

GERIATRIC EMERGENCY PREPAREDNESS AND RESPONSE (GEPR)  
WEBINAR SERIES 2015  
STRENGTHENING PREPAREDNESS AND RESILIENCE CAPABILITIES  
IN VULNERABLE OLDER POPULATIONS  
SESSION TWO

Sponsor: The GEPR Collaborative  
Host: Stanford Geriatric Education Center  
Webinar Coordinator: Melen McBride, PhD, RN, FGSA



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“ACTIVE SHOOTER” RESPONSE AND BEHAVIORAL IMPACT IN LONG TERM  
CARE AND ASSISTED LIVING COMMUNITIES – PART 2  
APRIL 22, 2015

Presenters

**Judith A. Metcalf, APRN-BC, MS, FMGS**  
Director, University of New England, Maine Geriatric Education Center  
Nurse Practitioner, UNE Mature Care  
University of New England School of Community and Population Health

**Kathy Knight, RN, BSN, CHEC**  
Director, Eastern Maine Healthcare Systems (EMHS), Center for Emergency  
Preparedness, Northeastern Maine Regional Resource Center (NE-MRRC), and  
Northeastern Maine Medical Reserve Corps



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Judith A. Metcalf, APRN, BC, MS

Judith A. Metcalf is Principle Investigator and Director of the University of New England Maine Geriatric Education Center. Ms. Metcalf has her Bachelors in Nursing from Salem State College, Salem, Massachusetts, her Masters from Boston University and her Post-Masters Adult Nurse Practitioner Certification in Primary Health Care Nursing from Simmons College Boston, Massachusetts.

- Ms. Metcalf has directed the programs of the UNE-MGEC since 2003. Focus areas include evidence based practice falls and quality of falls care team training for emergency department health professionals, geriatric health literacy collaborative team training, Living Art – Living Well Studio for health professionals and emergency preparedness training for health professionals in long term care and assisted living communities. UNE-MGEC is also one of six HRSA funded GECs that are members of the Geriatric Emergency Preparedness Response (GEPR) Collaborative. Her position, as Director of the UNE-Maine GEC is complemented by her involvement in the UNE Mature Care Practice as a nurse practitioner providing primary care to older adults in residential, assisted living, rehabilitation and long term care settings.
- She serves on several national and statewide committees and boards. She is currently President of Dirigo Maine Geriatrics Society.



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### Kathy Knight, RN, BSN, CHEC

- Kathy Knight is the director of the Northeastern Maine Regional Resource Center (NE-MRRC), the EMHS Center for Emergency Preparedness, and the Northeastern Maine Medical Reserve Corps.
- Since 2004, she has worked in partnership with Maine Centers for Disease Control (MeCDC) and 21 regional hospitals to develop local, regional and state-wide Medical, Behavioral and Public Health Emergency Preparedness and Response Plan for the northeastern area of Maine. She facilitates the assessment of resources and regional needs, engages in all-hazards emergency and bio-event planning efforts with stakeholders, develops, coordinates and conducts disaster exercises, provides consultative services to healthcare organizations and businesses, lectures nationally and coordinates education and training offerings.
  - Kathy worked 23 years in EMMC's Emergency Department in a variety of positions as nursing staff, department nurse manager, hospital emergency preparedness coordinator and staff developer. She is actively engaged in volunteer activities with the Critical Incident and Stress Management Team, Northeastern Maine Medical Reserve Corps, State of Maine Disaster Behavioral Health Team, and the Central Maine Incident Management Assistance Team.
  - Kathy obtained and managed the Comprehensive Continuum of Care Operational Preparedness and Emergency Response (CCOPER) Grant to improve the level of preparedness among Long Term Care Facilities, Home Healthcare Agencies, Hospices and Residential Care Facilities by developing standardized templates for emergency management plan, training and educational offerings and integrating these organizations into the traditional emergency response community.



