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Subject:	April 30th Community Safety Task Force deliverables
Date:	Wednesday, April 30, 2025 6:27:07 PM
Attachments:	Foci 1. Community Safety Protocols.pdf Foci 2. OR Mass Violence Fact Sheet.pdf

Hello Task Force leaders,

Please find the OHSU April 30th Task Force deliverables attached here. These address the first two of six OHSU focus areas, as follows:

Foci #1. Current community safety protocols, including at hospitals and behavioral health facilities,
with recommendations for improvement.
Research approach: Interview safety experts/administrators from urban and rural hospitals and behavioral health facilities in Oregon to summarize current protocols in use and perceived barriers and facilitators to the implementation of best practices. Review existing literature to identify best practices for these safety protocols.
Deliverable: Findings will be shared with Task Force members via brief oral or written report.

Foci #2. Key locations and events frequently targeted by community safety threats.
Research approach: Summarize mass violence threats identified in Gun Violence Archive data and those for which ERPOs were filed. Results will be presented by county.
Deliverable: Findings will be summarized in a fact sheet shared with Task Force members and made accessible to the public via the OHSU Gun Violence Prevention Research Center website.

Thank you,
Kathleen

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Oregon Task Force on Community Safety and Firearm Suicide Prevention

Current Community Safety Protocols at Hospitals and Behavioral Health Facilities

Prepared by the OHSU Gun Violence Prevention Research Center

Introduction

For this research focus area, our goal was to understand the safety protocols currently in use in hospitals and behavioral health facilities in Oregon, identify the best practices that inform these protocols, and determine the barriers and facilitators to their implementation from the perspective of those working within the facilities.

To achieve these aims, our team:

1) Conducted informational interviews with representatives currently working in leadership positions from hospitals and behavioral health facilities across Oregon; and

2) Reviewed peer-reviewed and grey literature on safety best practices.

Methods

Informational Interviews

We identified potential respondents for conversations about safety through direct outreach to hospitals and behavioral health organizations across Oregon. We made contact attempts with sixty-four potential respondents from organizations in urban and rural areas of Oregon. To guide the conversations, we developed an interview guide that included questions on current safety protocols in use at the respondent's facility, how they were developed, how they are communicated to staff, factors that facilitate or act as barriers to their implementation, and other pertinent details.

We spoke with nine[1] individuals in leadership positions involving safety and security across eight organizations:

- Director of Security, Cascadia Health
- Director of Enterprise Risk Management, Central City Concern
- Chief Clinical Officer, Klamath Basin Behavioral Health
- Emergency Department Nurse Manager, OHSU
- Manager of Patient Safety, OHSU
- Trauma Program Manager, Saint Alphonsus Medical Center
- Director of Safety, Willamette Valley Medical Center
- Trauma Nurse Coordinator, Willamette Valley Medical Center

Most professionals that we recruited did not immediately respond to our meeting request or were not available to meet before our deadline.

Literature Review

We conducted a literature review on best practices for safety within hospitals and behavioral health facilities in peer-reviewed scientific journals as well as through toolkits, reports and policies published in the grey literature. We first conducted a search of all databases available online through the OHSU library using combinations of the keywords 'hospital', 'behavioral health', 'healthcare', 'mental health', 'firearm', 'firearm safety', 'gun', 'gun safety', 'violence', 'gun violence', 'prevention', 'safety', 'protocol', 'best practice', 'guidelines', 'security', and 'risk management'. We also searched the reference lists of relevant publications to find additional sources on safety best practices and conducted Google searches to find relevant grey literature.

Results & Discussion

Current Safety Protocols and Best Practices Currently Implemented in Facilities Across the State

The safety protocols currently in use across the state differ widely based on location, type of facility, size of organization, allocation of administration and staff to safety initiatives, and physical infrastructure. While responses varied widely, we have summarized key themes that emerged across interviews, including 1) stated policies and procedures, 2) technology & physical environment, 3) training and education, 4) incident tracking, 5) review and maintenance of protocols, 6) standardized codes and alerts, 7) protocols for patients at risk of suicide, and 7) prevention practices.

