Active Shooters in the Hospital Setting

Presented by
Rosemarie Savino, RN, BSN, MJ, CPPS
Objectives

- Define active shooter and Code Silver
- Profile of an Active Shooter
- Recognize potential workplace violence indicators
- Inherent Hospital Risk Factors
- Discuss Johns Hopkins Study and Statistics
- The Joint Commission standards
- Incorporating Active Shooter Incident Planning Into Health Care Facility Emergency Operations Plans
- Ethical challenges
The Active Shooter Defined

An “Active Shooter” is an individual engaged in killing or attempting to kill people in a confined and populated area, in most cases, active shooters use firearms.
Active Shooter Event

- Highly dynamic, rapidly evolving
- Staff and public have the potential to affect the outcome of the event based on their responses. (FBI, 2014)
- “Code Silver” term widely used for Hospitals
Code Silver (Weapon / Hostage)

- A weapon is defined as any firearm, knife, or instrument that can cause bodily harm or injury.

- If a person is found (or suspected) of having a weapon, call emergency number immediately.

- If someone is being held hostage, call emergency number immediately.

- Seek cover and warn others of the situation.
Profile of an Active Shooter

http://www.buildings.com/Portals/1/images/Magazines/2014/0314/B_0314_HardenBuilding1.jpg
RECOGNIZING POTENTIAL WORKPLACE VIOLENCE
Indicators of Potential Violence by an Employee

- Increased use of alcohol and/or illegal drugs
- Unexplained increase in absenteeism; vague physical complaints
- Noticeable decrease in attention to appearance and hygiene
- Depression / withdrawal
- Resistance and overreaction to changes in policy and procedures
- Repeated violations of company policies
- Increased severe mood swings
- Noticeably unstable, emotional responses
- Explosive outbursts of anger or rage without provocation
- Suicidal; comments about “putting things in order”
- Behavior which is suspect of paranoia, (“everybody is against me”)
- Increasingly talks of problems at home
- Escalation of domestic problems into the workplace; severe financial problems
- Talk of previous incidents of violence
- Empathy with individuals committing violence
- Increase in unsolicited comments about firearms, other dangerous weapons and violent crimes

Source: DHS Active Shooter Booklet
Inherent Hospital Risk Factors

- Increasing number of acute and chronically mentally ill patients being released without f/u care
- The availability of drugs or money in hospital or clinic
- Public Building-unrestricted movement in most areas
- Presence of Street gangs in some locations
- Trauma patients are many times victims of violence
- Distraught family members
- Domestic disputes which may spill into the work environment
- Low staffing levels during periods of increased activity
- Isolated work with clients
- Remote locations
- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior
“Chaos, panic and fear can only be minimized - never eliminated - when it is preceded by preparation and planning.”

Capt. George Deuchar, Law Enforcement Training Consultant
Johns Hopkins Hospital
Hospital-Based Shootings in the United States: 2000 to 2011

Gabor D. Kelen, MD, Christina I. Callcott, MD, Ichhuan G. Kubit, MD, Yu-Hsiang Hsieh, PhD
From the Johns Hopkins Office of Critical Event Preparedness and Response, Johns Hopkins Institutions, Baltimore, MD (Kelen, Callcott); the National Center for the Study of Hazards and Catastrophic Event Response, Johns Hopkins University, Baltimore, MD (Kelen, Callcott, Hsieh); and the Department of Emergency Medicine, Johns Hopkins University School of Medicine, Baltimore, MD (Kelen, Callcott, Kubit, Hsieh).

Study objective: Workplace violence in health care settings is a frequent occurrence. Emergency departments (EDs) are considered particularly vulnerable. Gunshots in hospitals is of particular concern; however, information about such workplace violence is limited. Therefore, we characterize US hospital-based shootings from 2000 to 2011.

Methods: Using LexisNexis, Google, Medscape, PubMed, and ScienceDirect, we searched reports for hospital-based shooting events in the United States for 2000 through 2011. All hospital-based shootings with at least 1 injured victim were analyzed.