### Background

- National Association of Geriatric Education Centers Initiative**  
**Geriatric Emergency Preparedness, Response (GEPR) Collaborative**
- . **2001 – 02: National Association of Geriatric Education Center (NAGEC)** surveyed GECs; presented position statement to HRSA on the need for geriatric emergency preparedness training
- . **2004 – now: HRSA funded 6 GECs (CA, KY, MO, NY, OH, TX), initially called** the Bioterrorism Emergency Preparedness in Aging (BTEPA) , developed interprofessional training for health professionals; continues its work today as the
- GEPR Collaborative ~ **Consortium of NYGEC, Ohio Valley Appalachia Regional GEC, University of Kentucky, Saint Louis University Gateway GEC of MO & ILL, Stanford GEC, Stanford University, Texas Consortium GEC, and University of New England, Maine GEC.**



### Background

- National Association of Geriatric Education Centers Initiative**  
**Geriatric Emergency Preparedness, Response (GEPR) Collaborative**
- . **2010-2015: GEPR committed to offer inter-professional geriatric** preparedness programs through GECs' HRSA funded educational activities.
- . **2010-2015: Three members of the Collaborative formed a national** consortium to provide a Webinars Series on Geriatric Emergency Preparedness hosted by Stanford GEC. The Ohio Valley Appalachia Regional GEC, University of Kentucky, the University of New England, Maine GEC, and Stanford GEC has offered four session and will have two more this year and six others on various topics in geriatric preparedness through the SGEC/GEPR Webinar Series program.



### Background

UNE Maine Geriatric Education Center & EMHS Center for Emergency Preparedness collaboration.



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### Learning Objectives



- Identify at least 2 possible indicators for a potential “active shooter” situation in a LTC facility.
  - Describe constructive strategies that can be adapted in LTC facilities to prevent or prepare for a potential “active shooter” situation.
  - List at least 3 ways that LTC personnel can assist law enforcement responders during a crisis.
- Describe the impact of the “Active Shooter” event on organization, employees, residents and family members.
  - Identify strategies to manage the behavioral health impact on an organization, organizational employees, residents and family members following an “Active Shooter” event.



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### What Would You Do?

It is lunchtime at the your facility and the staff are assisting residents with their meals. You glance up and observe a noticeably agitated adult male entering the building. He is wearing a jacket and carrying a duffle bag. As he enters through the front door, you recognize him as “John Smith”, a disgruntled employee who had recently been terminated as a result of several altercations with the nursing home administrator.



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What Would You Do?

John enters the administrators office and is overheard angrily addressing her. His voice begins to escalates in volume as he becomes more agitated. You hear him yell, "You can't do this to me!"



Suddenly, you hear loud screams and "popping noises". You stand frozen in place by shock and disbelief. Other personnel in the immediate vicinity rush into the hallway to see what is going on.



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What Would You Do?

As John turns to leave the superintendent's office, he spots the people in the hallway, raises his weapon and begins firing rapidly. People begin screaming and trying to run away. The scene unfolds in what seems to be slow motion. It is utter chaos. Thirty seconds later, John has fired an entire magazine of ammunition and 5 people lay dead or injured.



**He reaches into his bag, pulls out another clip, and begins to reload.....**



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Could it happen to you?



In the time you have worked at your organization, has there been at least one incidence where you thought a co-worker, patient or visitor was contemplating attacking another person?



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### Content

- **Statistics** related to active shooter events in healthcare settings.
- **Preparing** for an active shooter situation.
- **Preventing** an active shooter situation.
- **Responding** to an active shooter situation.
- **Interacting** with First Responders.
- **Impact** of an active shooter situation.
- **Intervention** for post-event behavioral health needs



### Active Shooter Definition

An individual actively engaged in killing or attempting to kill people in a confined or populated area.