[1] One interviewee did not consent to having their title or organization shared.

While not an exhaustive list of all safety protocols currently in use in facilities across Oregon, respondents discussed the following:

1) *Stated Policies and Procedures*

- No weapons policies, declaring that no weapons are allowed within the facility, or on campus.
- Weapons/contraband search and seizure.
- Increasingly stringent rules on what is allowed in certain higher-risk areas, and for high-risk patients.

2) *Technology & Physical Environment*

- Alert technologies:
    - 2-way communication for staff to communicate with each other.
    - Mass communication to all staff in case of threat of violence or emergency.
- Metal detectors at entrances.
- Panic alarms that notify security or police dispatch when pushed.
- Security cameras, especially in registration areas and waiting rooms.
- Badge-access only internal and external doors.
- Shatter-proof/bullet-proof glass.
- Visibility of intake room and other high-risk areas from nurses' stations.

3) *Training and Education*

- Regular training on verbal de-escalation.
- Annual training for all staff on crisis intervention:
    - Crisis Prevention Institute (CPI) Training[2].
- Mock active shooter drills.
- Hands-on training exercises that allow staff to notice safety vulnerabilities in their daily operations.
- Regular training on when to use different codes/protocols, including what situations are appropriate for each, and the response each receives.

[2] Multiple respondents referenced CPI Training by name, describing valuable hands-on de-escalation and crisis intervention training: https://www.crisisprevention.com/

4) *Incident Tracking*

- Physical whiteboard in ED for all staff to mark when they experience workplace violence.
    - Recently implemented in one ED as a low-barrier way to effectively gather more data on incidence of workplace violence.
- On-campus security tracking of all incidents.
- Requirements that staff report all incidents to organization.
- Requirements that organization report all incidents to accreditors and other governing bodies.

5) *Review and Maintenance of Protocols*

- Regular review of incidents through multi-disciplinary committee – distinct from tracking of incidents, review of violent incidents or near misses gives organizations a chance to identify vulnerabilities and address areas of the safety protocol that require attention.
    - One facility holds a daily manager's meeting to discuss *all* violent encounters that occurred in *any* ED within their entire hospital system, noting that hearing reports from across the system kept them engaged and helped inform their own safety protocols.
- Centralization of safety and risk mitigation teams.
- Ongoing discussion of educational needs and knowledge gaps.
- Workplace violence committees.

6) *Standardized Codes*

- Respondents discussed Code protocols that were standardized to their entire facility, emphasizing the importance of ensuring that every unit and staff member be aware of the connotation and expected response, regardless of where the Code originated. While the names of these codes may vary, common examples include:
    - Code Silver: used to indicate that an individual has been seen with a weapon, activating a security response, facility lockdown and communication with law enforcement.
    - Code Green: used when help is needed to de-escalate an agitated patient, response includes Nurse, Physician, Pharmacist and Social Worker that are in closest proximity, as well as security.
    - "Dr. Strong": a more discrete approach to indicate to nearby co-workers that one needs assistance redirecting an agitated patient, without escalating the situation.

- Behavioral Response Team: an alert that calls a specialized, on-site team that is highly trained in verbal de-escalation and responds to situations where a person is escalating and may threaten harm to themselves or others. A few respondents spoke about this type of response, noting that it takes a lot of specialized training to verbally de-escalate someone in this state, though none were currently utilizing it within their facilities.

7) Protocols for Patients at Risk of Suicide

- Screening for all patients for risk of suicide using validated screening measures and subsequent protocols for those who screen moderate or high risk:
    - Separation from other patients, belongings and clothing removed, provided with paper scrubs, brought to specialized room, provided with continuous observation if necessary.

8) Prevention Practices

- Distribution of gun locks and gun safes.
- Flags on patient charts in the Electronic Health Record (EHR), indicating to current and future care teams that patient has a history of violent behavior.
- Security or staff monitoring people as they enter the building.

