1. Welcome

2. Speaker introductions

3. Healthcare Security

4. The Role of Police and Security Response Forces

5. Closing

*****NOTE**:   *This presentation is not nor is it intended to be a comprehensive presentation surrounding healthcare security. This presentation is reviewing healthcare security as it relates to workplace violence prevention, protection, and response.*

Agenda

Welcome and speaker introductions

Welcome

Multi-part educational series on violence in healthcare

Session 1 — **Violence in Healthcare: Defining the Threat, and Preparing for and Managing Aggression and Violence**

- Chad Barnes, Marsh Advisory and Tyler Kerns, St. Alphonsus Health System
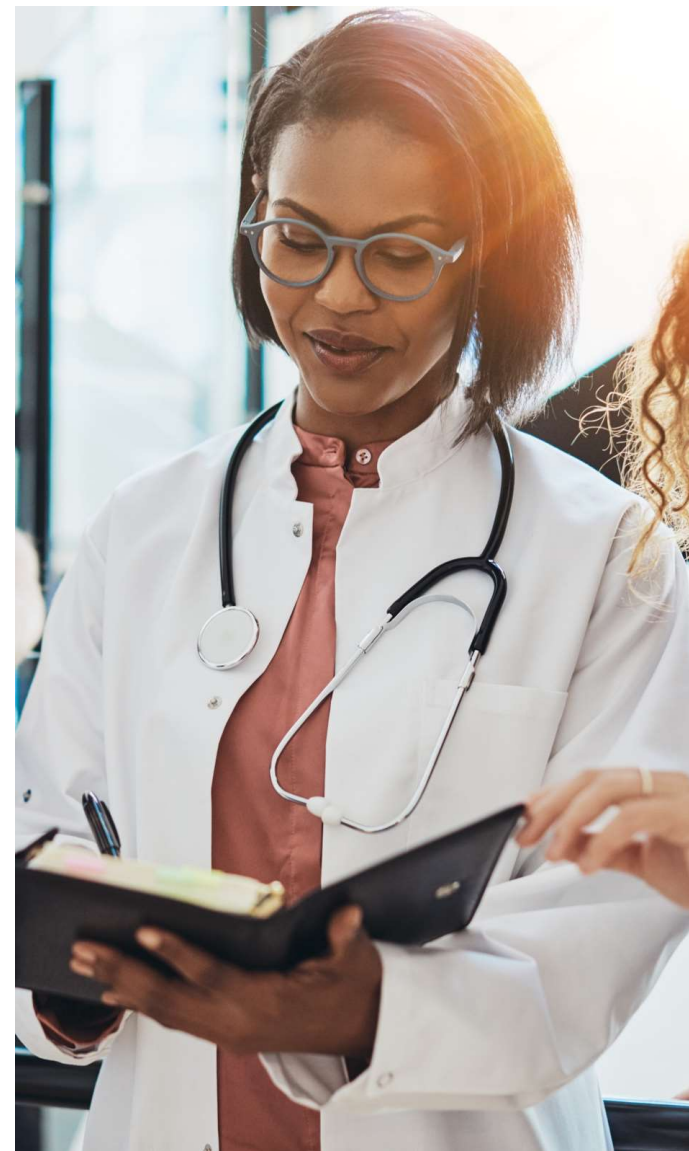
Session 2 — **Healthcare Security and the Role of Police and Security Response Forces**

- Chad Barnes and Jonathan Frost, Marsh Advisory and Tyler Kerns, St. Alphonsus Health System

Session 3 — **Care for the Caregiver**

Session 4 — **Risk Financing Considerations and Transfer of Risk**

*   Organizational and caregiver surveys

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Speaker Introductions

Industry leaders in healthcare security and violence prevention and response

Chad Barnes, CPP, PSP, PCI, CSC

Senior Vice President, Security Practice Lead
Marsh Advisory, Consulting Solutions

Credentialed security consultant with 20+ years of experience in inpatient and outpatient environments as well as a pre-hospital emergency medical care responder.

- Certified Protection Professional (ASIS)
- Physical Security Professional (ASIS)
- Certified Security Consultant (IAPSC)
- Partner Member – IAHSS, Member - ATAP

Jonathan Frost, CPP, PSP

Senior Security Consultant
Marsh Advisory, Consulting Solutions

Credentialed security consultant with 20+ years of experience in numerous security fields, law enforcement, and military security operations.

