GUEST EDITORIAL

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Active Shooter: Are We Complacent?

After the horrific active shooter events of recent years, simply walking into a theater, mall, airport, or train station may incite anxiety for our safety. Active shooter events are often sensationalized in the media, leaving us desensitized to the potential threat that may exist. Following an investigation, the gruesome aftermath is highlighted, while suggestions from authoritative commentators for prevention of future events are vague at best, and often nonexistent.

At Brigham and Women’s hospital in Boston, Massachusetts, Stephen Pasceri walked into the hospital and asked to speak with cardiothoracic surgeon Dr Michael J. Davidson. As the cardiothoracic surgeon entered an exam room to speak with him, Pasceri simultaneously pulled out his gun and killed Dr Davidson.1 Hailed as one of the most prepared hospitals for such an event, this January 2015 shooting is a stark reminder of how easily we can become the target of an active shooter. On November 27, 2015, in Colorado Springs, Colorado, Robert Lewis Dear began shooting his rifle as he entered a Planned Parenthood Center.2 Three people were killed, and 9 wounded including 5 law enforcement officers.2 These events were unpredicted and ghastly brutal.

What prompts an individual to engage in such a horrific event is not totally clear but several triggers are identified. The active shooter may be an employee or disgruntled former employee. The event may be triggered as the result of a domestic disturbance. In the case of the Brigham and Women’s Hospital event, the shooter had a personal issue with his mother’s care.

Although indicators that may trigger an individual to engage in an active shooter event are varied, 75% of hospital events were found to be highly targeted.3 Characteristically, the majority of perpetrators are young and male.3 The experience of a personal loss, the development of a personal grievance, history of criminal behavior, an ill relative, and mental instability are some of the other experiences of an individual that may trigger an event.

In the OR environment, a sense of seclusion, even isolation from attacks prevents us from understanding how they unfold, leaving us with no real sense of how to prepare for such an event. For healthcare professionals, it’s important to realize that hospitals are just as vulnerable as any other public space.

Violent events within healthcare settings most often happen in the emergency department but the OR is also a potential environment for such an event. The OR is a locked area, which renders a false sense of security. In hospitals, visitors are not routinely screened for identification prior to entry, and security measures such as a metal detector are rarely present. Kelen et al,3 found that about one-third of hospital-based shootings were likely preventable by a metal detector. The doors may be locked to get into the OR but trespass can readily be accomplished by a motivated individual. Often individuals appear in our work area who are unfamiliar to us and yet we continue our day without question.

An increase in active shooter incidents demonstrates a need for education to prepare us should we encounter this critical situation.2 All geographic regions of the United States have experienced a hospital-based active shooter event, accounting for 40 of the 50 states.4 Both urban and rural hospitals with bed size from less than 100 beds to more than 400 beds have all been impacted.4 The vulnerability of OR workers is currently underappreciated and understudied.

Are we prepared? Is the active shooter training or education that may be provided by healthcare institutions taken seriously? A sense of complacency or false security can overshadow or even extinguish the need to be prepared.

During 2014 and 2015, active shooter events resulted in 231 casualties; 6 of these incidents ended with quick citizen action.2 Two of these events took place in healthcare facilities.2 Having personally experienced an active shooter event in a rural hospital, an event resulting in the death of a federal prison guard during a prisoner escape attempt, I can attest that this lingering fear stimulates a need to emphasize the importance of preparedness training for any potential future events. Even maximum-security precau-
tions do not ensure complete safety in the occurrence of such an event. I believe that all healthcare personnel should be engaged in training and education.

All hospital employees and contractors should be included in active training for dealing with an active shooter event. Specific plans for action should be extensively explored and developed to implement training exercises to enhance preparedness for all staff. The OR workers, including anesthesia providers should not be excluded from active training drills in their workspace. Many hospitals have policies and drills but few, if any, practice them in the OR environment. The unique OR environment with anesthetized patients poses its own challenges for the development and practice of active shooter training drills.

How to Prepare
The Department of Homeland Security provides information and video instructions for active shooter preparedness. “Run, Hide, Fight” is the message throughout the preparedness training. In an OR environment where would you Run, Hide, or Fight? Consider how you would communicate. Are you ready? How would you react? The Department of Homeland Security and the Joint Commission recommend the development of plans and periodic drill training for all employees.

