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NOVEMBER 2017 Vol. 29, No. 11; p. 121-132

INSIDE

AHC Media
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Hurricane Harvey Pushed Southeast Texas Hospitals to the Limit

Early activation of disaster protocols credited with ensuring adequate staffing for an emergency that lasted multiple days

The chief clinical officer at Franklin, TN-based IASIS Healthcare, **Tedd Adair II**, RN, BSN, MA, CEN, CCRN, has been through several hurricanes while working in southeast Texas, so he was perhaps better prepared than most to confront Hurricane Harvey, the juggernaut that swept through the region in late August.

However, the extent of the flooding and devastation left in the storm's wake placed unprecedented strain on several of the healthcare system's facilities operating in the affected area.

> THE EXTENT OF THE FLOODING AND DEVASTATION LEFT IN THE STORM'S WAKE PLACED UNPRECEDENTED STRAIN ON SEVERAL OF THE HEALTHCARE SYSTEM'S FACILITIES IN THE AFFECTED AREA.

"We were fine relative to water not coming into our buildings, but we became very isolated on islands, so the typical modality to get a patient or staff member to us was by vehicle until they hit water, and then by flat-bottomed boat, most likely an air boat until they got close to the hospital, and then it was by dump truck ... to bring them up close to the hospital," Adair explains. "Helicopters were [also] able to get close enough to bring in patients and help us transport patients."

One of the harder-hit IASIS facilities was its Victory Campus in Beaumont, TX, a satellite of the Medical Center of Southeast Texas in Port Arthur, TX.

Financial Disclosure: Physician Editor **Robert Bitterman**, Author **Dorothy Brooks**, Editor **Jonathan Springston**, Nurse Planner **Diana S. Contino**, Executive Editor **Shelly Morrow Mark,** and AHC Media Editorial Group Manager **Terrey L. Hatcher** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

ED MANAGEMENT®

ED Management®,
ISSN 1044-9167, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
AHC Media, LLC
PO Box 74008694
Chicago, IL 60674-8694

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SUBSCRIPTION PRICES:
Print: U.S.A., 1 year with free *AMA PRA Category 1 Credits™*: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469
Outside U.S., add $30 per year, total prepaid in U.S. funds

Back issues: $82. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

ACCREDITATION: Relias Learning LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP #13791.

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This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 36 months from the date of the publication.

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"The challenge at Victory was ... water overwhelmed the city water pumps and they were flooded, and so they ... quit pumping," Adair notes. "We moved our patients in-house to our main campus, but we did maintain an emergency presence there. We sanitized as we could with gel sanitizers, but we kept our doors open. There are 150,000 people who live in Beaumont, and we were the only medical facility available to them."

The other hospitals operating in the Beaumont region closed, so the Victory Campus continued operating with physicians and staff.

"We had the ability to get supplies in and out through air transport," Adair adds.

The main campus in Port Arthur fared better, perhaps thanks to the kind of preparation that evolves from hardened experience. The Medical Center of Southeast Texas had been through four hurricanes before Harvey, Adair notes.

"One of those storms was Gustav [in 2008] when we did a full evacuation. It didn't hit the hospital, but then Ike hit us the next week, so we have punched a hole in the ground and we have our own water supply now," he says. "We also have our own generation system for power."

Plan for Staffing Needs

However, with flood waters hindering access to and from the Port Arthur facility, maintaining adequate staffing for an extended period presented multiple challenges. Fortunately, personnel from IASIS facilities in other states volunteered to travel to the region and work shifts in the affected IASIS facilities, helping relieve local staff after long shifts.

"Everybody was scheduled with their flight reservations, with the corporation sponsoring and paying for these flights," Adair explains. "They could not get to Houston because of the flooding, so we brought them into Oxford where we rented buses and vans to bring them in. We set up a basic intake area at St. Joseph Medical Center [in Houston] where every single one of the 75 nurses was processed."

The volunteering staff members received passwords, a ID badges, cots, and any supplies they needed, Adair says. While some of the volunteers remained at St. Joseph Medical Center to relieve staff there, others required transportation to the hospital in Port Arthur, a route that was 100% impassable by ground, Adair explains.

"The Texas Rangers came in with their high-water vehicles and loaded up the nurses," he recalls. "We moved about 37 nurses over the next 12 hours to Port Arthur with the understanding that they were going to work 12- to 18-hour shifts."

