in these areas, individuals should silence all personal communications devices, turn lights off, pull curtains, and any other activity that can increase concealment. Individuals hiding should be encouraged to call 911 and report their location if they feel it is safe to do so.
  - **Lock out.** Ideal places for cover and concealment would have lockable doors. Though these may be limited in any healthcare facility, examples could be provided in guidance (e.g. conference rooms, bathrooms, offices, medical supply/pharmaceutical rooms). In addition, guidance should be provided for occupants who work in areas that are normally locked down. For example, any ICUs in hospitals already have locked doors that prevent ingress into the ICU without permission. Individuals in these types of areas should remain in their workplace and limit any traffic through the locked doors to prevent an active shooter entrance.
- ✓ **“Taking out shooter:”** Some law enforcement sources recommend that individuals who encounter the active shooter consider “taking out” the shooter if no other option is available to the individual. This is a personal choice made by the individual when there is no other option. It, therefore, should not be presented as formal organizational guidance.
- ✓ Provision of medical care: Guidance should be provided in response procedures that outline where and how medical care is to be provided during an active shooter incident. This is best presented as life saving treatment only while the threat is active and if it can be accomplished in a concealed manner (e.g. behind a locked ICU/OR door).
- ✓ Security’s role: Building occupants should understand the role of their security force if the facility possesses one (as noted above). Many security forces are not armed or adequately protected (e.g. bullet resistant vests) and hence, cannot be expected to actively engage an active shooter. Instead, they will be more helpful in tracking the shooter in the facility and in facilitating a rapid law enforcement response. Armed security forces may elect to quickly engage an active shooter per their facility’s policies. One of the first measures that should be taken by security is to lock down the facility to preclude anyone other than law enforcement from entering the facility. Careful monitoring of video cameras and other detection devices and sharing pertinent updated information will be vitally important.

- ✓ Law enforcement response: Response procedures should clearly outline what building occupants should do when law enforcement arrives on the scene. As law enforcement may not initially have a good description of the shooter, it is imperative that building occupants follow their instructions and not do anything that could be misperceived as a threatening action. These instructions may include recommendations such as:
  - Always display your ID badge prominently
  - Do not attempt to carry anything with you
  - Keep your hands visible and your fingers spread
  - Remain in place until instructed to move by law enforcement
  - You may be searched by law enforcement (as the shooter may attempt to escape with others)
  - You may be interviewed by law enforcement once in a safe location

- Demobilization:

The immediate termination of any threat during an active shooter incident will most likely be determined by law enforcement. For example, there may be concerns about a second shooter (and/or explosive devices) even if one has been apprehended or otherwise eliminated as a threat. This may take some time to determine conclusively. Once an all clear has been given to the healthcare facility, an announcement should be made to building occupants. Depending on the type of facility and its capabilities, this may be an overhead page, notifications to personal devices, or involve law enforcement going floor to floor making the announcements.

- Transition to recovery:

There are many issues a facility must be prepared to address after the conclusion of an active shooter incident. These may dictate that the Incident Management Team established for response remains in place or even potentially be expanded. Issues include:

- ✓ Personal injuries: These may be cared for at the facility or transferred to another facility for care. The facility involved in the active shooter incident should track these individuals throughout their care. Family notifications must be done correctly and effectively; support for arriving family should also be planned
- ✓ Facility damage: The incident may result in facility damage including that from law enforcement actions. Consideration may be given to addressing obvious signs of conflict (e.g. bullet holes) which may be shielded until more permanent repairs can be made.
- ✓ Disruptions to normal service schedules: Outpatient, inpatient and personnel schedules may all have to be adjusted as necessary after the conclusion of the incident.
- ✓ Investigation issues: continuing efforts to address any on-going investigations.
- ✓ Control of evidence: Certain items or areas may need to be secured or protected in conjunction with law enforcement.
- ✓ Behavioral health issues: This can be one of the most significant issues to address at the conclusion of any active shooter incident. It should be distinguished from any after action report process as the goal is different. Behavioral health issues should be identified (through surveys, group meetings or other means) and addressed through briefings and counseling as necessary. Planning should address support for those not directly impacted as well as those who were as well as staff families.
- ✓ Media messaging: Messaging to the public about the operational status of the facility will be important.
- ✓ Staff messaging: Staff and patients will need to be kept regularly abreast of the evolving situation and provided appropriate instructions and reassurance.
- ✓ Communications: The facility should anticipate a surge of phone calls to the operator and other listed numbers from persons seeking various information. Establishing and publicizing the availability of a information hotline which is adequately staffed maybe warranted.

**ATTACHMENT A: DC EHC Sharing of Healthcare Facility Schematic Drawings  
with Public Safety Agencies Annex, February 2011**

**District of Columbia Emergency Healthcare Coalition**

**Sharing of Healthcare Facility Schematic Drawings with Public Safety  
Agencies Annex**

**I. Purpose:** Provide guidance on how healthcare facility and campus schematic drawings will be made available to the Metropolitan Police Department (MPD) and Department of Fire and EMS (DCFEMS) for use during emergencies.

**II. Situation and Assumptions**

Healthcare facilities (HCFs) may upon occasion be the site for an emergency where the assistance of police and/or fire/EMS may be required to resolve the situation. Depending on the circumstances rapid access by first responders to hospital design information may be vital for a timely, effective and a safe response. Thus, access to this information while enroute or immediately upon arrival is in the best interest of HCF and assisting public safety agency(s).

