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STRENGTHS

Education, preparation, and moral obligation: An examination of hospital employee role in active shooter training response

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ABSTRACT

As active shooter and armed intruder events continue to increase, hospitals have recently begun using the Department of Homeland Security-endorsed "Run Hide Fight" procedures to train employees on how to respond to violent situations. This study uses survey data collected from 333 staff in various employee roles at a Midwest hospital. Employees responded to questions related to "Run Hide Fight" policy education, feelings of preparedness for an active shooter event, and perceptions of moral obligation related to remaining with patients during a potentially fatal encounter. Results indicate variations in education and preparedness response among administration, clinical staff, and non-clinical staff.

Key Words Violence; armed intruder; Run Hide Fight; public health.

INTRODUCTION

Across the country, active shooter events are becoming increasingly common (Blair & Schweit, 2014; Sanchez et al., 2018). It is currently estimated that at least 2.5% of active shooting events nationwide take place within hospitals or on hospital property (Kelen et al., 2012; Jacobs & Burns, 2017). This is particularly disturbing when the vulnerability of patients and hospital staff are considered (Jacobs & Burns, 2017; US Department of Health & Human Services, 2014). In an effort to combat both the risks and casualties associated with shootings in hospitals, "Run Hide Fight" guidelines, specific for hospitals, have been introduced by The Healthcare and Public Sector Coordinating Council (HSCC). These recommendations provide a template for how hospital employees should be trained for, and act during, active shooter situations. Active shooter policy education and perceived preparedness for an active shooter event are important factors to consider, as various hospital employees play distinct roles in these procedures, remaining at varying levels of risk during actual events.

Literature Review

Hospitals, often lauded as places of healing and hope, are also surprisingly violent, with both the public and hospital professionals perceiving hospitals to be in jeopardy from active shooter incidents (Jacobs & Burns, 2017). The cost of violence in hospitals is substantial. It is estimated that, in 2016, over $847 million was spent by hospitals to curb, prevent, or limit violence in healthcare settings (Van den Bos et al., 2017). Additionally, hospital employees are more likely to be hurt at work and to need time off work due to victimization than those working in any other profession (Bureau of Labor Statistics [BLS], 2018). Research indicates that healthcare workers often consider violence "part of the job" and anticipate being abused during their shifts (McPhaul & Lipscomb, 2004, as cited in Arnetz et al., 2015). Workplace violence remains an increasing threat to healthcare workers (Wei et al., 2016), and, while it is known that violence in hospitals exists, research on violent hospital episodes is lacking (Arnetz et al., 2015).

Employee Role

Previous research has indicated that hospital employee role explains differences in "Run Hide Fight" policy knowledge retention and perceptions of active shooter training (Darais & Wood, 2019). While a few studies have investigated differences between clinical and non-clinical staff, little is known about the feelings of hospital administration related to "Run Hide Fight" policy education, preparedness, or acuity of moral obligation to patients. The lack of research related to the perception of administrative staff is puzzling, considering

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their oversight of both clinical and non-clinical employees. It is well known that nurses and other clinical staff are at particular risk of being victimized while at work, with one large-scale study of nurses revealing that over about half of nurses experienced at least one episode of violence a year (Wei et al., 2016). Other research has found that clinical staff, or staff in direct contact with patients and administering medical care, are at increased risk of being hurt while working, specifically while they are working in the emergency room (Kelen et al., 2012).

Non-clinical staff comprises those who work at the hospital but do not provide direct medical care to the patients. Among non-clinical staff are custodial crews, food handlers, and security. Research has determined that, after nurses, security officers are most likely to be victimized by patients (Arnetz et al., 2015). This was particularly true in cases where patient restraints were used or when patients were in transition, such as when a security officer is moving a tenant from one location to another.