Integrating the volunteering staff from out of state into the workflows of the affected hospitals was not as difficult as it might have been, given that the corporation has institutionalized many processes and procedures.

"We use a common electronic medical record [EMR], and we have a common platform for medication administration, so literally other than having a unique password for the locality and finding out where the break or the supply room is, the volunteering nurses literally went right to work," Adair observes. "I know some companies have fractured EMRs, and even some hospitals with multiple campuses have different [electronic tools] ... and you lose all the efficiency of being

able to pool your resources when you have to."

Anticipate Post-storm Surges

The influx of fresh staff was invaluable, particularly considering the personal losses that many of the local personnel at Port Arthur suffered from the storm. For example, Adair notes that one employee who reports to him had to chop through his attic to facilitate a roof rescue.

"A significant number lost their homes and their vehicles. If the family had a business, it was gone," he says. "We did have one of our nurses call back when she got home and say that she was done, and was not coming back [to work]."

The toughest loss by far involved an operating room technician who drowned in the flood waters while trying to escape with her infant child. While rescuers were able to save the infant, they could not get to the woman in time, Adair laments. Although the incident was not work-related, it hit the victim's coworkers hard.

"It is really tough. She had worked at the hospital for many years," Adair says. "[The staff members] are going to have to have assistance and increased counseling support."

Despite the fact that flood waters hampered access to the Port Arthur hospital, the number of patients arriving to the ED surged from roughly 85 on a typical day to more than 120 in the aftermath of the storm.

"In Port Arthur, we were the only fully operational hospital," Adair notes.

Patients presented with issues ranging from problems associated with exposure to water for a long period and rescue-related lacerations to strokes, heart attacks, and traumas.

Adair adds that during the storm period, clinicians performed two emergency coronary artery bypass grafting surgeries, one balloon angioplasty, and they cared for one patient with significant trauma from a motor vehicle accident.

"It was everything we would see on a typical day plus the added complexity of people who were cold, wet, and hungry," Adair recalls. "We didn't have any drownings, as those were typically dealt with on the scene by first responders."

Consider Dialysis Needs

St. Joseph Medical Center in downtown Houston remained relatively unscathed by the storm's hurricane-force winds, but most of the major roads surrounding the facility were flooded, making it difficult to get in or out of the facility. However, the hospital is just four blocks from the convention center where evacuees were shuttled in by

EXECUTIVE SUMMARY

With several medical facilities in southeast Texas affected by Hurricane Harvey, Franklin, TN-based IASIS Healthcare pooled its resources, shuttled in relief staff from hospitals in other states, and found creative ways to reach hospitals surrounded by flood waters. The massive storm, which swept through the region a week before Labor Day, left the IASIS facility in Beaumont, TX, without water, although physicians and nurses continued to see emergency patients there with liberal use of gel sanitizers. St. Joseph Hospital in downtown Houston created a mass casualty area on a loading dock to manage a surge in patients to the ED in the storm's aftermath. The Medical Center of Southeast Texas in Port Arthur kept its doors open, taking in patients from Beaumont while also treating patients who presented with storm-related injuries as well as other emergency care needs. However, one hospital employee died tragically in the flood waters. Numerous other staff members experienced flooded homes and/or vehicles.

- Patients made their way to the hospital in Port Arthur by way of flat-bottomed boats, helicopters, and dump trucks high enough to wade through flooded areas.
- With a common electronic medical record used at all IASIS healthcare facilities, staff transported from other states to relieve personnel in Texas were able to integrate themselves into the local workflows with relative ease.
- Emergency staff at St. Joseph Medical Center credit leadership with activating the facility's disaster protocols early, giving two full shifts of staff time to set up in the hospital before the flood waters hindered access to the facility. The approach enabled the two shifts of personnel to work and sleep in alternating cycles for the duration of the flood emergency.
- One of the biggest challenges at St. Joseph Medical Center was the surge in patients who required dialysis. With dialysis centers in the region closed, at one point between 30 and 40 patients were awaiting dialysis at the hospital.

helicopter, creating a gradual surge in volume to the ED once the Houston Fire Department found an access route into the hospital on Aug. 27.

