CFDMC FSED Guidelines and Best Practices

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FSED Standards for Behavioral Health Management:

With an increase of behavioral health patients being seen in the ED, there are generally more patients than there are rooms designated to manage them. This has become a pressing concern, as the Emergency Nurses Association recently conducted a survey of nearly 500 members in which 56% of respondents said they had been physically or verbally assaulted or faced threats of violence in the 30 days prior. Ten percent of respondents said they're considering exiting the profession due to workplace violence.

Last year, reported assaults against nurses were up 5% compared to 2022, according to an April 2 Press Ganey Report on safety culture in healthcare. From 2022 to 2023, the rate of reported assaults against nurses jumped from 2.59 per 100 personnel to 2.71, an all-time high. The report also found that nearly a third of registered nurses report experiencing violence "occasionally" or "frequently" from patients or their family members while at work.

To address the challenge of managing the increasing number of behavioral health patients and to enhance the safety of both patients and healthcare providers, a practical solution involves the use of Flexible Equipment Management carts. These carts utilize a universal rail system allowing clinical team members to remove and strip rooms of devices and other potentially hazardous equipment. These carts will work with all conventional pre-installed headwall rail systems thereby facilitating on-demand transformation of any exam room into behavioral health "Safe Rooms". This approach not only maximizes the efficient use of available space but also ensures that the environment is adapted to meet the specific needs of behavioral health patients, reducing the risk of harm and improving overall safety and care delivery in the ED.

FSED Standards for Decontamination: FSEDs should have a built-in shower room and should check flow water periodically to test to make sure lines do not get stagnant and remain clear. See HCA Florida Osceola Hospital plan (attached).

Facility Guidelines Institute (FGI): It is recommended that the guidelines for Facility Design pertaining to the design of Free-Standing Emergency Departments (FSED) as published by the Facility Guidelines Institute (FGI) be adopted as best practice for our region. The FGI is a national standard which defines essential services and basic design requirements for a variety of facilities. These standards are updated every 4 years, with the next revision to be published in 2026.

Regional Best Practices:

Orlando Health:

- FSEDs should follow the CFDMC Minimum Equipment List to ensure they are outfitted and resourced appropriately.
- Everyone that works within a FSED should be patient decontamination trained so that anyone can assist with the decontamination of patients. This includes clinical, ancillary department, and nonclinical staff.
- The Nurse Operations Manager office should be established as the command site for the FSED. An alternative must be set-up at the nurses' station because the nursing leader may be needed on the floor to assist with the incident due to staffing.
    - Due to this the nurses' station should be equipped with a video conferencing system and technology to be able to call into the parent hospital's HICS room.
    - There should be a quick autodial telephone at the nurses' station, where if you pick up the telephone it auto dials the HICS Ops Chief at the parent hospital HICS.

- Due to the minimal staffing at FSEDs HICS should be minimal as all staff will be needed in patient care. So the command center at the FSED should only be a Hospital Command Post with just the Operations Chief.
- FSEDs should have the same level of communications as the parent hospital ED to include EMS radio and EMResource.
- The FSED needs to have enough water on hand to meet the Florida Building Code requirements.
- There should be a quick escalation response approach to where if an incident occurs the parent hospital immediately sends staff to assist with clinical are within the FSED as well as decon trained team members if decon is activated.
- There should be a quick escalation response approach to where if additional clinical staff are immediately needed within the FSED and none are available onsite or at the parent hospital that a 911 call is made to request EMT and/or paramedic assistances at the FSED.

AdventHealth Central Florida Division:

- Due to limited storage space at the FSED's, a reduced resource list is utilized to accommodate staff & patients. Water storage is critical and a plan to bring on more water must be emphasized since patient relocation could be delayed for various reasons.
- Staff is trained annually for decontamination procedures while simultaneously activating EMS for transport of patients to hospitals since FSED's are not postured for long-term care.
- Key staff are trained annually in HICS however FSED's do not have their own command centers. Command Centers are activated at their primary hospital and liaise with FSED senior staff as an extension of the CC to manage the incident. This is because the FSED does have the infrastructure to support a CC and the limited staff on hand will be heavily tasked with patient care.
- Communications methods mirror hospital capabilities (radios, mobile devices, virtual, etc.).

HCA Florida Osceola Hospital:

- Due to the limited amount of staffing at the FSED, we have deployed Lucas Devices to all of them to assist with cardiac arrest.
- See HCA decontamination standards below

HCA Florida Osceola Hospital Decontamination Standards:

SCOPE

This Water Safety Plan identifies the methods for preventing contamination of the free-standing emergency department water distribution systems, which could result in the growth and distribution of waterborne pathogens such as Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi). This plan is designed to ensure appropriate, effective responses to potential or confirmed incidents of waterborne diseases that could affect the safety of patients, staff, and visitors. This plan guides addressing risks that could impact the health of staff, patients, and visitors.

