

Assessing Active Shooter Preparedness in U.S. Hospital Systems

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Table of Contents

Introduction 3
Key Findings & Insights 4
Next Steps..... 6
Methodology 6
Contributors 6

A full version of this report can be found at the [American Journal of Disaster Management](#).

Introduction

An active shooter event is horrifying, tragic and an unfortunate common reality in the United States. Hospitals represent unique targets of opportunity for active shooter events, as they have many visitors and staff and a considerable building footprint with multiple entrances. **National data** show that active shooters who target hospitals are likely to have a personal connection to the hospital; these individuals may have worked at the hospital in the past, received care themselves, or had a family member treated at the hospital.

Multiple government agencies (including the Federal Bureau of Investigation and the Federal Emergency Management Agency) have published guidelines designed to assist hospital systems in preparing mitigation strategies to counter the threat of active shooter crises. **Occupational Safety and Health Administration guidelines**, last published in 2016, advocate a “run-hide-fight” approach that prioritizes fleeing from an active shooter scene as a first principle and leave much to be desired in protecting hospitalized patients. But this strategy falls short in safely caring for many patients who cannot be expeditiously evacuated. A “secure-preserve-defend” model seeks to provide continuity of care for patients who cannot be escorted out of harm’s way in an active shooter situation.

The contrast between “run-hide-fight” and “secure-preserve-defend” illustrates the complexity of the multiple decisions needed to protect patients in an active shooter situation. Furthermore, it remains unknown what policies, if any, exist regarding the orderly care and protection of critically ill patients who could not quickly evacuate in an active shooter crisis.

To better understand hospital systems' protocols to prepare for active shooter situations and more specifically, how to manage patients that are not able to be evacuated, Vizient collaborated with clinical executives from the Vizient Networks to conduct a web-based survey in June 2022.

Key findings from the survey, emailed to 294 hospital leaders of which 60 responded, include about one-third of hospital systems have experienced an active shooter event in the past. Over 98% of hospital systems respondents have enacted an active shooter protocol, but management practices in these situations varied substantially. Responses existed on a spectrum between “run-hide-fight” and “secure-preserve-defend.” Of those hospital systems with dedicated plans for critically ill patients, approximately 35% utilize a “run-hide-fight” paradigm. Hospital systems that had experienced an active shooter event in the past were more likely to practice active shooter response simulations than those health systems that had never experienced an active shooter event.

The conversation surrounding hospital protocol for active shooter preparedness is uncomfortable but vitally necessary. Generating plans to care for critically ill patients, practicing protocols and staging life-saving equipment in strategic locations will invariably save the lives of patients, families and staff. While most hospitals are already committed to putting active shooter protocols in place, now is the time to refine with consideration for patients who can’t be evacuated and actively practice these protocols on an ongoing basis.

“The potential for gun violence occurring within hospitals are a tragic reality that health systems across the U.S. must now be prepared for.”

Susan Chishimba, Vizient Senior Network Director

Key Findings & Insights

About one-third of hospital systems surveyed have experienced an active shooter event in the past. Two of these incidents involved a single gunman firing indiscriminately with multiple casualties. However, most incidents involved a targeted attack in which the attacker singled out a particular person, generally a coworker. Other key findings from the survey include:

Finding #1 — Active Shooter Protocol & Emergency Preparedness:

Over 98% of hospital systems participants have enacted an active shooter protocol. Most respondents (70%) stated that this plan was devised in coordination with local or national law enforcement agencies with the incorporation of best practice guidelines. Fifty-two percent of hospital systems routinely practice active shooter drills to ensure that staff members are well-versed in these protocols.

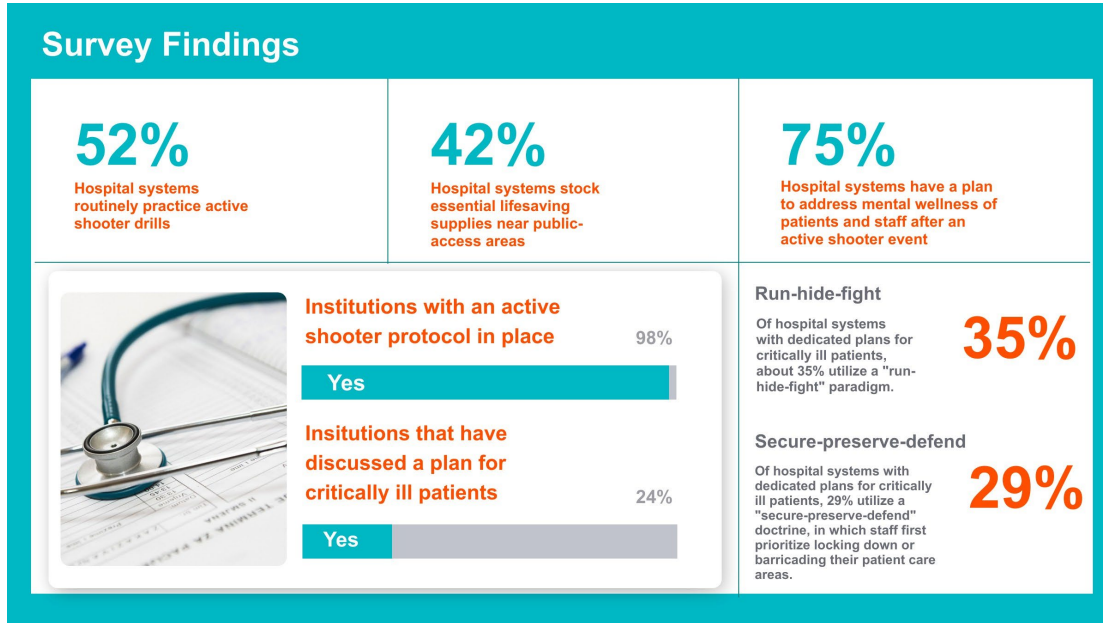
Regarding emergency preparedness for active shooter events, 42% of hospital systems stock essential lifesaving supplies near public-access areas. These supply kits typically include tourniquets, gauze and gloves, among other necessities. These items are staged near entrances, exits and the Emergency Department. Approximately 41% of hospital systems train hospital employees (both medical and non-medical) in hemorrhage control techniques, including the American College of Surgeons [Stop the Bleed®](#) training program. Several respondents mentioned that these classes are offered to hospital personnel but are not mandatory.