"We saw an increase in volume at that point, but the thing that really increased was the acuity of the patients," explains **Trent Tankersley**, BSN, RN, the director of the ED at St. Joseph. Typically, this volume of acute cases would have been dispersed among several medical centers, but St. Joseph was the only hospital downtown that the Houston Fire Department could access at that point, he observes.

"We did see a big increase in patients coming in with flood-related injuries such as broken bones, lacerations, cuts, scrapes, and bruises," Tankersley notes. "We also saw a lot of injuries related to long-term exposure to water, such as mild hypothermia and some skin breakdown. We actually had one lady who was in labor who showed up in the bed of a dump truck. That was the only way they could get to her through the flood waters."

Tankersley adds that there was a tremendous problem with patients who needed dialysis. "The dialysis centers were not available and not functioning, so we had one point when 30 or 40 patients were waiting on dialysis," he says.

The ED at St. Joseph includes 16 acute beds that are monitored and an additional nine fast-track beds, but by Tuesday, Sept. 5, in the aftermath of the weekend storm, administrators needed to create additional capacity. "We developed a plan to actually open up our loading dock as a mass casualty triage and treatment center," Tankersley explains.

"In that area, patients would actually come in via ambulance or walk in and be seen and treated, unless they needed to come into the main ED." The loading dock treatment area supplied an additional eight beds, and it was set up as an extension to the ED, Tankersley relates. "They had diagnostics and IV fluids and medications. We set up a small satellite pharmacy there with a pharmacist," he says. "We estimate that during the storm period, we saw between 1,000 and 1,100 patients in the ED only."

"WE ESTIMATE THAT DURING THE STORM PERIOD, WE SAW BETWEEN 1,000 AND 1,100 PATIENTS IN THE ED ONLY."

Physicians from every department as well as medical students stepped in to help care for patients coming through the ED. "All of that really helped to keep our ED decompressed so that it wasn't mass chaos," notes **Heidi Wolf**, MSNA, BA, RN, the chief nursing officer at St. Joseph. "It was such a phenomenal thing to see everyone come together and work well to take care of that volume."

Prepare Staff for Challenges

Fortunately, the hospital's advance emergency planning included enough staffing flexibility to accommodate the increased capacity. "When we called the external disaster [protocols], we requested and were able to achieve a level of staffing where we could staff two shifts," Wolf explains. "We asked that they remain in the building throughout the storm and during some of the receding waters until we could get relief staff in to work."

The two shifts of personnel were in place before the storm became severe and access to the facility was hindered. Wolf explains that this arrangement enabled a sufficient number of personnel to sleep and then work in cycles at least until relief personnel arrived.

After working through Hurricanes Ike, Rita, and Katrina, Wolf knows from experience that the biggest surges tend to happen after a storm has moved through. "A lot of it happens with the cleanup, so in order to be prepared you have to start out by preparing your staff to ride through the hurricane or flooding disaster," she says. "Then, relief personnel need to be prepared to come in, and a lot of times the more extensive piece of the emergency is that recovery phase because it takes so long to get back to normal."

Wolf adds that it helps if healthcare personnel understand what to expect in a storm as serious and devastating as Hurricane Harvey. "A lot of times the places they have lived in for a long time are so devastated that it is difficult for them emotionally to come back [to work], but if you prepare enough ahead of time, and get everyone in the mindset of what it is going to be like, it seems to make it a little bit easier to handle," she offers.

The hospital made sure that both shifts of personnel assigned to the hospital during the storm were provided with meals and any resources they needed. For example, if a clinician did not bring a sleeping bag to work, one was provided. In addition, a makeshift canteen was set up in the command center where

staff could obtain any personal items they needed.

"People have really stepped up," Wolf observes. "We have directors here who are doing laundry for their staff. We have just outstanding people who are cooking, bringing in food, and dropping off pallets of water and supplies. There has just been an outpouring from our internal community to ensure that there is quality care for patients in downtown Houston."

Take Stock of Lessons Learned

In the midst of all the devastation caused by Harvey, there were several instances when staff and patients would cry together, Wolf observes. She also notes that many staff members who experienced severe storm-related losses found coming to work to be therapeutic. "Having a place to come back to some normalcy, like the place of your employment, can help staff get through these events sometimes ... it gives them a routine to look forward to," she says. "I have found that to be the case at several different facilities."