### FBI Report (Published September 16, 2013)

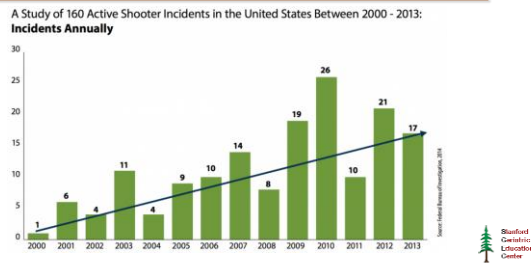
- **Scope:**
  - 160 “active shooter” incidents from 2000-2013
  - All venues
  - Excluded gang or drug related violence
- **Conclusion:**
  - All but 6 incidents involved male shooter (Only 2 involved more than one shooter)
  - Average of 6.4 incidents annually in first 7 years of study
  - Average of 16.4 incidents annually in final 7 years of study
  - 66.9 % of incident ended prior to arrival of police at the scene (suicide, fleeing the scene, etc.).
  - Law enforcement officers were killed or injured 50% (21 out of 45 incidents) of the time when they were able to engage the shooter.



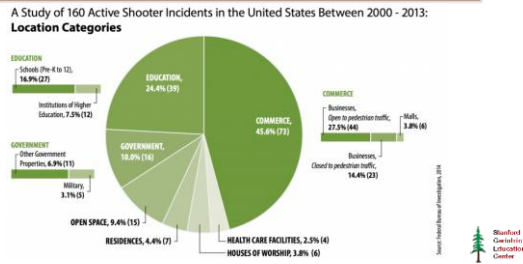
Overview of Findings



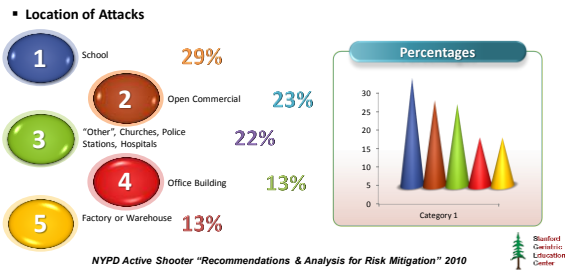
Incidents Annually



Location Categories



Active Shooter Venues NYPD



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Active Shooter Venues



Although active shooter situations are typically associated with schools, the threat of an active shooter exists in any type of facility.



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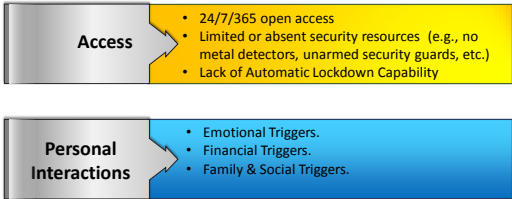
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Vulnerabilities of Healthcare Settings



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### Security & Workplace Violence

"Impenetrable hospital security in an open society represents a particular challenge, and zero risk is not achievable."  
*The Joint Commission*

"Like it or not, every organization is vulnerable to workplace violence, regardless the size or type. An incident of workplace violence can be devastating to an organization – to its bottom line, to employee morale, to employee retention and recruitment, and to its reputation and brand."  
*Chubb, "Managing Threats of Violence in the Workplace" 2012*



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### Workplace Violence

- Healthcare professionals are 16 times more likely to be attacked on the job than any other service professional.
- 80% of attacks on healthcare professionals go unreported.
- Nurses experience workplace crime at a rate of 72% higher than medical technicians and at more than twice the rate of other medical workers.
- NIOSH reports an average of 69,500 assaults against nurses annually.

*"Workplace Violence in Healthcare Settings", Developed by Center for Personal Protection and Safety*



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### Most Likely Healthcare Venues

**Predominance of Healthcare Shootings**

- Five states, Florida, California, Texas, Ohio and North Carolina accounted for more than a third of the events.
- Shootings within hospital walls averaged 12/year.
- Large hospitals (>400 beds) had highest incidence.