Development of Safety Protocols

Respondents discussed using administrative requirements, industry standards, employee feedback, and reactions to sentinel events to develop safety protocols. Concrete knowledge of specific vulnerabilities was a key driver of protocol change. Several discussed the need to understand facility and unit operations in order to successfully implement safety protocols. Respondents from most facilities indicated that current safety protocols had been developed by committees, multi-disciplinary teams or shared governance groups, and that regularly reviewing ongoing incidents and tracking patterns helped inform their work.

Healthcare and behavioral-health workers are at increased risk for workplace violence-related injuries[3], therefore prevention is key. A key theme that emerged during these conversations is that organizations respond after sentinel events have already occurred, but not all respondents felt that their organization was prepared for incidents, and how detrimental that is for the organization and staff.

Respondents described varying levels of structure for their safety protocol implementation and maintenance. In some cases, the structure was well-established, and

[3] The National Institute for Occupational Safety and Health (NIOSH). Occupational Violence. Available online at: https://www.cdc.gov/niosh/topics/violence/. Accessed April 18th, 2025.

inter-disciplinary teams were working together to plan, implement, maintain and evaluate safety practices. In other cases, there were very few stated policies and procedures, with safety practices that were pieced together "ad-hoc" across the organization. An overarching strategic plan for security goals, with safety administration to oversee the plan, emerged as a key to success. Many described the feeling of it just being "a matter of time" before something happens, and how detrimental it felt for the organization and staff to be unprepared. In one case, there was a single person who was in charge of developing and implementing safety protocols for a statewide organization, and this person felt that they could accomplish more, and make faster progress, with dedicated staff and financial resources.

Respondents cited the concerns that they most often heard from staff, visitors, or others within the facility as: patient/client behavior, including behavioral health crises, increased violence in the community and fear that it would "spill-over" into their facility, rising levels of workplace violence, especially among healthcare staff, and gang-related activity.

Recent Changes to Protocols

Several respondents discussed recent changes in their safety protocols following major incidents that led to injury or death in their facilities, often noting that they began to think about their environment and safety protocols only after intentional acts of violence.

In one case, a patient was stabbed by their partner while in the Emergency Department. Subsequently, the respondent described a major shift in protocols, as well as feeling among staff – they had never felt unsafe at work before and had never even required intervention from their hospital security team, which was only on-site for 8 hours per day at that time. Following the stabbing, they immediately increased security coverage to 24 hours per day, and over the course of several months, had panic buttons installed in all units, locked external doors, changed internal doors to badge access, and increased security presence. The respondent reported that staff now think about their own safety, when they did not before, citing that it often takes something impactful to happen for things to change.

In another case, a shooting incident occurred in the Emergency Department of a large, urban hospital that was part of the same hospital system as the small, rural facility that the respondent worked in. In the months following the shooting, they examined safety protocols at all facilities within the hospital system and implemented changes, such as upgrading to bulletproof glass, and installing more security cameras. These structural upgrades inform their operations and daily decision-making: being able to see a live video feed from the hospital entrance via security cameras provides valuable reaction time.

Perceived Barriers and Facilitators to Hospital Safety Practices

Respondents had different levels of responsibility regarding creation, implementation, training and maintenance of safety protocols. All respondents shared factors that helped facilitate or acted as barriers to safety protocols at their facilities:

Barriers

- Tension between providing trauma-informed care and maintaining safety for staff.
- Cost of implementing best practices.
- Lack of physical safety infrastructure.
- Aging buildings, making it hard to upgrade or redesign with more physical safety features.
- Lack of dedicated funding and staff focused on safety.
- Skill and experience gaps among staff.
- Emotional connections to clients that can cloud staffs' judgement in potentially violent situations.
- Lack of dedicated personnel to develop prevention strategies, write protocols and train staff.
- Changing environment: more acuity, more substance use, more weapons and dangerous items, deterioration of mental health due to substance use.
- Reporting mechanisms are confusing or too cumbersome.
- Staff often feel that violence is part of the job.
- Under-reporting.
- Inconsistent application of safety protocols.
- Requirements by law to treat all patients seeking care from the ED, regardless of their risk for violence or possession of a weapon.
- Corporate or administrative restriction on training, including dismissal or cancellation of training that staff would find helpful.
- Difference in perception of safety versus actual safety.
- Requests or need for technology such as security cameras or metal detectors that require dedicated staffing to monitor. Often, there are no resources available to allocate to these technologies, and without constant and consistent staffing, they are not effective.
- By Oregon law, it is not a felony to assault a healthcare worker.