Results: Of 9,360 search "hits," 154 hospital-related shootings were identified, 91 (59%) inside the hospital and 63 (41%) outside on hospital grounds. Shootings occurred in 40 states, with 23% injured or dead victims. Perpetrators were overwhelmingly men (92%) but represented all adult age groups. The 33 offenders were the most common site (29%), followed by the parking lot (29%) and patient rooms (19%). Most events involved a determined shooter with a strong motive as defined by grudge (27%), suicide (21%), "outpacing" an ill relative (14%), and personal escape (11%). Ambient society violence (9%) and mentally unstable patients (4%) were comparatively infrequent. The most common victim was the perpetrator (45%). Hospital employees comprised 29% of victims; physician (3%) and nurse (6%) victims were relatively infrequent. Event characteristics that distinguished the ED from other sites included younger perpetrator, more likely in custody, and unlikely to have a personal relationship with the victim (ill relative, grudge, coursework). In 29% of shootings within the ED, the weapon was a security officer’s gun taken by the perpetrator. Casualties inside the hospital were much lower in the ED setting (19%) than other sites (79%).

Conclusion: Although it is likely that not every hospital-based shooting was identified, such events are relatively rare compared with other forms of workplace violence. The uncountable nature of this type of event represents a significant challenge to hospital security and effective deterrence practices because most perpetrators never determined and a significant number of shootings occur outside the hospital building. (Ann Emerg Med. 2012; 60(2).)

Please see page XIX for the Editor’s Capsule Summary of this article.
Location of Incidents at the Hospital/Healthcare Facility:
The locations of incidents at the hospital varied, but the majority of incidents occurred in the Emergency Department treatment area, waiting areas, or immediately outside the ED, followed by inpatient areas.
The Joint Commission Accreditation Standards

- Emergency Management
- Environment of Care
- Human Resources
- Leadership
- Provision of Care
- Performance Improvement
Since January 2010, The Joint Commission has received reports of:
19 shootings that resulted in more than 27 deaths.
The Joint Commission and Emergency Management

Incorporating Active Shooter Incident Planning Into Health Care Facility Emergency Operations Plans

Four phases of emergency management:
- Mitigation
- Preparedness
- Response
- Recovery
Emergency Operations Plan

https://www.fema.gov/national-preparedness-cycle
Run  Hide  Fight

http://www.brighamandwomens.org/publicaffairs/Images/Bulletin2013/ActiveShooterScreenGrab.jpg
Ethical Challenges

- Allocate resources fairly with special consideration given to those most vulnerable
- Limit harm to the extent possible. With limited resources, healthcare professionals may not be able to meet the needs of all involved
- Treat all patients with respect and dignity, regardless of the level of care that can continue to be provided them
- Prepare to decide to discontinue care to those who may not be able to be brought to safety in consideration of those who can
- Realize some individuals who are able to avoid the incident will choose to remain in dangerous areas. Consider how to react to those situations
- To the extent possible, think about the needs of others as well as yourself. Consider the greater good as well as your own interests
Chaos, panic and fear can only be minimized - never eliminated - when it is preceded by preparation and planning.

Capt. George Deuchar, Law Enforcement Training Consultant
QUESTIONS

Rosemarie Savino, RN, BSN, MJ, CPPS
Patient Safety Specialist
Office of Quality and Patient Safety
The Joint Commission
rsavino@jointcommission.org
References

- **Quick Safety - Issue Four, July 2014**: Preparing for active shooter situations
- **Active Shooter Planning Emergency Operations Plan** - (DHHS, FEMA, FBI - 2014)
- **Incorporating Active Shooter Incident Planning Into Health Care Facility Emergency Operations Plans** The Departments of Homeland Security and Health and Human Services
- 2016 Comprehensive Accreditation Manuals The Joint Commission
- Hospital-Based Shootings in the United States: 2000 to 2011 Gabor D. Kelen, MD, Christina L. Catlett, MD, Joshua G. Kubit, MD, Yu-Hsiang Hsieh, PhD
- **From the Johns Hopkins Office of Critical Event Preparedness and Response, Johns Hopkins Institutions, Baltimore, MD**