- Certified Protection Professional (ASIS)
- Physical Security Professional (ASIS)
- Marine Corps Security Forces Veteran
- Retired Law Enforcement
- Civilian Response to Active Shooter and AVERT Trainer

Tyler Kerns, M. Coun, LPC

Violence Prevention & Education Consultant
Saint Alphonsus Health System

Licensed Professional Counselor with 15 years of experience in the mental health field including inpatient, outpatient, residential treatment, wilderness therapy, and crisis response teams.

- Membership in the SAHS Violence Prevention Committee and the SAHS threat assessment team
- Lead the Emergence Team 7 Violence prevention initiative to create a guide for standardizing violence prevention programs
- Lead creation of a Trinity Health proprietary de-escalation and violence prevention curriculum that will be used as the standard training for all Trinity Health ministries

Healthcare Security

Session 1

A very quick recap

- The epidemic of workplace violence in the healthcare environment

- Definition of the threat

- Developing a workplace violence prevention program/strategy and the use of evidence based methodologies to gauge and predict violence

- Environment of Care – Security

- Accreditation agency changes and additions to standards and EPs that began in January of 2022

- Zero tolerance policy

- Active violence planning and response

Session 1 Replay Link

Session 1 Slide Download Link

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In the News

Hospitals and health care workers face inordinate violence. They need our protection.

The very people charged with safeguarding the health of the public face an unsafe environment themselves.

Police arrive at Jefferson University Hospital in Philadelphia after a nursing assistant shot and killed a coworker in October. NBC News / NBC 10

Woman Carjacked at St. Elizabeth Community Hospital, Held Hostage

The elderly victim, who was forced to drive the vehicle, jumped out of the moving car after police deployed a spike strip.

St. Louis Hospital Security Officer Fatally Shoots Suspect

Before being shot, the suspect ran over the hospital security officer with his car.

Providence Journal   + Follow

Latest incident of 'patient self-harm' at state hospital prompts a review of 'leadership'

Katherine Gregg, The Providence Journal - Dec 8

React   3

Healthcare Security

The Healthcare Environment

- One of the most dynamic, complicated, and threat rich security operational environments compared to any other industry

- Working with patients and visitors during potentially the worst time in their lives, **security must focus on EMPATHY and problem solving**

- Heavily regulated and scrutinized

- Human fallibility is the biggest security vulnerability in the healthcare environment (has to be engineered out to extent feasible)

- Diverse operations and stakeholders all with the primary goal of patient safety and wellbeing but at the same time with potentially very different and often times competing approaches to achieve it

- Diverse number of organization/facility categories and types (level 1 trauma, inpatient behavioral, etc.)

- At the end of the day the environment needs to be a "healing environment" filled with empathy and compassion, terms that are not always synonymous with security and law enforcement **BUT ABSOLUTELY NEED TO BE** in the case of healthcare which requires a shift in culture

Healthcare Security (cont.)

Administration and Management

- How is security managed, structured, staffed, and deployed within your organization?
  - The good 'ole *"Director of Facilities, Safety, Security, and Emergency Management"* title, job description, and role

- How is security embedded in the patient treatment process and how is it enhancing the patient experience?

- What predictive analytics, benchmarking, metrics, success stories, and marketing are you employing to justify, existence, requested physical/operational capital, and staffing?

- How are you presenting your needs case and return on investment to the C-Suite? How is security viewed?

- How are you thinking outside of the box to deliver high performing and efficient security services to your organization?

- Is this your organization below?

Security Budget Pre-Incident

Security Budget 6 Months Post-Incident

Security Budget Immediately Post-Incident

Security Budget 12 Months Post-Incident

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Healthcare Security (cont.)

How're you getting the message and image you want surrounding security out to everyone?

- Community Health System, Central California
  - Community Medical Centers

Security Is Layers of Protection
Hope for the worst and prepare for the worst (hope is not a strategy)

Deter: Make it uninviting for abnormal users (security patrols, cameras, fences, warning signs, and clear property delineation)

Detect: Discover abnormal users before they can act or as an incident is initiating (BOLOs, alarms, cameras systems/analytics, situationally aware staff)

Notify: Alert responders and staff of a potential threat or initiation of an incident (mass notification systems, public address systems, duress devices, radio systems, communication devices)

Delay/Deny: Delay or prevent overt or covert actions on assets

Respond/Defend: Responding to and against a threat actor to mitigate the threat (security officers, police/peace officers, properly trained staff)