**Location of Shootings**

- 154 events
- Shootings Occurring Inside Facility:
  - 34% occurred inside the ED
  - 29% inside patient rooms
- 41% of Shootings Occurred Outside on Hospital Grounds:
  - 56% occurred in parking lot areas
  - 21% near the ED

*"Hospital-Based Shootings in the United States: 2000 to 2011", Gabor D. Kelen, MD, Christina L. Caffert, MD, Joshua G. Kubit, MD, Yu-Hsiang Hsieh, PhD, Annals of Emergency Medicine 2012*



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### Hospital-Based Shootings in the U.S.-2000-2011

Gubar D, Koles, MD, Christine L. Caffert, MD, Joshua G. Kubit, MD, Yu-Hsiang Hsieh, PhD, Annals of Emergency Medicine September 2012

- 154 Hospital Related Shooting Events-235 Victims
- 91% of shooters were men < 45 yo
- Most perpetrators had a personal association with their victims
  - 32% estranged intimate relations
  - 25% current or former patients
  - 5% current or former employees
- In 18% of cases, the shooter did not bring firearm. 50% of shootings in the ED were with security personnel's firearm
- Similar rates to lawyers' offices and post offices
- Only 30-36% of events were likely preventable by the use of a metal detector
- 61% of events had only 1 victim and 55% were innocent victims



### Hospital Based Shootings

- Rate of assaults on healthcare workers is 8 in 10,000 compared to 2 in 10,000 for private-sector industry
- ED accounts for a third of all active shooter events
- Most shooters had a personal relationship with their victims
- Most frequently ascribed motives were:
  - Grudge or revenge (27%)
  - Suicide (21%)
  - Ending the life of an ill hospitalized relative (14%)
  - Escape attempt by patient in police custody (11%)
  - Societal violence (9%)
  - Mentally unstable patient (4%)
  - Perpetrator takes security personnel gun (8%)



### Recent Long Term Care/Assisted Living Active Shooter Events

| Date          | Location          | Event                           | #       |        | Disposition               |
|---------------|-------------------|---------------------------------|---------|--------|---------------------------|
|               |                   |                                 | Injured | Killed |                           |
| May 2014      | Worthington, MN   | Man shot wife                   | 0       | 2      | Shooter commits suicide   |
| December 2013 | Los Angeles, CA   | Man kills sister                | 0       | 1      |                           |
| November 2013 | Clarks Summit, PA | Nurse kills patient             | 0       | 2      | Shooter commits suicide   |
| March 2009    | Carthage, NC      | Gunman shoots staff and patient | 2       | 8      | Shot and killed by police |



The above incidents include some of the most recent active shooter events in U.S. nursing homes.



### Carthage Nursing Home Shooting

- Lone gunman (45 yo, Stuart) burst into Pinelake Health and Rehab Center, (110 bed facility) Carthage, North Carolina, March 2009 at 1000 am.
  - History of violent tendencies.
  - Carried more than one weapon
  - Barged into rooms of terrified patients
  - Killed 7 residents (2 of which were in W/C's) and 1 nurse
  - Wounded 1 police officer (first into the facility)
- Shooter wounded by responding law enforcement officials and taken into custody.



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### Duration of Active Shooter Event

The average active shooter incident lasts 12 minutes.

Thirty-seven percent last less than 5 minutes.



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### Preparing for an Active Shooter Situation

- Development of an emergency operations plan
- Build relationships with first responders
- Staff training



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### Phases of Emergency Management Cycle

- Mitigation and Prevention
- Preparedness
- Response
- Recovery



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### Mitigation & Prevention Phase

**Definition:**

Activities undertaken to lessen the impact that the disaster may have on the organization and the community.



**Examples:**

- Hazard Vulnerability Analysis (HVA)
- Community Threat Assessment
- Facility Security Assessment
- Review Regulatory Compliance
- Policy Review:
  - Standardized Color Codes (e.g., Code Silver)
  - Lockdown vs. Evacuation
  - Nursing Home Incident Command System (NHICS) Activation
  - Memorandum of Understanding (MOU)
  - Access Control and Badging
- Gap Analysis
- Closed Circuit Monitoring and Recording
- Alert Notification Systems



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### Preparedness Phase

**Definition**

Activities designed to identify resources needed in a disaster.



**Examples**

- Response Plan Development or Update (Business Continuity and Recovery Plans, Color Codes, etc.)
- Integrate and coordinate plans with law enforcement.
- Communication Plan:
  - Alert and Notification
  - External Communication
  - Internal Communication
- Training Staff on Response Plans
- Workplace Violence Training
- Stage Critical Supplies for Entry Team:
  - Floorplan
  - Key/Card Access
  - Location of Command Center
- Prepare for Mental Health Needs
- Practice (Exercises, Drills, etc.)