With some medical facilities in the region likely to be out of service for months, the hospital is now in the process of planning for extra demand on certain departments for a long period, especially obstetrics, Wolf observes. "We are really concentrating on how we are going to handle the increased volume," she adds.

Administrators are already examining what steps they might take to improve their planning and preparation for the next natural disaster. High on the list is a better plan for dialysis patients as well as how to handle some of the unique attributes of a long flooding emergency. "Usually these situations last for 24 to 48 hours, but this event lasted so long that we really have to think about having a more detailed plan because there are so many more patients that it affects," Wolf says. "A lot of people have backup generators ... but with flooding, a backup generator isn't necessarily going to help you. It is a longer event than any of the hurricanes with wind damage because you just can't get back to normal."

> "HAVING A PLACE TO COME BACK TO SOME NORMALCY, LIKE THE PLACE OF YOUR EMPLOYMENT, CAN HELP STAFF GET THROUGH THESE EVENTS SOMETIMES."

There have been many lessons in the response to Harvey, Tankersley observes. "One of the things that myself and some of the other members of the emergency management committee have decided to do is take the experiences that we have had and actually develop a step-by-step plan," he says. "We learned a lot of things, especially with regard to setting up the mass casualty area [on the hospital's loading dock]."

Tankersley contends that crafting a carefully developed approach for setting up a mass-casualty site rather than trying to figure it out on the fly will make a difference. "We had a general idea of what needed to be done, but there is only so much a drill can teach you," he says. "When you actually get into a situation, I think everybody's combined experience — in the event that there is another situation like this — is going to make it a little bit better."

Anticipate the Worst

One of the things that the hospital's executive team got right was calling for implementation of the disaster protocols on the morning of Saturday, Aug. 26, a day earlier than many of the other facilities in the region, Tankersley explains. "There were some moments of hesitation on our part, but it really turned out that they made the right decision at the right time ... and that is one reason why we weathered the storm as well as we did," he says. "We were prepared in advance."

Rising flood waters on Saturday evening made it difficult for some hospitals to get extra staff in to work. That meant that existing staff had to work constantly for days. "We called our people in [on Saturday morning] and just tried to stay ahead of the situation," Tankersley recalls. "We were hoping for the best and planning for the worst."

Tankersley adds that when a disaster is imminent, it is important not to second guess it. For instance, in the case of Harvey, the storm developed very rapidly. "Within about 24 to 36 hours, it went from a tropical depression to a Category 4 hurricane," he says. Fortunately, as early as Thursday, the emergency management team was making plans and letting staff know that they might need to come in, and that they would need to be prepared to stay.

With staff working such long hours for an extended period, one would think that tempers might flare and nerves would fray, but it didn't happen, Tankersley observes. "The staff made it very easy to manage the situation because [clinical and administrative leaders] were able to focus all of their time on managing the crisis, and not on managing difficulties with staff," he says. "We just didn't see the difficulties that you would think you would have with 700 people or so living in close quarters for five days in such proximity ... the staff did a tremendous job."

Look for Talent, Training

While southeast Texas, Florida, Puerto Rico, and the Virgin Islands were all hit hard this year, there will be other natural disasters that affect different regions. Hospitals must be ready. Adair's advice to colleagues is to look for employees with extra training or military experience that can be helpful in managing disasters. "Not every leader has that experience, and sometimes the calls are tough," he says.

However, there are many well-trained people in the healthcare delivery system in the United States, some of whom have been deployed in Iraq and Afghanistan, Adair observes. In fact, he notes that such individuals were instrumental in helping set up the mass casualty area on the loading dock at St. Joseph Medical Center during the storm. "Look to the talent you have in your hospital because some of those resources are unbelievably valuable," he offers. "Make sure to listen to them."

Further, hospitals that are part of a large network should grease the skids so that they can take advantage of their connections and work cooperatively when a member hospital is under stress and needs help in the midst of a big storm or other disaster. "I enjoy the luxury of being part of a fairly large health system, with 3,500 beds and 15,000 employees in seven states. It is nice to be a part of a family. We are not out here alone," Adair notes.

"I know some small community hospitals don't have the ability to pull and push things that I have." ■

SOURCES

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Detailed Preparation Helped Miami Hospital Staff Withstand Hurricane Irma

Putting in place a detailed plan early and practicing often made the difference

While Hurricane Harvey was submerging much of southeast Texas with flood waters, another monster storm was aiming for Florida, and hospitals there were preparing for what forecasters said would be a historic hurricane in terms of size and the potential for damage.