Facilitators

- Engagement and accountability from staff.
- Strategic, organization-wide safety strategy developed by a collaborative, interdisciplinary committee, or shared governance group.

- Oversight from trained safety professional(s).
- Buy-in from leadership, with engaged, active support.
- Fear, and desire to feel prepared.
- Knowledge that ensuring safety for staff also creates a safer space for patients/clients.
- Knowledge that feeling safe at work enables one to provide higher quality of care.
- Direct, swift response to staff safety concerns.
- Clarity, including helping staff understand the "why" of protocols.
- Good communication and clear instructions.
- Transparency.
- Protocols that are easy to understand and remember.
- Supportive relationship with local law enforcement.
- Keeping safety in front of mind by continual review of incidents.
- Awareness from data: understanding trends by effectively tracking incidents.
- Practical, hands-on, and "real-life scenario" training.

Suggestions on How to Support Facilities in Oregon

As a final question to each respondent, we asked what this Task Force or the State of Oregon could do to help them in their work to keep those within their facilities and the community safer. Most wanted time to think about this, and we are still receiving responses. For those that felt comfortable responding right away, they were hesitant to ask for more statutes, as they felt those are often not effective, and that mandating requirements would be too cumbersome without the allocation of resources to fulfill the requirements. Their suggestions include:

- Dedicating funding, with criteria dictating what it can be used for.
- Providing communication devices.
- Increasing access to weapons screening protocols and technology.
- Mandating that facilities need to have security oversight from a certified security professional.
- Mandating that organizations have a strategic plan for safety.
- Examining state laws regarding assault against healthcare workers.

- Creating provisions allowing hospital security to more readily remove people from the facility for violent behavior before they injure someone.
- Bringing injury and violence prevention training to rural areas.
- Providing rural facilities with injury and violence prevention resources for patients.
- Making it easier to report violent incidents.

Literature Review

Upon review of the literature, many complicating factors became apparent: the issue of workplace violence against healthcare and behavioral health workers is growing, well-documented, and front of mind for local, state and national leaders in the field. In addition, creation of effective violence prevention programs is a labor-intensive, costly pursuit, that must be specific to the organization, taking its specific needs, environment, patient/client population and current readiness level into account. There is a wealth of guidance and resources available for those within hospitals and behavioral health facilities to consider as they develop and maintain their safety protocols. Several themes emerged from our literature search that mirrored many of the current practices discussed by interviewees, in addition to practices that they would like to implement, but are unable to for a variety of reasons. This literature review pulled from a variety of sources, which are listed at the end of this report. Below is a non-comprehensive summary of key themes that emerged from our search of the literature on best practices for safety:

Planning Stage

Many guidelines recommend that organizations first take the time to assess their current protocols, operations, strategies and practices, and/or conduct a needs assessment or gap analysis to identify areas of their safety plan that require attention. Resources also recommend that organizations conduct risk assessments and threat assessments to identify areas or staff that may be the most vulnerable to violence. Based on the results, organizations can determine needed resources. Crucially, a lot of emphasis is placed on gaining leadership support and encouraging managers, supervisors, executives and corporate leaders to actively and visibly support safety initiatives. Resources also emphasize the need for safety protocols to be developed by interdisciplinary committees, workgroups or task forces, and encourage organizations to collaborate across the entire facility, including representatives from all high-risk departments in the planning process.

Implementation and Maintenance

Guidelines encourage organizations to dedicate adequate time, personnel and other resources to the implementation of safety protocols, and outline other needed resources:

Engineering Controls: Environmental safety measures and physical design

- Controlled access to buildings or high-risk units.
- Physical and property searches for weapons.
- Monitored surveillance systems.
- Panic alarms.
- Adequate exits and escape routes.
- Communication devices.