While the risk for clinical and some non-clinical staff is relatively high, it appears that administrative staff are at the lowest risk of being victimized by gun violence in the hospital. Emergency rooms and intensive care units are among the most violent locations in the hospital (Kelen et al., 2012; Wei et al., 2016), theoretically putting some hospital personnel in more danger than others. For example, nurses and other clinical staff largely work these areas, but there is a lesser likelihood for administration to be permanently positioned in these departments. The motivations of hospital shooters (grudge, "euthanizing a sick patient," prisoner escape, and ambient society violence) also make administration unlikely targets (Kelen et al., 2012). Despite employee position, it is universal that all staff, to some degree, receive training or education designed to keep employees, patients, and patient allies safe in an active shooter situation (Van Den Bos et al., 2017).

Obligation

Research regarding moral obligation in the medical setting is minimal and in need of further study. Aside from voluntary caring, moral obligations to care revolve around a duty, sometimes accompanied by a legal responsibility (Engster, 2005). While it is true that many medical caregivers agree to "do no harm," it is unclear how far that oath extends. For example, since the 1980s, ethicists have been debating whether physicians have an obligation to care for patients diagnosed with acquired immunodeficiency syndrome (AIDS) (Angoff, 1991; Emmanuel, 1988), whether health-care workers have an obligation to be vaccinated to protect patients from disease (Maltezou & Tsakris, 2011), and whether patient abandonment is a violation of a primary obligation for physicians (Quill & Cassel, 1995).

As two doctors explain, "Nonabandonment is one of a physician's central ethical obligations; it reflects a longitudinal commitment both to care about patients and to jointly seek solutions to problems with patients throughout their illness" (Quill & Cassel, 1995, p. 368). While this angle makes it clear that doctors are required to see their patients through sickness, health, and possibly death, it does not anticipate a violent emergency while offering that care. Additionally, these views generally define abandonment as withdrawing care without transferring a patient to another source of care (Pellegrino, 1995), and only specifically recognize physicians, not nursing or other clinical operatives. Similarly, many of these "do no harm" concepts revolve around protecting against dangerous, deadly, or detrimental actions on the part of the physician, not around failure to act, as is the case when a medical caregiver attempts to protect themselves instead of their patient in an active shooter situation.

The decision to stay and care or protect oneself is a controversial choice, particularly in the hospital setting. Varying opinions have been voiced about obligation versus protection. In the *Journal of the American College of Surgeons*, researchers argue, "it is recognized that a healthcare professional's decision for action during an active shooter event is a personal decision" (Jacobs & Burns, 2017, p. 435). This statement is supported by findings that indicate the majority of the public and hospital employees feel hospital staff have a duty to protect patients to the same degree as law enforcement or fire fighters (Jacobs & Burns, 2017), although that duty might vary depending on other available options. For example, in one survey of hospital employees, the vast majority of respondents indicated that in an active shooter scenario they would first attempt to flee the scene. Fewer reported that they would first protect patients (Sanchez et al., 2018). However, this is also in contrast with the Department of Health and Human Services guiding principles that employees should not be specifically mandated to remain with patients in active shooter events (USHHS, 2014).

Education and Preparation

"Run Hide Fight," although potentially problematic in the hospital setting (Inaba et al., 2018), continues to be the best initiative for active shooter response. As hospital shooting violence has increased, the need for better and more available training has been amplified (Wands, 2016). "Run Hide Fight," endorsed by the Department of Homeland Security, is the training regimen that hospitals have naturally gravitated towards (Binkley, 2016; HSCC, 2015; Jacobs et al., 2013). Chiefly, "Run Hide Fight" offers a simple formula for active shooter response (US Department of Homeland Security, 2008) that includes fleeing from the shooter if possible. If running is not a viable option, then hiding should be employed. Those hiding should specifically seek areas that can be barricaded, preventing access from the intruder. Lastly, if running and hiding opportunities are not available, the third recommendation is to fight. Fighting should be aggressive, committed, use improvised weapons, and specifically have the goal of disarming or restricting the shooter (Morris, 2014).