Recover: Take necessary steps to maintain current operations and restore interrupted services (first aid, counseling, investigation, business continuity)
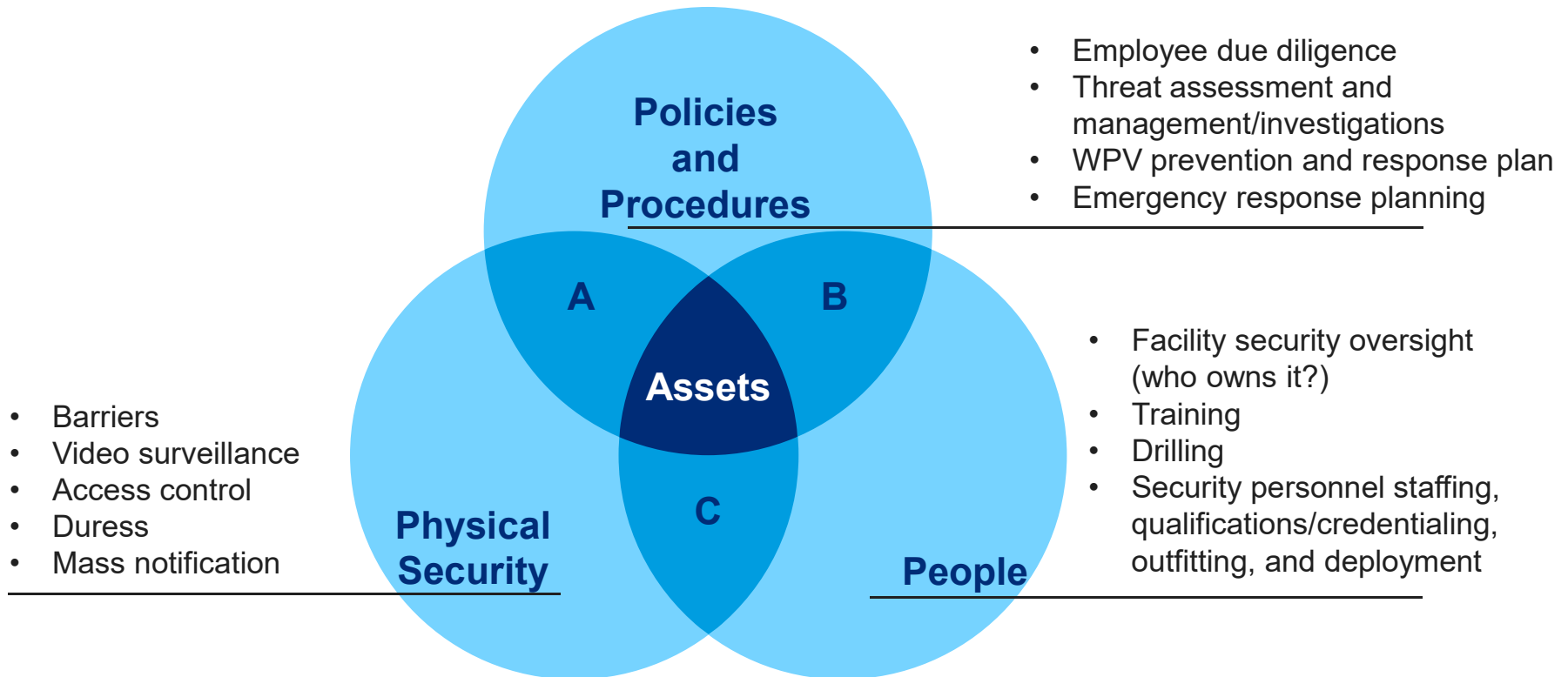
IT'S BETTER TO BE A WARRIOR IN A GARDEN THAN A GARDENER IN A WAR

Chinese Proverb

Security Has Three Primary Areas of Focus

Has to be a balanced and multi-prong approach (includes but is not limited to)

Policies and Procedures

Physical Security

People

A

B

C

Assets

- Employee due diligence
- Threat assessment and management/investigations
- WPV prevention and response plan
- Emergency response planning

- Facility security oversight (who owns it?)
- Training
- Drilling
- Security personnel staffing, qualifications/credentialing, outfitting, and deployment

- Barriers
- Video surveillance
- Access control
- Duress
- Mass notification

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Focus Area 1

Procedural

Policies Procedures and Plans (IAHSS, ASIS, and ATAP)