PURPOSE

Differences in water supplies, ambient environments, operational conditions, and other factors will determine the frequency of inspections and monitoring activities in the facility. This plan meets the intent of The Joint Commission standards to provide a safe care environment (see EC.02.05.02, Elements of Performance 1-4).

PLAN

A. Water system description

1. Hot, cold, and tempered wastewater is discarded through the sanitary sewer line.

B. Water risk management plan

    1. This plan addresses the use of water in buildings where water may have been stagnant for a period of time. Stagnant water is a significant concern in units housing immunocompromised patients. Actions to avoid stagnant water may consist of flushing.

    2. Immunocompromised patients are particularly vulnerable to Legionella infection, but also consider people 50 years or older; current or former smokers; people with chronic lung disease (COPD or emphysema); and people with underlying illnesses such as diabetes, kidney failure, or liver failure.

C. Management of control points: Develop monitoring protocols and acceptable ranges for control measures.

D. Monitoring: Conducting a planned sequence of observations or measurements of control measures' physical and chemical characteristics.

E. Control Point Monitoring:

    1. Control points can be any or one of the following: temperature permissive, stagnation, no disinfectant, conditions exist for bacteria spread, special considerations, and external hazards.

    2. The control point monitoring should include at least one of the following: visual inspections, disinfectant levels, and temperature. Any systems that are going under treatment must be monitored and recorded. Specific monitoring requirements may include but are not limited to:

        a. Cold Water Supply – As assigned based on risk assessment.

        b. Hot Water Storage (if applicable) – As assigned based on risk assessment.

        c. Hot Water Supply – As assigned based on risk assessment.

    3. The Program documents shall include the water treatment requirements to control microbiological activity, scale, and corrosion and shall also:

    4. Include the minimum required schedule for inspection, maintenance, and monitoring, and a corrective actions plan;

        a. Identify the minimum requirements for documenting system water treatment. Monitoring is based on the area/point. Complete the Quarterly Water Safety Management Reminder requirement to report control limits.

    5. Area or Point Condition:

        a. If the temperature is in the range of 77-108°F, determine the cause (potable water booster pump, exterior water supply pipe exposed to radiant heat, etc.) Determine a solution to reduce or increase water temperature outside this range and monitor accordingly.

        b. Aerosolizing condition. Verify that the temperature range is not within 77-108°F. If operating within this range, treat water to reduce waterborne pathogens. Monitor water treatment.

        c. Known exposure. Determine the root cause of the source, determine the solution to prevent future exposure, and monitor.

d. No flow conditions. Develop a process to recirculate water from that point back to the source, flush the no-flow area on a set frequency, or implement a treatment system to maintain water quality.

e. Known frequent disruption. If the water distribution system has areas that have demonstrated ruptures or breaks frequently, these areas shall be identified, and a plan for correction should be initiated. Coordinate with municipal water suppliers to determine the cause, establish a communication process for disruptions, provide flushing connections after restoration to prevent contamination of building water, and perform routine annual maintenance on backflow preventers.

F. Specific monitoring performance:

1. Showers and faucets. Your risk assessment shall determine the need for disinfection, descaling, or flushing of all fixtures.

G. Verification and Corrective Actions: When control points are operating out of the accepted measurable range, the facilities team must verify that the plan has been implemented as designed and that the facility is following the plan. Identify corrective actions and procedures to follow, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary. The activities must be documented and tracked according to the procedure requirement.

H. Program Validation

1. Clinical Legionella testing is based on physician clinical impression and epidemiological investigation for community or hospital onset pneumonia presentation. Expanding Legionella testing in specific patient populations may be necessary when outbreaks are suspected or confirmed.

a. Computerized Physician Order Entry diagnostic pneumonia order sets include check box options for Legionella testing.

b. Environmental validation (including water sampling) should be conducted with the guidance of Infection Prevention.

FSED MCI CHECKLIST

Conduct the following pre-planning activities on a routine basis:

- Designate an alternate(s) if the department head is unavailable.
- Develop, maintain and keep accessible a current emergency call list of team members.
- Review and update the department-specific plan.
- Ensure appropriate training of team members to ensure familiarization with the department's emergency response activities.
- Ensure equipment is procured, stored and maintained, and the location is communicated to all team members in the department.