- Strategic positioning of staff for improved patient visibility.
- Facility/unit design enhancing visibility of high-risk areas, including patient rooms, entrances, registration, intake areas, waiting rooms, common areas, etc..
- Barrier protections.
- Quick access to assistance.

Administrative Controls

Training and Education

- Staff knowledge and skills, including training for violence prevention and patient management strategies, such as de-escalation and trauma-informed care, incident management, active shooter scenarios, lockdown procedures.

Policies and procedures

- Code of Conduct.
- Weapons policy.
- Patient screening: identify, monitor, and manage patients and visitors at risk of violence.
- Adequate staffing.
- Data collection.
- Accessible processes for reporting and tracking incidents.
- Incident response.
- Post-incident response and investigation.

Security

- Adequate personnel, training and technology, and oversight and strategic planning from trained security professional.

Proactive Safety Planning

- Regular safety and security audits.
- Accessible reporting and tracking systems for violent incidents.
- Employee support.

Evaluation

Guidelines suggest that all organizations continuously evaluate their safety protocols for effectiveness, share planned and implemented changes with management, staff and governing bodies, and continually review ongoing safety issues. Experts recommend that organizations collect employee feedback, through surveys, town halls, or unit/staff specific safety meetings. They also emphasize the need to collect data on violent incidents so that trends can be analyzed over time and improvement can be measured. While data collection and reporting of sentinel events is often required by administrative bodies, guidelines recommended that organizations track internal incidents of violence as well and make adjustments to protocols and procedures in real time in response to these incidents.

Resources for Hospitals and Behavioral Health Facilities

Local, state, and national organizations have updated guidance for violence prevention in hospitals and behavioral health facilities. A non-comprehensive list of resources includes:

- Oregon Association of Hospitals and Health Systems, Workplace Violence in Hospitals: A Toolkit for Prevention and Management
- OSHA, Recommended Practices for Safety and Health Programs
- The Joint Commission, Workplace Violence Prevention Resources. This resource center includes a collection of resources, with links to toolkits, standards, handbooks, and other strategic and practical resources from organizations across the country for each of the following focus areas: Workplace Violence Prevention Programs, Worksite Analysis, Data Collection and Education and Training. For ease of use, links to each of the collections are included here, along with links to pertinent resources:
    1) Workplace Violence Prevention Programs
    2) Worksite Analysis
    3) Data Collection
    4) Education and Training
- American Hospital Association: Building a Safe Workplace and Community
- American Society for Healthcare Risk Management: Workplace Violence Toolkit
- American Hospital Association & International Association for Healthcare Security and Safety: Creating Safer Workplaces: A Guide to Mitigating Violence in Health Care Settings
- American College of Emergency Physicians, 2024: ED Violence: Dangerous, Rising and Unacceptable

- American College of Surgeons: Firearm Safety and Patient Health: A Proactive Guide to Protecting Patients and Their Families
- FBI Healthcare and Public Health Sector Coordinating Council: Active Shooter: Planning and Response
- US Department of Homeland Security: Hospitals & Healthcare Facilities Security Awareness for Soft Targets and Crowded Places
- Mayo Clinic: Security and Screening: Preventing Gun Incidents at Your Hospital
- Massachusetts Health & Hospital Association: Developing Healthcare Safety & Violence Prevention Programs within Hospitals
- Medical College of Wisconsin: Healthcare Threat Management: Patients & Guns
- Huddy HealthCare Solutions: Violence in the Emergency Department: Strategies for Prevention and Response
- Hamblin LE, et al: Worksite walkthrough intervention: Data-driven prevention of workplace violence on hospital units

Notably, the Stop Violence in Healthcare Toolkit from the Oregon Workplace Safety Initiative is at the top of the list of resources from the Joint Commission collection. Written by member organizations of the Oregon Workplace Safety Initiative, the Oregon Association of Hospitals and Health Systems and in collaboration with Washington State Hospital Association, this toolkit is among the most comprehensive of all resources cited in this review, with 214 pages of actionable tools and links to hundreds of additional resources. One stated goal of the Toolkit was to disseminate tools and lessons learned to all hospitals in Oregon to assist implementation of sustainable, effective workplace safety programs. When our team contacted the Hospital Association of Oregon to ask if this goal had been achieved, we received an immediate response stating with confidence that every hospital in the state of Oregon has used, or is currently using, all or part of the Toolkit, and that several of the shared tools are in regular use. They also shared that the Toolkit is popular around the county, and that they have granted permission for it to be used by over 200 organizations since it was first published. In particular, facilities report using the tools for conducting a gap analysis, the security & safety assessment checklist, and the resources in the Hazard Control and Prevention section.