- Security Vulnerability Assessments (initial and minimum annually/3-5 years)
- Security Master and Management Plans
- Crime Prevention Plan
- Investigation Procedures and Plans
- All Hazard Emergency Response Plan
- Threat Assessment and Management (Brøset, DASA, WAVR21, ATAP)
- Security Role in Patient Management
- Management of Weapons and Contraband
- Collaborating with Law Enforcement
- Violent Subject (Code Grey) Management (patient versus "other")
- Stopping and Questioning Individuals
- Emergency Department Security
- Correctional Patient Security
- Neonatal and Pediatric Security
- Behavioral Health Security
- Facility Design Standards

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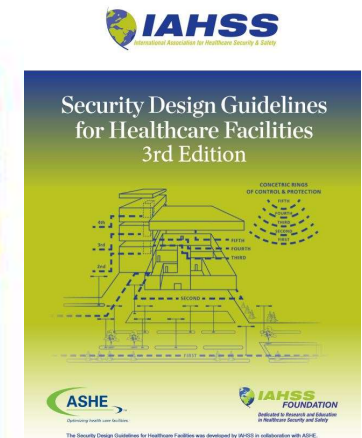
Focus Area 2

People

Personnel Staffing and Personnel Training

- Security personnel qualifications, training (in-service), and credentialing (IAHSS, ASIS, IFPO, APCO)
- Security staffing, organization, and deployment (static and dynamic posts/patrols)
- De-escalation/Non-violent crisis intervention training with advanced hands on skills (instructor level)
  - *Minimum of monthly time allotted to practice hands on skills*
- Mental health first aid training for non-mental health practitioners (instructor level)
- Hands on active violence training and drills (instructor level)
- Customer service training (Disney Institute, Phoenix Arizona Fire Department customer service SOP and manual)
- Situational awareness training
- Security dispatchers/operators
- Security systems specialist (should not sit in IT, IT is a support department, not the owner of ESS)
- Security facilities and workspaces
- Patrol vehicles
- Officer "kit" and monthly allowances

Focus Area 3

Physical Security

Physical and Electronic Protection Systems

- Security operations center and switch boards

- Threat intelligence (ONTIC, Dataminr, etc.)

- Visitor management

- Contraband detection (this is not the standard of care in majority of cases)

- Physical barriers

- Access management (including credential and brass key controls)

- Video surveillance, sensor integration, and analytics

- Mass notification

- Panic/duress systems

- Managing falls from height and ligature risks

What Healthcare Security Isn't

How you treat the security function will directly correlate to how the function is viewed by leadership and staff

The following tasks diminish the importance of the security function and take security personnel away from vital duties and the ability to respond to emergent events:

- Patient luggage assistance
- Medication runs
- Equipment/supply runs
- Patient transport
- Meal runs
- Wheelchair collection, cleaning, and staging
- Patient lift assists
- Non-violent, compliant patient sitters
- Suicidal ideation patient sitters (unless exhibiting outward violent behavior)
- Parking operations (unless in an enforcement capacity)

* This is not an exhaustive list, but it contains things we find during assessments at many agencies

* During local emergencies or crisis, yes, security many be called upon to take on additional "menial" tasks, but these tasks should not be a part of normal day-to-day operations

The Role of Police and Security Response Forces

The Role of Police and Security Response Forces

The safety of every person involved is the primary mission (Patients, Staff, Visitors, Family)

The healthcare security/public safety administrator

- Credentialed + Trained + HC security experience (IAHSS, ASIS, IFPO, state/local LEO academy, formal education)
- The days of hiring a retired LEO or police chief are no longer the standard of care
- Strategic, visionary, and a steward security and educates all stakeholders on security's role and responsibility
- Is a part of or reports directly to a C-suite position (CAO, CRO, CEO – span of control, let your security leader lead)

Protecting the healing environment

- Security has clearly defined and adopted mission, vision, and value statements and align/coincide with organization's overall mission
- Facilities need to be inviting and comfortable spaces, however patients, family, visitors, and staff need to feel safe
- *"There is a fine line between being careful and careless"* – Phillip Rivers

A profile of the healthcare peace/security/public safety officer of today

- Employee of the organization that is fairly compensated for value they bring and risks they take
- Credentialed (IAHSS, IFPO, state/local LEO academy)
- Commanding yet calming presence
- A primary stakeholder on the patient care team and integrated into the treatment plan
- **Fit** for duty (physically and mentally)
- The peace or security officer **CANNOT** be an escalating factor and needs to be evaluated during hiring/onboarding and during fitness for duty evaluations
- Healthcare security needs to follow a compassionate community policing and preventative approach model to gain compliance
- Firearms, less deadly implements, and use of force in the healthcare security program (taught, credentialed, and oversight by state/local LEO agency/academy)

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The Role of Police and Security Response Forces (cont.)