Notifications:

- Notification may be communicated to the Hospital/Freestanding Emergency Department by EMS, fire department dispatch, through EMResource or when a large number of patients arrive unannounced by vehicle or foot.
- The team member receiving an MCI notification must complete the required forms, taking note of the algorithms to help estimate casualty numbers and acuity levels.
- The decision to implement the MCI Plan is based upon the following:
    - Type of incident.
    - Length of incident.
    - Number of patients presently being treated in the Emergency Department.
    - Number of casualties and severities expected.
    - Current patient throughput.
    - Number of additional team members and equipment needed to implement the plan.
- To assist EMS with making transport decisions, facilities must routinely update EMResource. Information must include the total number of acuity types of patients the facility can accept (T-Cap), bed availability levels and current census.
- During the mass casualty incident, EMResource must be updated as follows:
    - ED/Freestanding Emergency Department provides updates to HICS on capacity.
- HICS Incident Commander (IC)/Operations Chief or designee updates facility status on EMResource.
- Updates to AHCA ESS must be made through the affected site's Administrative Supervisor (for hospitals), senior nursing leader (for Freestanding ED's), or their designees.
- Notifications to local city/county Emergency Operations Centers (EOC) for additional resource requests must be made through Corporate Emergency Management.
- Essential hospital services in non-hospital facilities must be continued during an MCI unless the Incident Commander determines otherwise.

Activation of an MCI – Standby:

FSED:

- After the initial notification and subsequent verification of a possible MCI, the Administrative Supervisor and/or Administrator on-call must activate the MCI – Standby Plan.
- Upon implementation of the MCI Plan, the Administrative Supervisor or the Administrator on-call must notify the PBX Operator or facility specific contact.
- If there is a potential for, or it is confirmed that the incident involves, a contaminant the Administrative Supervisor and/or Administrator on-call must initiate a decontamination team activation in accordance with facility plan.
- After the initial notification and subsequent verification of a possible MCI, the senior nursing leader must:
    - Ensure all building occupants are aware of an MCI – Standby activation through one the following actions:
    - Call the PBX operator immediately or use a facility-specific direct-dial number
    - Use verbal notification
    - Use runners within the facility
    - Use any other means
- Team members shall secure the facility.
- The Administrative Supervisor at the parent hospital must notify Security at the parent hospital.
    - Security must notify:
    - Security Manager
    - Corporate Emergency Management or On-Call Duty Officer
    - Media Relations
    - Director of Safety
- The site nursing leader must activate the Hospital Incident Command System (HICS).
- Each department must implement their staff call lists and prepare their department for activities associated with receiving mass casualties, such as:
    - Preparing designated patient receiving areas such as red, yellow, green and black acuity areas. This may require notification to Conference Services for assistance in the immediate preparation of previously identified acuity areas.
    - Diagnostic areas prepare to handle multiple treatments.
    - Ancillary departments prepare to contribute manpower and/or supplies and deliver equipment (e.g. stretchers, wheelchairs, IV poles etc.) to designated patient treatment areas.
    - Clinical areas prepare for the rapid discharge of patients.
    - Determine bed availability, to support decision-making by the HICS.
    - Reporting status to site nursing leader and/or HICS

Activation of Mass Casualty Incident (In Effect)

- The Emergency Department shall notify the senior nursing leader that patients have been received.
- If not previously activated, the senior nursing leader must activate HICS, assume the role of Operations Chief and verbalize they are in command.
- The Operations Chief must notify:
    - 911 and request Emergency Medical Services. Where the incident has the potential to involve a contaminant, a request for Hazardous Materials (HazMat) team support must be made.
    - Building occupants using through calling the PBX operator or the designated facility specific number, through verbal notifications, use of runners within the facility, or any other means necessary.
    - The parent hospital Administrative Supervisor that the MCI Plan is in effect.

Other Considerations:

Patient Registration – document in facility EMR or on paper:\

- Patient Name
- Medical Record Number
- Emergency contact
- Approved visitor(s)
- Arrival Date/time
- Disaster acuity/color
- Patient nationality
- Revenue location

HICS:

- Expanding treatment areas to other areas of the hospital/campus (e.g., creating additional outpatient capacity in on-site clinics, same-day surgery, or observation/short-stay areas).
- Increased throughput by reducing length of stay (e.g., expedited charting, moving patients to “results pending” area after tests obtained).
- Expanded hours and capabilities of on-site clinics.
- Planned early/coordinated discharge for both inpatients and outpatients.
- Coordinated with local healthcare coalition, emergency operations center, emergency medical services dispatch or communications system, if possible, to manage patient distribution throughout the community.