As in Texas, hospitals in Florida routinely plan and drill for hurricanes, and this preparation paid off for the University of Miami Hospital (UMH) as the storm reached the mainland on Saturday, Sept. 9. "We have a disaster preparedness management center, and we go through [practice] exercises for the first six months of the year," explains **Tanira Ferreira**, MD, the chief medical officer at UMH and an assistant professor of medicine. "Our whole management team meets, and we have a very well-described plan in the event we go into disaster mode."

For Hurricane Irma, part of that plan involved emptying the hospital as much as possible before the storm made landfall, Ferreira notes.

"We tried to plan for safe discharges where appropriate, and we tried to get as many patients as possible home," she says.

In addition, the hospital organized two teams of nurses to staff the hospital during the storm emergency, with both teams stationed at the hospital. Team A was in place and on duty before and during the storm.

"It was a very robust team, and [these nurses] could only leave once team B was in place to relieve them," notes Ferreira, explaining that the teams worked and slept in alternating cycles. The physicians also worked in two teams, and some physicians, including Ferreira, remained on site for three days.

"We also had to flex in additional staff in the ED, and we planned for that because we knew we were going to have a surge in volume [once the

storm passed through]," Ferreira notes.

The hurricane shifted to the west before making landfall so that Miami managed to miss the strongest hurricane-force winds. However, the region still was blanketed by sheets of rain and violent wind gusts.

Fortunately, the hospital did not lose power or water during the storm, although the hospital's primary bank of elevators proved problematic. The elevators stopped working three times during the storm, including once with people inside. The fix required an operations supervisor to reach the roof of the 14-story facility, and then climb an open staircase to enter a small motor room where the elevators could be restarted.

It was a treacherous mission in the midst of a hurricane, but the issue did not affect operations, Ferreira notes.

"We were able to manage the situation," she says. "We made a conscious decision to put our air conditioning on generators so that we didn't overflow the capacity for normal power ... but the elevator problem did not interfere with the patient floors or patient safety."

Volume to the ED was extremely low during the weekend storm, but then surged on Monday, Sept. 11, Ferreira recalls. In fact, in the immediate aftermath of the storm, volume to the ED at UMH increased by more than one-third, she says. The ED saw patients who had run out of critical medicine for high blood pressure, diabetes, and other chronic diseases, and there were patients who had delayed needed care until after the storm, Ferreira observes. Also, similar to what happened in Houston following Hurricane Harvey, the ED at UMH saw a big increase in the number of dialysis patients who had missed dialysis sessions during the storm.

ALTHOUGH THERE IS NO WAY TO BE SURE WHEN OR WHERE A DISASTER THE SIZE OF HURRICANE HARVEY OR IRMA WILL OCCUR NEXT, FERREIRA'S ADVICE TO COLLEAGUES IS TO PREPARE.

"The dialysis centers, which are usually outpatient clinics, were not open until a couple of days after the storm," Ferreira notes. Consequently, these patients traveled to the ED. Although the spike in volume was anticipated, it did create difficulties. "We started seeing a lot of patients, but we didn't have the ability to safely discharge them because a lot of the rehabilitation places, nursing homes, and home healthcare agencies were not accepting discharges — not until Wednesday [following the weekend storm]," Ferreira says. "It took us until several days after the storm to get back to normal."

What made this storm particularly difficult was its sheer size and scope.

"It affected a very large area — many, many counties, so there were massive evacuations," Ferreira observes. "What we did really well was to have teams A and B accessible to our building to assure that staff would report to work before, during, and after the storm," she says.

Although there is no way to be sure when or where a disaster the size of Hurricane Harvey or Irma will occur next, Ferreira's advice to colleagues is to prepare.

"Have a well-developed disaster plan in place," she says. "You don't put that plan in place a day before the storm. It takes months of preparation, and I think that is why we did so well here." ■

SOURCE

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Shocking Nurse Arrest Prompts Discussions About Working With Police Officers

Nursing association reaches out to leading law enforcement organizations to work toward preventing future incidents

Hospital workers and law enforcement officers often drill together, and they generally work cooperatively to ensure safety and security. Consequently, while disputes are not unheard of, the well-publicized arrest of a Utah nurse on July 26 who refused to comply with a police detective's request for a blood sample is a reminder that frontline providers must be well-versed in how to handle such requests. These requests must be handled in accordance with a hospital's legal counsel, and hospitals should create specific guidelines and put resources in place. This will help frontline providers when law enforcement personnel make improper requests or resort to bullying tactics.