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Purpose of Response Plan



- Goal: Survive and Protect
- Prevent, reduce or limit access to potential victims and to mitigate the loss of life.



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Principles Used in Plan Development

- Seek to maximize the protection of life.
  - Reduce number of people in harm's way.
  - Facilitate police response.
- Individuals will make their own decisions how best to maximize protection of life and what tactics to employ.
- “Duty to care” for patients will impact employees’ response to the event.



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Acronym Soup


**ALICE**

- **A** = Alert
- **L** = Lockdown
- **I** = Inform
- **C** = Counter
- **E** = Evacuate

**The 4 “As”**

- **A**ccent the emergency is occurring
- **A**ssess what to do
- **A**ct: lockdown, evacuate, etc.
- **A**lert: law enforcement





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### Development of An Emergency Operations Plan (EOP)

- Methodology for organization report the active shooter event?
- Lockdown procedures.
- Update your evacuation policy.
- Emergency escape procedures and route assignments.
- Incident Command System (ICS).
- Notification of local emergency response agencies.
- Communication with those that have language barriers.
- Notification of individuals at remote locations within premises or other campus buildings.



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### Conduct Training and Exercises

- Train key workforce members
- **PRACTICE.....**  
**PRACTICE.....**  
**PRACTICE.....**  
Develop and use exercises to test plans
- **PRACTICE MORE....**  
Participate in community based exercises



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### Clinical Training Affecting Healthcare Response

**Clinical personnel are trained:**

- To run toward source of a problem, not away
- Shelter-in-place
- Decrease disturbances for patients and avoid disruptions that may impact patient comfort or recovery
- “Patient First”
- Do not desert your patients

**Response Results In:**

- Getting into harms way
- Hesitation
- Indecision
- Panic
- Refuse to leave patients



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### Untrained Personnel

- Experience: Alarms, gunfire, explosions, people shouting and screaming.
- Untrained personnel will:
  - Experience Initial Disbelief
  - Be Startled
  - Feel Fear
  - Feel Anxiety



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### Training Commitment

**Trained Response**

- Survival Mindset
- Survival Reaction
- Recall Learned Info
- Survival Behavior
- Live and Win

***“WE CAN DO THIS!”***

**Untrained Response**

- Panic Reaction
- Denial and Disbelief
- Shock and Helplessness
- Do nothing.....

***“This can’t be happening to me!”***



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### Trained Personnel

- Research shows that:
  - People do not panic when given clear and informative warnings,
  - They want to have accurate information and clear information and instructions on how to protect themselves in an emergency.



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### Personal Responsibilities of Employees

- Three-Fold Responsibility:
  - Learn the signs of a potentially volatile situation and ways to prevent an incident.
  - Learn the best steps for survival when faced with an active shooter situation.
  - Be prepared to work with law enforcement during the response.



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### Window of Life

- A person in crisis has four responsibilities:
  - A person's **first** responsibility is for his or her safety.
  - A **second** responsibility is to those in the immediate vicinity, those who are within line of sight or ear shot of where you are.
  - A **third** responsibility is to those who may be affected by the crisis so that they may have more time to respond.
  - A **fourth** responsibility is to notify public safety.

44 • Safe Haven International



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### Maintain Situational Awareness

- Remain alert
- Have a rudimentary mental plan in the event of an emergency situation.
- Focus attention on the environment
- Look out for odd or threatening behavior
- Know the location of security personnel
- Locate stairwells
- Take note of unattended packages
- Note the locations of alarm pull stations.



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### Preventing an Active Shooter Situation

- Identify common pre-attack behaviors
- Provide anonymous reporting mechanism for staff
- Train a team that may assess risks individuals may present



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### Characteristics of an Active Shooter Event

- Rarely impulsive events
- Attack is thought out and planned in advance, but there is no pattern or method to their selection of victims.
  - Almost every attacker had engaged in behavior prior to shooting that seriously concerned others
  - In many cases, warning signs are ignored, downplayed, or misjudged in severity
  - Most active shooter situations evolve quickly.
  - Because most incidents are over within minutes, we must be prepared to deal with the situation until law enforcement personnel arrive.