Hospitals have different methods for educating and training their employees about "Run Hide Fight" procedure, and employees have varying levels of understanding of the curriculum, as well as assorted levels of confidence in their volume of training for the three-step model. One study surveying both hospital employees and the general public found that the majority of both indicated hospitals were somewhat or very prepared for an active shooter event (Jacobs & Burns, 2017). Another study determined that hospital employees feel more prepared for an active shooter situation after receiving active shooter education (Sanchez et al., 2018). Additional research has indicated that specific variables, such as

hospital employee role, level of employee education, and work schedule, can influence "Run Hide Fight" knowledge and perceptions of adequate training (Darais & Wood, 2019).

While research has been conducted regarding perceptions of moral obligation to remain with patients during active shooter events (Jacobs & Burns, 2017), feelings of preparedness following active shooter training (Sanchez et al., 2018), and employee understanding of the "Run Hide Fight" curriculum (Sanchez et al., 2018; Darais & Wood, 2019), none of these studies has specifically looked at differences in response based on employee position.

The current study evaluates survey responses from hospital administration, clinical staff, and non-clinical staff to gain insight on hospital employee role in relation to the hospital's "Run Hide Fight" policy. Specifically, this study asks the following research questions:

1. Are employees knowledgeable about the hospital "Run Hide Fight" policy?
2. Do employees feel prepared for an active shooter/armed intruder event in the hospital?
3. Do employees perceive a moral obligation to stay with patients during an active shooter/armed intruder event?
4. Do responses differ based on employee role?

Methodology

Data for this study was retrieved from a survey of hospital employees at a Midwest Level III trauma hospital. This medium-sized hospital employs approximately 725 staff and sees over 21,000 patients each year. "Run Hide Fight" is the current active shooter procedure used at this institution, with the simple premise of the policy being that employees should run when possible, hide if appropriate, and fight the intruder as a last resort during an active shooter event. The policy does not make any statement about staff obligation to remain with patients, and it is distributed to staff only (no patients or visitors are privy to the policy). Policy information is disseminated to employees in a variety of ways. First, at hiring, "Run Hide Fight" is introduced in an orientation video. Second, table-top exercise invitations are extended to all employees but are not required. Lastly, all hospital staff have access to the written policy, located in their online health system employee portal.

Sample Population

This hospital was selected because of its centralized location, which means that it serves individuals of various socio-economic, racial and ethnic, and cultural backgrounds. An electronic survey was distributed to all hospital employees, including administration, non-clinical staff (including security agents, cafeteria employees, guides, and lobby volunteers), and clinical staff working directly with patients. The e-mail containing the survey hyperlink, along with a brief description of the purpose of the survey, estimated length of time to complete the survey (eight minutes), and a request to complete the survey within seven days, was sent by the hospital emergency manager. Follow-up e-mails were sent four days later reminding employees to complete the survey by the end of the week. The survey consisted of 15 questions specifically aimed at assessing knowledge of active shooter policy, knowledge of policy location, feelings of preparedness, and perceptions of moral obligation.

Variables

The dependent variable in this study was employee role. Dummy variables were created to form three dependent variables: Administration, consisting of all employees whose primary role is to manage or direct executive hospital functions; Non-Clinical Employees, consisting of all employees whose primary role is to assist with the day-to-day functions of the hospital outside of providing medical care; and Clinical Employees, consisting of those employees with direct patient contact for the purpose of administering medical care. Responses were coded as (0) specific employee role (either Administration, Clinical, Non-Clinical), (1) other. Because the dependent variable was dichotomous, logistic regression was used.