The Joint Commission issued an advisory for healthcare organizations to prepare their staff for an active shooter event. The recommendations included are: involve local law enforcement, develop a communication plan, implement processes and procedures to ensure patient and employee safety, and train and drill employees. Do you have a lockdown plan? If so, do you know how to implement it during an active shooter event? You should know how to manage an active shooter event in your OR.

Nurses at one hospital enhanced the hospital’s protocols for potential violence through the development of a formalized active shooter education program and conducted follow-up drills. The nurses found, that by developing and practicing the training, they felt empowered with knowledge and actions that they could use to avoid injury in the event of an active shooter. Should we be conducting drills in the OR? What would this look like?

When there is an active shooter event, we must make quick decisions. Such decisions are likely to carry complex moral, legal, and personal implications as a single provider’s actions may have consequences for others. How would you react? How has your institution prepared you?

In responding to an active shooter event how will you respond? Will you run, hide, or fight? Can you run or hide when you have a patient in the OR who is under your care? How will you fight if confronted by the shooter? How will you communicate? Such questions are not easily addressed, especially given that such an event is likely to be novel, defying a simple one-recipe-fits-all approach.

Conclusion
While we may feel safe behind locked doors and elevators in our individual ORs, are we prepared to react during an active shooter event? Can we save lives through our actions when using developed processes and drill training? Complacency in our work environment does not breed a culture of safety. Processes and procedures should be developed and practiced to improve all of our safety. We need to communicate the seriousness of our risk in the OR to institution leaders if no plan is in place. Another suggestion is to develop a unit specific plan, and put the plan into action with practice drills. These drills may save lives. Education that includes briefing and debriefing of OR personnel is essential.

Are we required to wait for a horrific event in order to move us to action? CRNAs are highly educated and often face situations that require critical thinking, review of the evidence, and rapid decision-making to best serve our patients. We practice crisis resource management to prepare for similar critical events during anesthesia. We take pride in our strong history of patient safety. Perhaps CRNAs should take the lead to develop a specific plan to address concerns for an active shooter scenario within an OR setting. We can be the leaders in the development and research surrounding this topic. The opportunity awaits CRNAs to become authoritative commentators in a discussion to address an active shooter event, defending our patients and colleagues from a potentially devastating outcome.

Hospital shootings are rare but as soft targets we remain vulnerable. Removing an attitude of complacency is the first step toward developing a culture of safety.

REFERENCES
Effect of Ultrasound-Guided Placement of Difficult-to-Place Peripheral Venous Catheters: A Prospective Study of a Training Program for Nurse Anesthetists

To the editor: I appreciated the recent article published in the AANA Journal entitled: “Effect of Ultrasound-Guided Placement of Difficult-to-Place Peripheral Venous Catheters: A Prospective Study of a Training Program for Nurse Anesthetists.” The study’s focus on nurse anesthetists is a great way to inspire readers to use this technology if they are not already. I have a considerable amount of experience utilizing ultrasound for IV insertion and hope to increase the reader’s enthusiasm for this skill by adding some insight to the above study. After inserting over 1,000 ultrasound guided IVs over my last 2 years as a critical care nurse, I discovered some techniques that can help a practitioner achieve near 100% accuracy and decrease the time to cannulation to under 1 minute in almost any patient.

I, along with others, believe that using a dynamic version of the short axis view gives the fastest and most accurate vessel cannulation for both novice and experienced practitioners. The key is keeping the needle tip in view at all times, from the skin surface all the way to the middle of the vessel. There is no need to watch for blood return; your eyes should remain on the screen. Relying on blood return often leads to misplaced catheters. This dynamic technique allows the practitioner to cannulate extremely small and tortuous vessels with ease. Veins that overlie arteries and nerves can safely be cannulated, and 14-gauge IV catheters can be easily inserted into patients previously deemed “difficult sticks” as well.

I have found using a tourniquet to be detrimental to this skill, especially for novices. When learning, it is common to accidentally drive the needle through the posterior wall of the selected vessel. This posterior puncture allows infiltration of blood into the surrounding tissue, forcing the practitioner to abandon the attempt. With no tourniquet, the needle can easily be redirected into the lumen. The risk of posterior wall puncture outweighs the tourniquet’s minimal enlargement of deeper vessels. I hope this insight might aid the above study to inspire readers to make more use of ultrasound for difficult IV access.

REFERENCES

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DISCLOSURES
The author has declared no financial relationship with any commercial interest related to this letter.