What image are we going for?

No

Resounding No

Resounding No

Yes

The Role of Police and Security Response Forces (Cont.)

Contracted off duty police officers and outside police response

Contracted Off Duty Police Officers

- High probability to escalate the situation further (may already have a negative history with the subjects/patients)
- Outside police will want to take charge and will have no clinical background
- Agreements with Municipalities/public agencies

Outside Police Response and Liaising

- High probability to escalate the situation further (may already have a negative history with the subjects/patients)
- Outside police will want to take charge and will have no clinical background
- Bound to laws outside of the clinical setting that they have a duty to enforce which could potentially escalate a situation
- Communication and training with local law enforcement to set response expectations

Security needs to be integrated into the patient treatment plan and a part of the care team

- Robust security officer training and credentialing program with field training officer shadowing and sign off
- There has to be a relationship between clinicians and security staff (mutual respect and significant rapport)
- When a situation is **immediately dangerous to life and health** (to patient, caregiver, or bystander/visitor), security takes on the lead role with clinician support until the situation has been stabilized
- Don't confuse the need for security intervention and utilizing security as a patient care tool to gain patient compliance, that's not what we're saying and **should never be the case** (using security for intimidation and coercion are never, ever ok)

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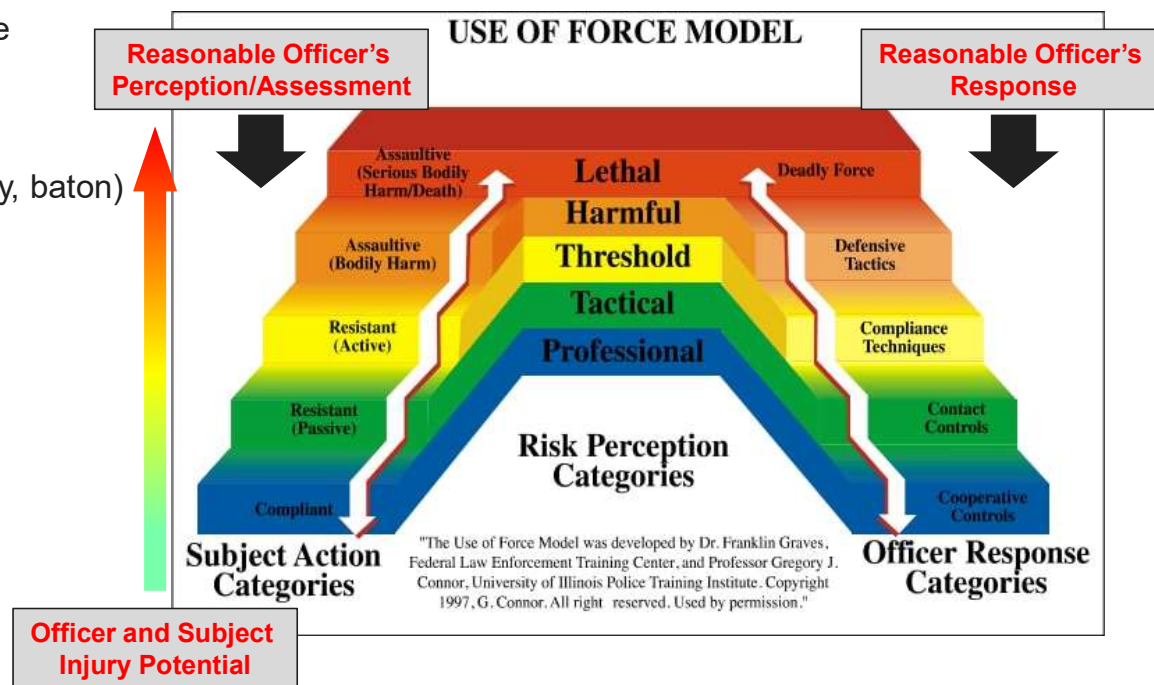# The Role of Police and Security Response Forces (Cont.)