Independent variables in this study included indicators of education about the "Run Hide Fight" policy, perceptions of preparedness, and sense of moral obligation regarding remaining with patients in active shooter situations. Employee education (Education1) was first determined as knowledge of active shooter procedure—specifically, employees were asked "Where would you expect to find an active shooter/armed intruder policy?" Secondly, education (Education2) was gauged as the ability to identify the correct response, (i.e., "Run Hide Fight") to an active shooter or armed intruder in the hospital. For both education variables, correct responses were coded as (0) and incorrect responses as (1). Perceptions of preparedness were determined by how prepared the employee felt for an active shooter/armed intruder incident. Those who reported feeling unprepared or very unprepared were coded as (0), and those who reported feeling prepared or very prepared were coded as (1). Lastly, sense of moral obligation was determined by asking respondents whether they felt a moral obligation to remain with patients in an active shooter/armed intruder situation. Responses were coded as (0) for no and (1) for yes.

Findings

Surveys were electronically distributed to all hospital employees (725). A total of 341 surveys were completed, yielding a response rate of 47%. Eight respondents did not identify their employee role, and their responses were removed from the sample, leaving a total sample of 333 evaluated surveys. Of the total sample, approximately 9% of respondents were administration, 30% came from non-clinical staff, and 61% came from clinical staff. This employee role breakdown appears to be representative of the total hospital employee role breakdown. The majority of respondents were older than 35, were full-time employees (working 32 or more hours a week), had a college degree or higher, were employed for five years or more, and were overwhelmingly female (Table I). The significant gender disparity in the responses is consistent with hospital representation, as the hospital typically employees 85 females to every 15 males. Non-clinical staff was the only employee role that had a majority of employees holding less than a college degree. This remains consistent with positions that often do not require advanced education, such as cafeteria employees, custodial staff, or lobby attendants.

When asked where they would expect to find an active shooter policy, administration were most likely to produce a correct response (94%), followed by clinical staff (83%) and non-clinical staff (80%; Table II). Additionally, when asked what the initial response should be when hearing an active shooter/armed intruder warning, only half of the overall employees produced the correct response. The majority of administration (65%) reported a correct answer, followed by non-clinical staff (54%) and then clinical staff (46%). When asked about how prepared they felt for an active shooter/armed intruder incident, administration reported feeling the least prepared, with 51% feeling either very unprepared or unprepared. Approximately 46% of clinical staff felt very unprepared or unprepared, while 31% of non-clinical staff felt very unprepared or unprepared. In terms of a sense of moral obligation to remain with patients during an active shooter situation, the majority of employees reported yes and were similar (83–85%) across employee roles.

Three employee role regression models were created, resulting in findings related to "Run Hide Fight" education and feelings of preparedness (Table III). Due to the comparatively small administration sample size, the significance level

TABLE I Employee descriptive statistics

	Administration (31) *N* (%)	Non-Clinical (98) *N* (%)	Clinical (204) *N* (%)	Total *N* (%)
Gender				
Male	8 (26)	15 (15)	28 (14)	51 (15)
Female	23 (74)	83 (85)	176 (86)	282 (85)
Age				
34 and younger	2 (6)	13 (13)	55 (27)	70 (21)
35 and older	29 (94)	85 (87)	149 (73)	263 (79)
Work schedule				
Full time	28 (90)	81 (83)	169 (83)	278 (83)
Part time	3 (10)	17 (17)	34 (17)	54 (17)
Level of education				
Less than college degree	3 (10)	64 (65)	56 (27)	123 (37)
College degree or higher	28 (90)	34 (35)	148 (73)	210 (63)
Length of employment				
Less than 5 years	7 (23)	31 (33)	83 (42)	121 (36)
5 or more years	24 (77)	66 (67)	119 (58)	209 (64)

TABLE II Education, preparation, and moral obligation survey responses by employee role