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### Common Characteristics Of An Active Shooter

- Male < 45 yo
- Loner, usually quiet, with defiant outbursts, emotionally unstable
- History of violence
- Elevated frustration level
- Erratic behavior
- Pathological blamer or complainer
- Strained work relationships
- Reduced productivity
- Extremist views
- Threatening behavior
- Changes in health or hygiene
- Feels victimized, makes threats
- Fascination with weapons
- Exhibits paranoia
- Seems depressed
- Dependence on alcohol or drugs
- Is involved in a troubled, work-related romantic situation
- Suffers dramatic personality swings or depression
- Evidence of psychosis



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### Triggers Do Exist! “People Don’t Just Snap”

- Violent behavior or the potential for violent behavior is **rarely new** for perpetrators
- Usually demonstrate **patterns** of negative thinking, feeling, and/or behavior as **part of his/her history**
- Certain triggers intensify** the negative behavior
- Planning** for a violent response or action (by the shooter) usually takes place over time
- During this time, **signals, flags** and sometimes **threats** exist but are **rarely seen as serious** or are **not reported**



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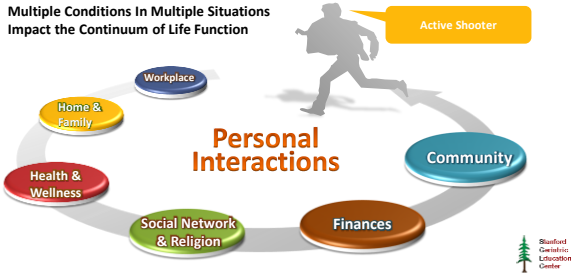
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### Impact of Personal Interactions

Multiple Conditions In Multiple Situations  
Impact the Continuum of Life Function



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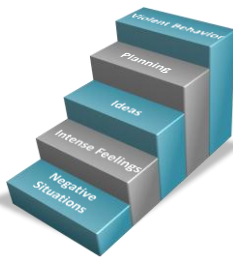
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### Individual Violent Process



- VIOLENT BEHAVIOR**
- PLANNING**  
Weeks/Months/Years
- IDEAS**  
“Change is not possible in peaceful way”  
“Violence is necessary and justified”
- INTENSE FEELINGS**  
Anger, Hostility, Retaliation, Vengeance
- NEGATIVE SITUATIONS**  
Personal, Social, Political, Religious, etc.



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Workplace (Non-Terrorist) Shooters



- Individual is concerned about current situations and specific problems (i.e., job termination, conflict with another person, financial difficulty, marital problems, bullying, etc.).
- Shooter believes the violence will “solve the current problem”.
- Persons or company resources are specifically targeted.



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Active Shooter Behavior Pattern

- Tend to engage more than one target and are intent on harming a large number of people as quickly as possible.
- Target densely populated areas. (e.g., schools, malls, movie theaters, etc.)
- Have some degree of knowledge of the building or location they have chosen to attack. (e.g., former or current employee, client, visitor, patient, etc.)
- Likely to be indiscriminant in their violence or seek specific victims. (e.g., Westroads Mall, Omaha, Nebraska; Aurora Movie Theater, etc.)
- Show no interest in escaping police, hiding their identity or concealing their crimes. (e.g., Columbine, Virginia Tech, etc.)
- Only stop when they:
  - Run out of targets or ammunition,
  - Are confronted by police,
  - Are overpowered by citizens or commit suicide.
- Examples include Oslo, Carthage, Central Peninsula Hospital, etc.