Conclusion

From our conversations with representatives from hospitals and mental health facilities across Oregon, and from an extensive literature review, we have found that safety is front of mind for organizations across the country and that a wealth of knowledge on best practices has been published and shared from local, state, national and international sources. Still, implementing these practices can be challenging due to the diverse needs of different facilities and resource limitations. Those currently working to implement, maintain or change safety protocols in facilities across Oregon expressed that staff are

both afraid that violent incidents will happen within their facilities, and accept that violence is part of their job and that they can't prepare for every possible violent scenario. Occurrences of high-profile violent incidents within or near healthcare facilities have encouraged staff at these facilities to become more attuned to their safety protocols and have motivated collaborators from all levels to develop new safety protocols and follow best practices for safety using available resources. Still, representatives from organizations that we spoke with commented on the barriers to implementing best practices, including limited resources, funding, and institutional support. These individuals expressed a desire for more dedicated resources, personnel, and training to support community safety within Oregon's healthcare facilities.

Mass Violence in Oregon: Remembering Tragedies and Exploring Opportunities for Prevention

Data from the Gun Violence Archive were used to summarize mass shooting incidents in Oregon from 2018-2023. Data from Oregon's Extreme Risk Protection Order (ERPO) law were examined to understand threats of mass violence, including mass shootings, in the state.

IN OREGON FROM 2018 TO 2023:[1]

18	13	73
mass shooting incidents* occurred	individuals were killed	individuals were injured

*A mass shooting incident is defined as 4+ people being injured or killed, not including the shooter.

2/3 of the incidents occurred on weekends (Fri.-Sun.)

All but 1 incident occurred between 6 PM and 6 AM

4 incidents were drive-by shootings

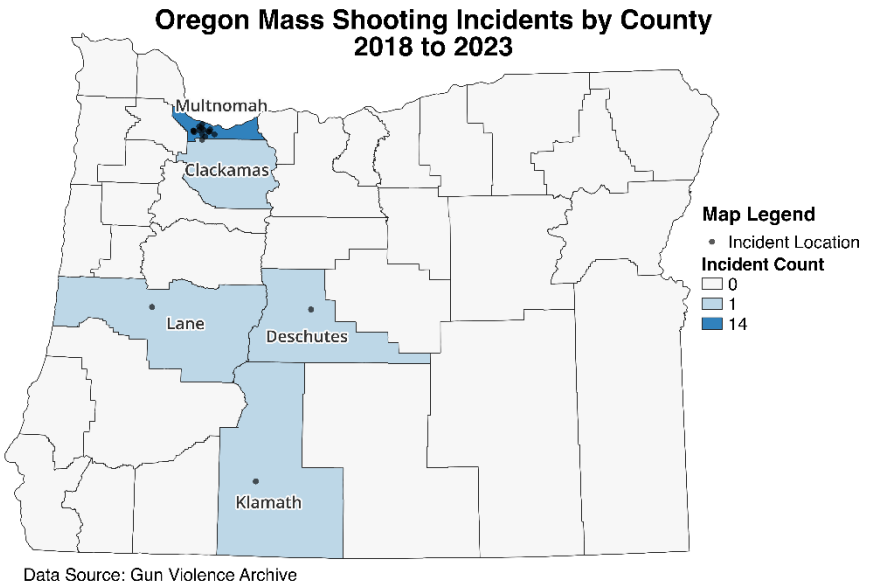
8 incidents involved shooting into large crowds

2 incidents started as apparent robbery attempts

2 incidents occurred at vigils for victims of gun violence

Where did these mass shooting incidents occur?