	Administration (31) *N* (%)	Non-Clinical (98) *N* (%)	Clinical (204) *N* (%)	Total *N* (%)
Education1				
Where would you expect to find an active shooter policy?				
Correct response	29 (94)	78 (80)	169 (83)	276 (83)
Incorrect response	2 (6)	20 (20)	35 (17)	57 (17)
Education2				
What should your initial response be when hearing an active shooter/armed intruder warning?				
Correct response	20 (65)	53 (54)	93 (46)	166 (50)
Incorrect response	11 (35)	45 (46)	111 (54)	167 (50)
Preparation				
How prepared do you feel for an active shooter/armed intruder incident?				
Very unprepared	1 (3)	2 (2)	12 (6)	15 (5)
Unprepared	15 (48)	28 (29)	82 (40)	125 (38)
Prepared	11 (35)	62 (63)	106 (52)	179 (54)
Very prepared	4 (13)	6 (6)	4 (2)	14 (4)
Moral Obligation				
Do you feel a moral obligation to remain with patients during an active shooter situation?				
Yes	26 (84)	81 (83)	174 (85)	281 (84)
No	5 (16)	17 (17)	28 (14)	50 (16)

TABLE III Logistic regression models of employee role and education, perceptions of preparation and moral obligation in hospital active shooter situations

	Administration			Non-Clinical			Clinical		
Variable	**B**	**(B)exp**	**S.E.**	**B**	**(B)exp**	**S.E.**	**B**	**(B)exp**	**S.E.**
Education1	1.175	3.238	.750	-.379	.684	.315	.045	1.046	.303
Education2	.689*	1.991	.398	.216	1.241	.246	-.423*	.655	.229
Preparation	.521	1.684	.384	-.692**	.500	.257	.408*	1.504	.234
Moral obligation	.060	1.062	.520	.291	1.337	.333	-.271	.763	.315
Constant	1.506			1.010	2.746	.369	-.262	.770	.343
Naglekerke R^2	.024			.031			.031		
Cox and Snell R^2	.051			.043			.023		

*<.10
**<.05
S.E. = standard error

was extended to $p < .10$ to recognize marginal significance. While this level generally demonstrates borderline or minimal significance, it can be an indicator of general significance, depending on the sample size, as appears to be the case in the administration regression.

Education related to what to do in active shooter and armed intruder situations was mildly significant for both the administration and clinical model, with administration being significantly less likely to know what to do in an active shooter situation than clinical and non-clinical staff, and clinical staff being significantly more likely to know how to respond to an active shooter/armed intruder encounter than administration and non-clinical employees.

Feelings of preparedness for an active shooter/armed intruder event were also significant for non-clinical and clinical employee roles, with non-clinical staff feeling unprepared compared with administrative or clinical staff, and clinical staff feeling more prepared than administrative and non-clinical staff. However, given the <.10 p level for the larger clinical sample, this significance should not be overstated and should be interpreted as minimal or mild.

DISCUSSION

Overall, it appears that all employee roles are relatively educated about where to find an active shooter policy, and less educated as to what to do in an active shooter/armed intruder situation. However, some employee roles, specifically administration, are more informed about where the policy is located and less informed about the information contained therein, a theme consistent with prior research (Darais & Wood, 2019). Furthermore, while the majority of all types of employees could correctly identify where the policy was located (the policy is housed on the Health System Intranet, couched among over 1,000 other policies), it is unknown whether employees could actually locate and/or isolate the *specific* policy. The inability of approximately half of employees to accurately identify the correct response to an active shooter situation has been described in violence and hospital literature as "troubling" (Darais & Wood, 2019). While it is unknown why clinical employees better understand the "Run Hide Fight" procedure, it has been hypothesized that clinical staff might recognize they are at an increased risk of violent victimization due to direct patient contact, as opposed to employees who may be largely working in offices (administration), or completing other responsibilities outside the patient sphere (Kelen et al, 2012; Occupational Safety and Health Administration, 2016).