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Active Shooter Exercises

- Transparency:
  - Provide all details pertaining to exercise
  - Frequent updates
  - Access to Exercise Plan
- Life Care Centers of America Facility (Colorado) Lawsuit:
  - Nurse not notified regarding AS FSE and taken hostage by gunman in drill.
  - “Man brandishing gun forced her into empty room while she was begging for her life”
  - Identified himself as Police Officer but she was unsure he was telling her the truth.
  - Suffer severe physical, emotional and psychological distress and had to resign
- Coordination with Law Enforcement
- Develop “Risk Register”
- Develop Communication Plan
- Education and Training:
  - Active Shooter Response
  - Expectations for Exercise
- Consider “OPT OUT” for Employees
- Survey staff regarding perception of level of preparedness
- Community Awareness
- Behavioral Health Support
- Don’t deviate from the script!



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“Take Home” Message



Organizational and staff preparedness will be the most influential factors impacting situational outcomes in an active shooter incident.

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Active Shooter Response



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Response Phase

Definition

Begins with notification of the incident and the initiation of site management. Focuses on saving lives and the activities are related to management of the actual disaster.

Examples

- Alert for “Code Silver, Active Shooter, Location, Instruction”
- NHICS Activation
- Lockdown or Evacuation (Track Patients)
- Establish Communications with Response Partners
- Activate Plan for Mental Health Support
- Documentation
- Management of Clinical Support Activities



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### Be Alert and Report Suspicious Situations

- **Call 911:** Immediately notify law enforcement and report the incident, including the following information:
  - Nature of the Incident
  - Location of the incident and the shooter
  - Description of property involved.
  - Number of shooters, if more than one.
  - Physical description of shooter (s).
  - Number and type of weapons held by the shooter(s).
  - Number of potential victims.



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### Response Processes

- Get Out
- Keep Out
- Hide Out
- Take Out



"Run, Hide, Fight Video", Ready Houston

- Run
- Hide
- Fight



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### Response In An Outpatient Setting or Business Occupancy

- **RUN !**
- **HIDE !**
- **FIGHT !**



<http://www.youtube.com/watch?v=5VcSwejU2D0>



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### Personal Response (Ideas)

**Move to safety**

Move as fast as you can away from the threat. An active shooter hits a moving target a small percentage of the time at close range.



**Look for an exit**

Look for any exit to get out of the line of fire, including emergency exits, windows and doors not typically used as entry and exit points.



**Take cover, stay low**

If there are chairs or anything else low in the room, duck to that height and stay behind it. Scramble on all fours to lower your profile.



**Stay sharp**

Realize the possibility that you can be shot and think through how you will react to the situation.



SOURCE: Matthew Measdam of Move2Safety. GRAPHIC: Alberto Cuadra - The Washington Post.



### Fight or Taking Out the Shooter

- Only recommended when no other choice remains.
- Throw anything at the shooter (aim at his/her face to disrupt aim)
- Attack as a group (Swarm)
- Use anything as a weapon to attack and secure shooter
- Grab the shooter's arms, legs and/or head and take them to the ground using your body weight
- Continue to fight until the shooter is no longer a threat. Gouge the eyes and/or do whatever it takes to survive. Understand that you are in a fight for your life.



### Law Enforcement Response

- The primary goal of law enforcement is to eliminate the threat and stop the active shooter as soon as possible.
  - **Resolution:** As the first responders' primary responsibility is to eliminate the threat, they will not be able to stop to help injured persons until the environment is safe.
  - Officers will need to take command of the situation.



### Arrival of Officers and Rescue Teams

- May wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment
- Be armed with rifles, shotguns, and /or handguns
- Use pepper spray or tear gas to control the situation
- Shout commands and may push individuals to the ground for their own safety
- Emergency medical personnel will also arrive at the scene
- Rescue teams will treat and remove any injured persons
- These teams may also request able-bodied individuals to assist in removing the wounded from the premises



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### When Law Enforcement Arrives



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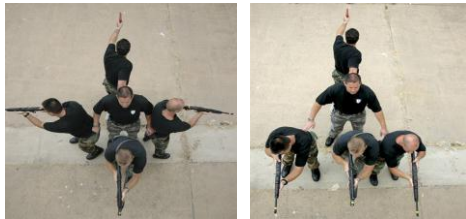
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### Clearing the Building



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Expectations for Law Enforcement



- Remain calm and follow instructions
- Keep your hands visible at all times
- Avoid pointing or yelling
- Avoid making sudden moves
- Know that help for the injured is on its way
- Do not ask officers for help while you are being evacuated from the scene. Rescue personnel will be in a safe area to provide assistance



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Recovery

Definition:

Begins when the incident has stabilized. The response phase may not have ended. Activities related to re-establishment of normal business operations following disaster situation.