Finding #2 — Care for Immobile Patients:

Twenty-four percent of hospital systems have discussed a dedicated plan to ensure continuity of care for patients who are critically ill or otherwise immobile (in active labor, in the operating room, receiving hemodialysis treatment or ventilator dependent).

Management practices in these situations varied substantially ranging on a spectrum between “run-hide-fight” and “secure-preserve-defend.” Of those hospital systems with dedicated plans for critically ill patients, approximately 35% utilize a “run-hide-fight” paradigm. Respondents describe protocols in which staff attempt to evacuate patients to a secure location, if possible, shelter in place if needed, or fight if all else fails. Conversely, 29% of respondents stated that their hospital protocol aligns with the “secure-preserve-defend” doctrine, in which staff first prioritize locking down or barricading their patient care areas. The remaining respondents described a combination of these two doctrines to varying degrees.

With 76% of hospital systems not having a dedicated plan to manage critically ill and otherwise immobile patients in the event of an active shooting represents a significant opportunity for improvement in U.S. hospitals. In an active shooter situation, healthcare workers experience considerable emotional distress, leading to potentially suboptimal decision-making in providing care for these patients. A clear pre-existing protocol would ease some of the cognitive load required of healthcare workers in these situations.



Regardless of mitigation strategy, the reality of the active shooter situation is that some healthcare workers will be exposed to significant danger in caring for patients. But the expectations for these healthcare workers vary; some organizations believe doctors and nurses have a special duty to protect their patients while others think that accepting personal risk exceeds the limits of duty and is not a moral obligation but an option. Leaving staff behind to continue caring for patients is a controversial topic but bears mentioning as a possible component of hospital active shooter protocol.

Beyond leaving employees to stay and provide care for patients, hospital systems and providers must consider the medical response to casualties injured in the active shooter event. These violent, chaotic events often require the response of a code team or trauma team to treat injured victims. However, if too many personnel respond, the likelihood of these individuals becoming caught in the crossfire increases. It is incumbent on hospital systems to clearly notify staff that an active shooter event is transpiring and ensure that only those individuals tasked with responding to code situations arrive on the scene.

Finding #3 — Impact and Aftermath of Active Shooter Events:

Hospital systems that had experienced an active shooter event in the past were more likely to practice active shooter response simulations than those health systems that had never experienced an active shooter event. Of the hospital systems that experienced an active shooter event, 71% run routine drills. Conversely, of the hospital systems that have never experienced an active shooter event, 43% run routine practice drills.

Regarding the psychological aftermath, 75% of hospital systems have a plan to address the mental wellness of patients and staff after an active shooter event. Of those hospital systems with a codified psychological wellness plan, 90% described detailed strategies for connecting employees with dedicated employee assistance programs. Many institutions also refer patients and staff to dedicated trauma counselors and chaplain services. Several respondents cited the importance of debriefing and the significance of dedicated peer support with peer counselors after these events.

Next Steps

The conversation surrounding hospital protocol for active shooter preparedness is uncomfortable but vitally necessary in the U.S. Preparing for this worst-case scenario demands a significant investment from the hospital and staff, and straightforward solutions are rarely available. Generating plans to care for critically ill patients, practicing protocols and staging life-saving equipment in strategic locations is not without an upfront cost. These actions, however, will invariably save the lives of patients, families and staff. Most hospitals are already committed to putting active shooter protocols in place. It is now time to refine and actively practice these protocols on an ongoing basis.

Methodology

The objective of this study was to survey U.S. leaders at acute care hospitals regarding standard policies and practices currently utilized in response to active shooter crises, specifically seeking insight regarding policies related to managing critically ill or otherwise immobile patients in these scenarios.

The targeted audiences were hospital chief executive officers, chief medical officers, chief nursing officers and other executives who directly influence hospital policy. The electronic survey was posted to Vizient member provider forums, including Ambulatory, Medical, Nursing, Accreditation, Risk Management, Perioperative, and Cardiovascular. In total, these forums comprise 294 participating hospital systems. Forum members were emailed directly and invited to participate in the survey. Representatives from 60 of these organizations responded to the study.

There was a bimodal distribution in the data regarding hospital size; the most significant percentage of hospital systems — about 45% of respondents — comprised more than 425 beds, while 38% of hospitals comprised 249 beds or fewer. Over half of the hospital systems were community-based, while 38% were academic teaching hospitals. The remaining hospitals represented a hybrid of the two classifications.

The web-based survey assessed current active shooter protocols in U.S. hospital systems and consisted of 11 multiple-choice questions with multiple opportunities for participants to provide in-depth written responses. Repor Prospective participants were provided with a description of the project and its objectives, pertinent definitions of key concepts (for instance, distinguishing between “run-hide-fight” and “secure-preserve-defend” policies), and a link to the secure survey.

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