**Assumptions**

- Fires, structural collapses and medical emergencies may occur at a HCF and require the assistance of the DC Fire and EMS Department to resolve
- Acts of violence (including but not limited to theft, hostage barricade and active shooter) may occur at a HCF and require the assistance of the Metropolitan Police Department to resolve
- Terrorists may attempt to inflict some form of primary or secondary harm to a HCF

**III. System Description**



HCFs maintain the responsibility of keeping current their building and grounds plans. Most often this responsibility falls to the Building Engineer and /or Facility Director. This information is most often maintained in print, CD, or thumb drive formats.

MPD and DCFEMS will periodically conduct formal inspections and walk - throughs to familiarize themselves with building design and meet key points of contact. In some cases these visits may be done to insure HCF compliance with local ordinance requirements. While site visits may be helpful for those completing them, most members of both departments lack sufficient operational awareness of the HCFs facility design and hence depend on written plans and diagrams.

#### **IV. Concept of Operations**

##### **Pre Incident**

The Security Director and Facility Director will submit their facility and campus schematic drawings to the MPD Commander -Technical Information Division via email as a PDF file. Updated plans will be submitted via email to this same address when construction/renovation projects are completed.

MPD will insure the security of these plans at all times and will not allow them to be seen by other than authorized MPD Special Operations Command personnel and DCFEMS command personnel.

Each HCF shall also maintain current facility and campus plans in print form and/or CD and/or thumb drive so they are readily available for arriving MPD/DCFEMS incident command personnel. Each facility is also encouraged to maintain facility and campus schematic drawings in their Command Center for reference by hospital command personnel as necessary.

##### **During an Emergency Response**

Depending on the circumstance MPD/DCFEMS command personnel may access the plans provide on the secured web page while enroute or once on scene.

A HCF security command officer or facility/engineering supervisor should be available at the front door or at the command post to meet with public safety command personnel to answer questions and /or provide schematic drawings of the campus and facility if requested.

## **V. CCTV Connectivity**

Each facility will discuss with MPD their willingness to allow their CCTV system(s) to be linked electronically into the Mobile Command Posts public safety agencies will bring to the scene. It is understood that a “live feed” will only occur during an emergency response according to a mutually agreed preplan.

## **ATTACHMENT B: Sample instructions for Building Occupants**

### **Active Shooter Operational Checklist – All Departments**

When these procedures are applied: An individual with a fire arm has been identified in the building or on campus and is threatening harm or harming persons. The following will be announced “XXXXX” via [Y] method.

Recommended actions:

- **Get out:** If near an exit and the path is clear, leave the building.

If unable to get out:

- **Spread out:** Do not congregate in groups.
- **Hide out:** Find places of concealment. Any location that blocks view of your presence is preferred. In addition, consider silencing your personal devices and making as little noise as possible. Call 911 only if you think it is safe to do so.
- **Lock out:** Lock, if possible any doors leading to your hiding place. Consider quick actions to block doors that do not lock with furniture or other items. If in an area that is normally locked (e.g. ICU with card wipe access), ensure no occupants exit the area permitting unwanted entrance to the locked area.
- Only attempt patient care activities if they are immediately life-saving
- If law enforcement is encountered:
  - Ensure your ID is prominently displayed
  - LISTEN to police instructions
  - Keep your hands visible at all times with fingers spread apart
  - Do not attempt to carry any items with you
- The conclusion of an active shooter response will be clearly announced via [Y] method.
- Once concluded, assist supervisors in clearing your department by checking all areas for other hiding persons, assisting with accountability, and reporting to the healthcare facility Command Post.

## **ATTACHMENT C: Example of Active Shooter Briefing Sheet (pre-incident)**

### **CODE SILVER-ORIENTATION**

#### **(ACTIVE SHOOTER)**

1. A Code Silver involves the unauthorized use of a gun in a threatening or physically harmful manner up to including firing the gun. The individual doing so is referred to as an “Active Shooter”. When the above situation occurs anyone observing this situation who works in the facility will call the facility operator immediately on extension “xxxx” to alert everyone within the facility where the incident is occurring. For example, the operator will announce over the facility intercom – “Code Silver, Two East” - When the announcement occurs the guidance below will be followed:
  - Everyone is to stay away from the area.
  - Alert others of the code silver and give the location.
  - Leave the floor that the active shooter is located on.
  - Seek cover and concealment. Hide
  - Call the operator and provide the location, your name, and telephone number if it is safe to do so.
  - Close doors to patient rooms if it is safe to do so.
  - Call the operator at extension “xxxx” to report the movement of the active shooter.
  - Areas that are locked should remain locked and occupants should stay put.
  - Wait until the all clear is announced over the facility intercom by the operator, or by security.
2. After the all clear is given over the facility intercom, anyone having knowledge of the incident should contact the security department immediately.
3. Training  
The facility Safety/Security Director shall coordinate training given to facility personnel. This can be done using:

- A self training package disseminated to department leaders to administer to their departments,
- Class room presentations,
- Holding training sessions on each unit. This will allow review of safe rooms, escape routes, sounding the alarm and review of individual responses,
- A joint table top drill with the local police department
- Placing training information on the intranet.

Directors and Managers will review the Code Silver and other emergency codes with their staff annually. Training completion records should be forwarded to Safety/Security Director for filing and reporting to the Environment of Care/Safety Committee, as needed.