Triage:

- An attending emergency physician and/or surgeon and an ED nurse shall serve as triage officers (initial triage) at the ED designated receiving entrance. The site must consider self-deployed victims, who may attempt to enter the facility by other entrances
- The Physician Triage Officer shall act as a Medical Director in determining patient category. Red, yellow, green, and black acuity colors are used to determine the severity of trauma.
- A Patient Access Office Representative(s) shall assign ED charts at Triage. The record must go with the patient to the treatment area.
- Victims shall be assessed for likelihood of exposure to another person's blood when a mass casualty incident has occurred. When there is a possibility of a blood exposure Infection Prevention and Control shall be notified to assess the level of exposure and outline appropriate post exposure protocols for the patients at risk.
- Triage shall continue until the emergency situation is declared over and all patients have been received.

Internal Surge Capacity Response:

- Patients should be directed to designated patient care areas.
- The Hospital Incident Commander/Hospital Command Location shall reassign appropriate team members to patient care areas as needed.
- The Hospital Incident Commander/Hospital Command Location shall identify surge areas.
- Tiered staffing may be implemented to accommodate surge capacity in critical care and step-down areas.

Altered (Crisis) Standards of Care:

- Dependent on the scope of the incident, there is the possibility that standard of care may need to be temporarily altered to provide the greatest amount of care possible to the greatest number of people possible.
- Special considerations must be given to any circumstance where altered standards of care may be needed. Ethical issues concerning how decisions will be made in the event healthcare be done in consultation with:
    - Hospital Incident Commander
    - Corporate Emergency Management
    - Chief Medical Officer or designee
    - Chief Nursing Officer or designee
    - Legal Counsel
    - A critical care expert
    - A clinical ethics expert
    - A social worker
    - A chaplain
    - A person with a disability
    - Pediatrician (where pediatric patients are involved)
- None of the consulting team members identified in section IV.K.2 shall be directly involved in the care of any patient(s) being evaluated by the team.
- Any decisions made by the team to alter standards of care shall be communicated to:
    - County EMS Medical Director

- Local Emergency Operations Center(s)
- Local and State Department of Health
- AHCA

Death Notifications:

Non-Medical Examiner Cases:

- Physicians shall inform families of a death in the first instance. However, where circumstances prevent a Physician from performing this duty, and to reduce potential trauma to families caused by delays in information sharing, the Physician shall request assistance from Chaplaincy.
- When possible, the Chaplain shall be supported by the Charge RN.

Medical Examiner Cases:

- Follow hospital specific procedures for notifying medical examiner

Worried Well Staging Areas:

- Each impacted facility HICS must designate an area to be used as a "worried well/walking well" staging area. These locations must be used for staging areas for individuals believing they are ill or experiencing illness but are displaying no symptoms to that effect.
- These locations should be separate from the area designated for people needing to find information regarding individuals admitted into the facility.
- Security and Guest Services shall assist in routing people to these locations.

Patient Distress:

- Patients may see news reports of a mass casualty incident and become anxious. Staff on clinical units should perform regular rounds to provide additional support, reassurance and guidance where possible, as in:
  - Suggesting patients reduce the quantity of information they're exposed to by changing the television channel to something else. This will lessen their potential to be impacted by media overload.
  - Recommend they wait for official statements from local authorities, rather than accepting media statements that may be inconsistent/inaccurate.
  - Where patients have loved ones who may have been impacted by the MCI clinical staff must bring this to the attention of Patient and Family Counselors who shall assist the patient in making phone calls, where required.

Incident Termination:

The Operations Chief must notify the "all clear" when the incident is over, as follows:

- The Operations Chief must notify the parent hospital Administrative Supervisor.
- The Operations Chief must notify building occupants.

Recovery Actions:

- The Hospital Incident Commander/Operations Chief will determine whether team member assistance is needed and, where necessary, activate the Critical Incident Response protocol and team.
- The Hospital Incident Commander/Operations Chief must coordinate a Critical Incident Response Team debriefing session and Emergency Management Department hotwash discussion within 24 hours post incident.
- All departments, Incident Command Locations, and all areas affected by the implementation of this plan shall provide a written critique utilizing the Emergency Incident Critique Form on Swift Corporate Emergency Management within three working days. Any additional pertinent information not specifically included on the critique must also be submitted to help evaluate the performance of the overall plan.
- Departments that responded to the incident shall coordinate with Administration to provide stress debriefing for involved staff.
- The Hospital Incident Commander/Hospital Command Location must ensure all documentation is completed.

The Hospital Incident Commander must consider a status change on EMResource to a high census alert.

Triage Tag Training

https://vimeo.com/1109039806/9dca107c26?share=copy

Coming Soon: Trauma/Burn training video

Coming Soon: FSED MCI Cart List

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