Examples

- Reunification of staff, patients and visitors.
- Death notifications
- Navigating the Media
- Termination of Facility Lockdown and Response Activities
- Restore Critical Services and Return To Business as Usual
- Clean-up and Decontamination if needed.
- Spiritual and Mental Health Care Considerations
- Crime Scene Considerations
- Brand Recovery
- After Action Review and Corrective Action Plan



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Other Post-event Interventions

- Accounting of all individuals
- Notification of physicians off campus
- Notification of families of individuals affected by the event
- Assessing the psychological state of victims
- Identifying and filling critical personnel or operational gaps
- Conduct “debriefing” or “hotwash” or “After Action Review” (AAR)
- Identify opportunities to improve response capabilities, capacity and competency
- Develop Corrective Action Plan (CAP)



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### Impact of Active Shooter Event on Residents

- Stress of the event may exacerbate pre-existing conditions.
- Evacuation of residents may result in “transfer trauma” and ultimately increased mortality.
- Decreased cognitive function.
- Post-Traumatic Stress Disorder (PTSD)
- Physical Injuries
- Disruption of regimen of care



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### Victim Recovery

- Identify personnel and victims requiring behavioral health support:
  - Direct Victims (Patients, Staff and Visitors directly involved in the event)
  - Indirect Victims: Family Members, friends of Victims (Indirectly impacted)
  - Response Personnel
- Signs that a person is in need of trauma support:
  - Blank stare
  - Crying
  - Frantically trying to return things to order
  - Wandering around without purpose
  - Difficulty making decisions
  - Easily startled
  - Appears confused
- Provision of Psychological First Aid



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### Behavioral Health Resources

- Critical Incident and Stress Management (CISM) Teams
- Behavioral Health Care Facilities
- Local Behavioral Health Professionals
- State Disaster Behavioral Health Team
- Employee Assistance Program (EAP)
- Medical Reserve Corps
- American Red Cross
- Social Workers
- Clergy



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Thank you



- Stay Vigilant
- Be Proactive
- Remember to:
  - Run
  - Hide
  - Fight



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Presenter Contact Information

Judith A. Metcalf  
[jmetcalf@une.edu](mailto:jmetcalf@une.edu)

Kathy Knight  
[kknight@emhs.org](mailto:kknight@emhs.org)

Special Thanks and Credit

National Protection and Programs Directorate,  
Department of Homeland Security,  
The Office of Infrastructure Protection



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Resource Links (# 1)

- Nursing Home Incident Command System  
<http://cahfdisasterprep.com/NHICS.aspx>
- Ready Houston, “Run, Hide, Fight” Video  
<http://www.readyhouston.tx.gov/videos.html>
- Homeland Security Active Shooter Preparedness Website  
<http://www.dhs.gov/active-shooter-preparedness>
- FBI Active Shooter Resources  
<http://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents>



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### Resource Links (# 2)

- “Hospital-Based Shooting in the United States: 2000-2011”  
<http://www.medpagetoday.com/upload/2014/5/1/fa-gdkelen.Pdf>
- FBI Study, “A Study of Active Shooter Incidents in the United States Between 2000-2013”  
<http://www.fbi.gov/news/stories/2014/september/fbi-releases-study-on-active-shooter-incidents/pdfs/a-study-of-active-shooter-incidents-in-the-u.s.-between-2000-and-2013>
- California Hospital Emergency Codes  
<http://www.hasc.org/hospital-emergency-codes>



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Final Question  
Thank You for Participating!

Reminder: Please complete our short survey.  
We appreciate your feedback.  
**NOTE:** Continuing Education Participants must complete a final survey in order to receive CEU/CME credit



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