- 14 of the 18 mass shooting incidents occurred in **Multnomah County**.
- The **most common locations** of the incidents included:
  - **Public streets/sidewalks and motor vehicles** (n=5);
  - **Commercial establishments** (e.g., grocery store, gas station, bar; n=4); and
  - **Public gatherings** (e.g., concert, protest; n=3).



Data Source: Gun Violence Archive

1. Gun Violence Archive. Accessed April 18, 2025. https://www.gunviolencearchive.org/.

Oregon's Extreme Risk Protection Order (ERPO) Law Provides an Opportunity for Prevention

Oregon's ERPO law allows family/household members or law enforcement officers (LEOs) to petition a civil court for an order to temporarily restrict a person's access to firearms and other deadly weapons if the court determines that the person is at **imminent risk of harming themselves or others.**[1] Our team analyzed Oregon's ERPO court records[2] from January 1, 2018, when the law took effect, through December 31, 2023. Of the **835 ERPO petitions filed** from 2018-2023, **92 (11%) cited mass violence threats**.

Of the 92 ERPO petitions that cited mass violence threats:

90% were granted at the initial hearing

88% were filed by LEOs

58% also cited risks of suicide or self-harm

28% also cited risks of domestic violence

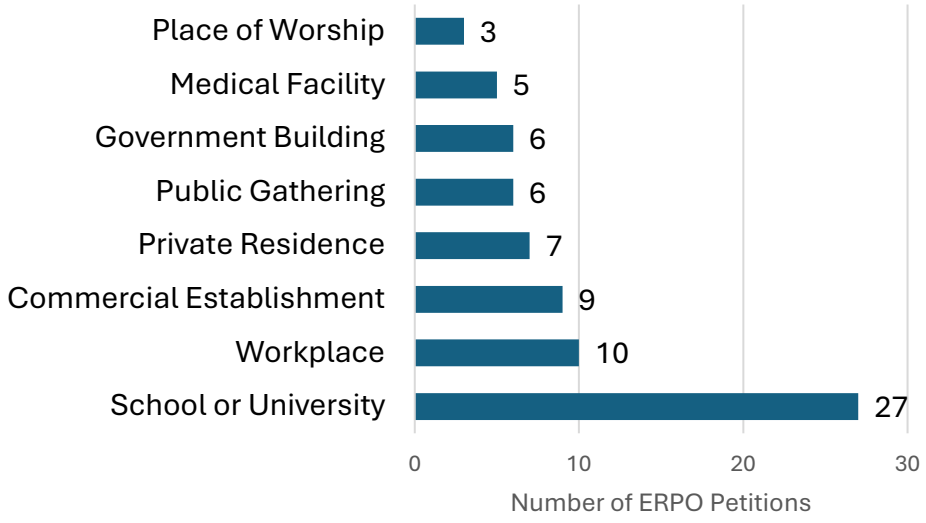
Example scenario from ERPO petition demonstrating threats of mass violence

The respondent was experiencing homicidal thoughts, saying that **voices were telling them to commit a school shooting.** The respondent **reported identifying with and idolizing perpetrators of school shootings** and expressed a **desire to become famous for committing a school shooting.** The petitioner was a law enforcement officer. The ERPO was granted.

What were the primary targets of these mass violence threats?

- **72%** were filed in **Washington, Deschutes, Clackamas, and Multnomah Counties**.
- Among mass violence threats with a known target (67), most targeted **schools/universities** or the respondent's **current or former workplace.**
- When respondents threatened specific people or groups, most threats targeted **family members** (19), **co-workers** (14), or **medical professionals/caregivers** (11).

Locations Named as Targets in Threats of Mass Violence*



* Some petitions included threats to multiple location types. There were 25 petitions that did not specify a location.

1. ORS §§166.525 to 166.543. Extreme Risk Protection Orders. Available at: https://oregon.public.law/statutes/ors_166.525.
2. Data were extracted from court records provided by the Oregon Judicial Department.

For more information, contact Dr. Kathleen Carlson, OHSU Gun Violence Prevention Center, OHSU-PSU School of Public Health, at: gunviolenceprevention at ohsu.edu

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