Leading up to the Utah incident, police were in a high-speed pursuit of a suspect on a state highway. The chase ended when the suspect's vehicle collided with a truck, killing the suspect and severely injuring the driver of the truck, who then was expedited to the University of Utah Hospital in Salt Lake City.

Reports indicate that although the truck driver was not suspected of being at fault in the crash, police requested a blood sample from the patient to definitively rule out the existence of any illegal substances in his blood. However, the patient was not conscious and therefore could not consent to the blood draw.

For this reason, Alex Wubbels, RN, a nurse on duty in the burn unit where the patient was receiving treatment, refused to provide the blood sample without a warrant, citing hospital protocols. A heated argument, lasting several minutes, ensued on the floor of the burn unit. Then, with the apparent support of his supervisor, Jeff Payne, the detective who was demanding the blood sample, took hold of Wubbels, shoved her out of the building, and then cuffed her hands behind her back. While Wubbels screamed that she was being assaulted, the detective insisted that she was interfering with an investigation. Hospital security reportedly did not intervene in the incident.

EXECUTIVE SUMMARY

The shocking arrest of a Utah nurse following an emotionally charged interaction with a police detective has prompted heated discussions among frontline providers and policy reviews at hospitals across the country. The arrest occurred after the nurse refused to supply a blood sample from an unconscious accident victim, citing hospital protocol. The nurse was not charged in the incident, and support for her has poured in from nursing leaders, but the incident remains under investigation.

- Legal observers suggest the nurse was correct to stand her ground in the incident, but fault her for resisting the arrest.
- Most experts agree the detective demanding a blood sample was derelict in his aggressive handling of the case, and should not have arrested the nurse.
- Experts urge ED leaders to review the case with staff and to clarify how to handle such incidents in the future so that disagreements are minimized, and interactions between law enforcement and hospital workers are collaborative and respectful.

Open Lines of Communication

Ultimately, Wubbels was not charged, but she told the press that she was angry and confused, and that she felt betrayed. Further, video of the incident circulated widely, generating considerable support for the nurse's attempts to stand up for her patient, particularly among fellow frontline providers. **Karen Wiley**, MSN, RN, CEN, president of the Emergency Nurses Association (ENA), calls the incident shocking, upsetting, and disappointing. "We applaud Alex for her commitment to doing what's right for the patient, and for using her platform to advocate for patient safety," she explains.

Wiley adds that the incident was a hot topic at ENA's annual conference in St. Louis in September, and that Wubbels made a surprise appearance at the conference. Further, Wiley notes that while the situation in Utah appears to have

been grossly mismanaged, it presents an opportunity for ENA members to focus on patient safety and advocacy. "Secondly, we encourage emergency departments to open the lines of communication with hospital security and local law enforcement officials in a productive and meaningful manner," she says. "The police responsible for what happened to Alex should be held accountable for their actions. However, that situation is not indicative of our historically collaborative working relationship with law enforcement."

In fact, the ENA has reached out to the International Association for Healthcare Security and Safety (IAHSS) and the National Association of Police Organizations. Wiley says both organizations are supportive of efforts to work together with the ENA to ensure that a situation like the incident in Utah never happens again. "We are encouraged at the opportunity we have to collaborate with these groups on a common goal and additional education as needed," Wiley observes.

In addition to advocating for patient rights, there are other lessons emergency personnel can learn from the incident, Wiley offers. "Alex remained calm and professional. She knew to bring in hospital administration and to clearly communicate her hospital's protocols and procedures," she says. "Starting a conversation with hospital security and law enforcement now can help build relationships and education in an effort to prevent this type of situation from happening in the future."

In a statement about the incident, the American Nurses Association (ANA) offered harsh reviews of law enforcement's actions in this case. "It is outrageous and unacceptable that a nurse should be treated in this way for following her professional duty to advocate on behalf of the patient as well as following the policies of her employer and the law," said **Pam Cipriano**, PhD, RN, NEA-BC, FAAN, president of the ANA. "Nurse Wubbels did everything right. It is imperative that law enforcement and nursing professionals respect each other and resolve conflicts through dialogue and due process."