The results related to feelings of preparedness are potentially connected to previous studies that have determined that non-clinical staff are less likely to feel their "Run Hide Fight" training was adequate compared with clinical hospital staff (Darais & Wood, 2019). It appears there could be a link between confidence in education and feelings of preparedness, with clinical staff being most likely to correctly respond to what to do in active shooter/armed intruder situations and also feeling the most prepared for such an event. In this sense, knowledge might be power when it comes to feeling safe and secure in the work environment. However, similar to a conclusion drawn from research about perceptions of being adequately trained for an active shooter event, it is likely that some individuals will never feel prepared for an active shooter situation, regardless of the level and quality of education received (Darais & Wood, 2019).

Interestingly, administration, who generally bear responsibility for distributing "Run Hide Fight" training, also are least educated when it comes to "Run Hide Fight" procedure. These findings are reminiscent of other research suggesting that hospital supervisors and administration might not take hospital violence as seriously as clinical staff and, in-turn, contribute to hostile or bully-based work environments (Berry et al., 2012; Thomas & Burk, 2009). Additionally, administration have concerns outside of the medical purview, such as profitability and public perception. The need to produce business or generate revenue streams might result in a desire to forgo violence-prevention mechanisms in favour of using that funding for other hospital needs, or administration may simply fail to see problems with their current violence-prevention protocol (Blando et al., 2015).

The large number of employees (84%) who expressed feelings of having a moral obligation to remain with patients during an active shooter situation is heart-warming, but also concerning, given the lack of specific training on how to assist patients consistent with the "Run Hide Fight" procedure. Best practices suggest addressing the "ethical implications

of hiding in or near patient rooms" (Darais & Wood, 2019, p. 11) and allowing employees the opportunity to debrief after trainings (Morris, 2014). This debrief likely should include a description of hospital expectations when it comes to patient care during a violent encounter, as well as a discussion of the Department of Health and Human Services protocols and an emphasis on employees' personal decisions (Jacobs & Burns, 2017; USHHS, 2014).

Limitations

There are limitations associated with this study. Chief among them is the inability to generalize these results to other healthcare institutions or government or education settings. While other organizations also grapple with active shooter education and training, this particular research was specifically designed for the hospital setting. Secondly, although it would have been ideal to expand the sample size instead of the significance level, the varying sample sizes among the different types of employees made this impractical and the significance level was therefore extended to $p < .10$. Despite providing what appears to be general significance, it is acknowledged that increasing significance also introduces more error, which is already inherent in a small sample. Lastly, time constraints prohibited the survey from being open for longer than a week. Although a decline in number of responses was observed each additional day into the response period, it is anticipated that if the survey had been open longer and additional follow-up messages been sent, the response rate would have increased.

Active shooter education and training in the hospital setting deserves increased attention. To our knowledge, very few other studies specifically look at employee role in hospital violence situations. Similarly, there is room for research regarding patient role and patient violent instigation in active shooter events. While studies of hospital violence have looked at patient–patient interactions, or patient–hospital employee dynamics (Arnetz et al., 2015), few studies investigate large-scale violence related to potential external sources, such as family or friends of those in the hospital, or internal disgruntled hospital employees. They also seemingly neglect to explore patient violent suicide or murder-suicide situations while in the hospital. Additionally, despite the findings of this study that clinical staff are most likely to know how to respond to an active shooter event, other research has concluded that patients and visitors are also at high risk of being victimized, and it is likely that "Run Hide Fight" education should be extended to the periphery of hospital patrons, instead of just hospital employees (Kelen et al., 2012). To increase understanding of these tragic and violent scenarios, additional research is needed.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest. This paper uses data and methodology consistent with another article (by the same authors). Different variables from the same dataset are used, and the methodology section has been re-worded. In short, these are two separate articles with the former article informing continued research that resulted in the current article. The article described can be found here: Darais, M., & Wood, M. (2019). Employee variables influencing "Run Hide Fight" policy knowledge retention and perceptions of preparedness in the hospital setting. *Crime Prevention and Community Safety, 21*(2), 81–93.

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