Be Professional

Generally, legal observers agree that the nurse in this case was correct to stand her ground. "We had a very experienced officer here, but it also sounds like [Wubbels] is an experienced nurse as well, which is fortunate," notes **Jennifer Brobst**, JD, LLM, an assistant professor of law at Southern Illinois University School of Law, serving as a faculty member in both the schools of law and medicine. "Had a nurse actually violated her own licensure ethics, she could lose her job."

The nurse is not beholden to law enforcement; she is beholden to the law and hospital policies, Brobst contends. However, from the video of the incident, Brobst believes that Wubbels could have done a better job in handling the arrest. "The video showed her kicking and screaming. Even if a person is inappropriately arrested, there is no reason to resist arrest. It is not going to help," Brobst advises. "That might be something to discuss because everyone is supposed to be a professional in that instance."

James Hodge, Jr., JD, LLM, director of the Center for Public Health Law and Policy at Arizona State University, suggests that it appears the police officers in this case were very focused on proving that the fiery accident was totally the fault of the fleeing suspect. At the same time, the nurse was just trying to do her job, he says. "She was put in a very difficult situation of having a rather forceful law enforcement officer demanding specific things without checking in with her superiors," he says. "As a result, you had a situation that across any ED on any given night in the United States could be replicated."

Hodge notes that when you take the incident apart, it appears that much of the dispute was driven by pure emotion. "That can always lead to regrettable consequences," he says. "It got emotional and sensational, and you see that sometimes."

Understand the Law

While nurses and physicians are entitled to protect the autonomy of their patients against any intrusions related to government interference, there are some caveats, Hodge explains. For example, if law enforcement has a warrant based on probable cause for a search, which in the Utah case would involve a blood draw, then the blood draw should proceed. "The warrant is what a judge issues pursuant to facts, and once that happens, the nurse or the physician must provide the sample. And that is with or without the consent of the patient," he says.

However, when there is no warrant, the law can be murky in the case of an unconscious patient who cannot provide consent. "There is a Utah state law that is replicated in a number of other places that has a very interesting facet to it," Hodge notes. "If you are a person who is within the realm of being suspected of being under the influence of drugs or alcohol or other substances and

driving on public thoroughfares in Utah or other states ... law enforcement is entitled under statutory law to imply that you consented to this blood draw."

In fact, the police officer in the Utah case, Jeff Payne, contended that there was implied consent to a blood draw, but Hodge notes that the unconscious patient in that situation didn't necessarily fit into the parameters of the law because he was not a suspect.

"If the person they were trying to draw flood from had been the actual fleeing suspect who was driving the vehicle that caused the collision, they would get that blood in a heartbeat," he says. "But the police weren't trying to get blood from a suspect. They were trying to get blood from a collision victim."

In fairness, Hodge notes that the Utah law is not crystal clear on precisely when police are entitled to a blood draw.

"That is where the problems arose, and most likely [the police officer] will lose on that point," he says. This is the case even though every minute counts on these types of blood draws, Hodge adds.

"If I were to walk into court with a blood sample that was withdrawn 24 hours after an accident in which a victim was harmed, it would be worth a lot less than a blood sample that was drawn one hour after the accident," Hodge explains. "You can see why the officers wanted access to [the blood sample], but you don't get it under those circumstances lawfully."

Hodge notes that the officers would have to get a judge to agree that there was probable cause to consider that this unconscious patient was at fault of criminal activity, but he notes that just being in a collision does not render probable cause for anything, especially when there is a fleeing suspect who is probably speeding down the highway. "That is the sort of thing where you have to look and ask whether the police have established any lawful basis for getting a non-consensual blood draw from a victim of a crime scene," Hodge notes. "The answer is generally no, and that is where things went wrong."

Provide Real-time Guidance

Hodge allows that the officer probably was under pressure from his superiors to get the blood sample without delays, but he was wrong to arrest the nurse as if she was resisting an active police investigation. "The foundations for that were highly derelict," he says.

"The reality is this went poorly, and I am sure you would [generally] want to have supervision and/or oversight at higher levels of discretion here."

To guard against such clashes, Hodge suggests EDs use this experience as an opportunity for review. "First, debrief completely your entire ED staff and exactly how to address this in the future," he says. "Second, always have on call at any point in time appropriate hospital executives tied into legal counsel who can instantly address the situation and be ready to provide real-time guidance, just as you would expect a physician on call to provide real-time medical guidance." Five minutes on the phone between the detective and the hospital's legal counsel might have produced a more positive outcome in the Utah case, Hodge offers.

A third piece of practical advice is to consider carefully how to handle volatile law enforcement personalities, Hodge adds.

"The detective [in the Utah case] had a lot of seniority who had been down this road before. He might have had multiple prior examples of hospitals resisting working with law enforcement," he explains. "He is not justified in what he did, but [it makes sense] to think about how hospital personnel might have better handled that volatile personality."

Sometimes, it is important to match a personality with the right arbitrator to makes things go better, Hodge observes.

"I don't think the hospital was caught off guard [in this case]. These were just two personalities that were not the right match for this specific circumstance," he says.

Review Policies, Procedures

The University of Utah Hospital already has implemented changes so that nurses no longer interact with police, although the hospital maintains that Wubbels' actions in this case were "exemplary." In the future,

hospital administrators will interact with police, according to Gordon Crabtree, the interim chief executive officer of the facility.

The hospital also has moved to bar police from patient care areas, although Brobst suggests this policy may be going too far.

"It might be feasible, but it is not pragmatic," she says, explaining that police often need to get statements expeditiously in the case of sexual assaults, shootings, and other incidents. "That seems like something [the hospital] might want to rethink."

Hodge agrees, noting that a judge can quickly overrule the policy. "I don't even know how a hospital would enforce that," he says.

The accident victim who was unconscious and receiving treatment in the burn unit at the hospital later died from his injuries.

Detective Payne and his supervisor have been placed on leave pending the results of both internal and criminal investigations. Salt Lake City police officials also are considering disciplinary actions. ■

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CME/CE QUESTIONS

1. **Trent Tankersley, BSN, RN, the director of the ED at St. Joseph Medical Center in Houston, explains that there was a big increase in volume to the ED following Hurricane Harvey, but the thing that really increased was:**

   a. congestion.
   b. confusion.
   c. the number of law enforcement officers.
   d. acuity.

2. **In the response to Hurricane Harvey, Tankersley also notes that the ED had a tremendous problem with patients who:**

   a. required dialysis.
   b. presented with mental health issues.
   c. were homeless.
   d. presented with addictions.

3. **Commenting on the dispute that resulted in the arrest of a Utah nurse, James Hodge, Jr., JD, LLM, the director of the Center for Public Health Law and Policy at Arizona State University, says that it appears that much of the dispute was driven by:**

   a. missteps on the part of the nurse.
   b. missteps on the part of the detective.
   c. missteps on the part of hospital security.
   d. pure emotion.

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2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

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UNITED STATES POSTAL SERVICE® **(All Periodicals Publications Except Requester Publications)**

1. Publication Title	2. Publication Number	3. Filing Date
ED Management	1 0 4 4 _ 9 1 6 7	10/1/17
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)*
950 East Paces Ferry Road NE, Ste. 2850, Atlanta
Fulton County, GA 30326-1180

Contact Person: Journey Roberts
Telephone *(Include area code)*: (919) 377-9913

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
111 Corning Rd, Ste 250, Cary, NC 27518-9238

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*
Publisher *(Name and complete mailing address)*
Relias Learning LLC, 111 Corning Rd, Ste 250, Cary, NC 27518-9238

Editor *(Name and complete mailing address)*
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The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
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13. Publication Title: ED Management
14. Issue Date for Circulation Data Below: September 2017

15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*			116	115
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	83	81
	(2)	Mailed In-County Paid Subscriptions Stated on PS Form 3541 *(Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)*	0	0
	(3)	Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS®	2	3
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c. Total Paid Distribution *[Sum of 15b (1), (2), (3), and (4)]* ▶			96	95
d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	5	5
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f. Total Distribution *(Sum of 15c and 15e)* ▶			106	105
g. Copies not Distributed *(See Instructions to Publishers #4 (page #3))* ▶			10	10
h. Total *(Sum of 15f and g)*			116	115
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Chief Operating Officer
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