Use of physical force in healthcare and the protection of police/security officers

Use of Physical Force in Healthcare

- Decision making process (judgment based on training and experience)
- Multi-discipline oversight, audit, and review committee
- Detaining individuals
- Force continuum and escalation of force
- Less than lethal force implements (taser, pepper spray, baton)
- Use of deadly force
- Positional asphyxia (spit hoods/hobbles)

Protection for police and security officers

- Uniforms/footwear (identification of authority)
- Non-clinical restraints (handcuffs, flex cuffs)
- Ballistic vests (internal, external, load bearing)
- Body cameras
- Communications equipment

USE OF FORCE MODEL

Reasonable Officer's Perception/Assessment

Reasonable Officer's Response

Lethal — Assaultive (Serious Bodily Harm/Death) — Deadly Force

Harmful

Threshold — Assaultive (Bodily Harm) — Defensive Tactics

Tactical — Resistant (Active) — Compliance Techniques

Professional — Resistant (Passive) — Contact Controls

Compliant — Cooperative Controls

Risk Perception Categories

Officer and Subject Injury Potential

Subject Action Categories

Officer Response Categories

"The Use of Force Model was developed by Dr. Franklin Graves, Federal Law Enforcement Training Center, and Professor Gregory J. Connor, University of Illinois Police Training Institute. Copyright 1997, G. Connor. All right reserved. Used by permission."

Can your security program earn a DHS Safety Act Certification? DHS Safety Act Certification Info

The Role of Police and Security Response Forces (Cont.)

Some unfortunate examples

Colorado Springs, CO

- Outside police agency

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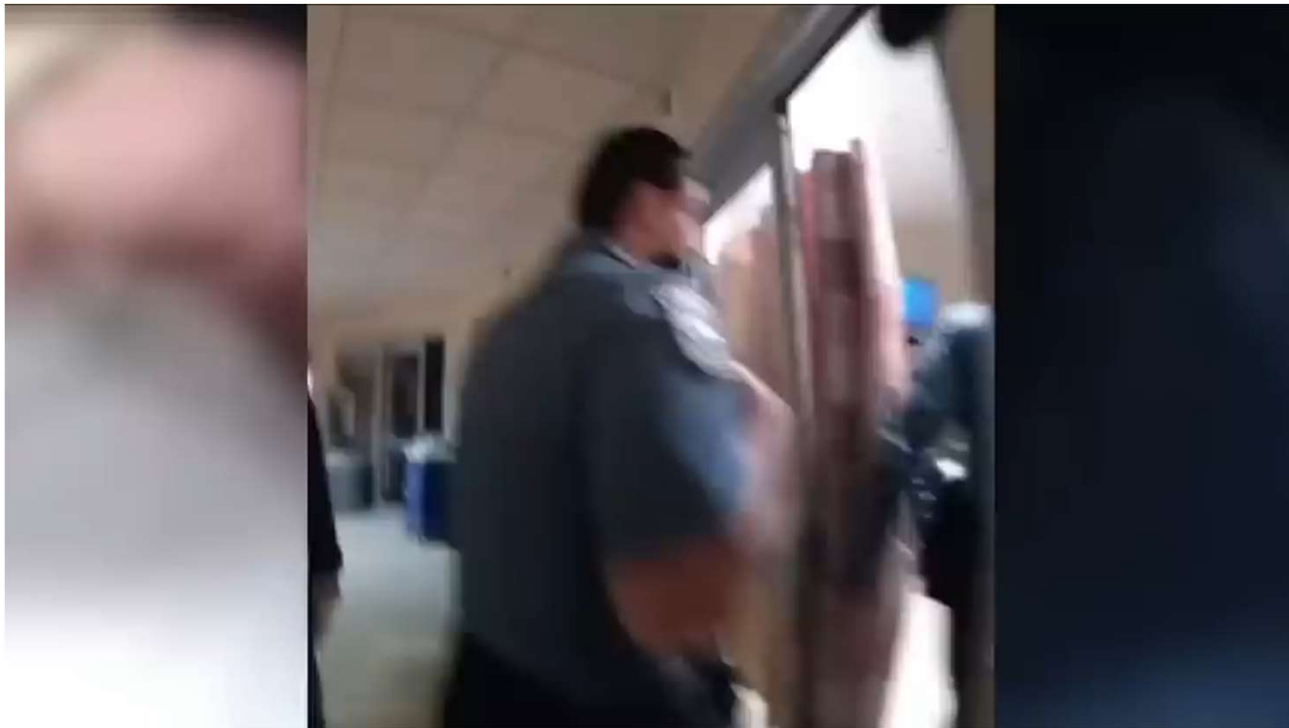
The Role of Police and Security Response Forces (Cont.)

Some unfortunate examples (cont.)

Green County, New York

- Village of Catskill Police Department

Closing

Resources

Additional information

International Association for Healthcare Security & Safety (IAHSS)

* https://www.iahss.org/news/584154/IAHSS-Launches-New-Workplace-Violence-Prevention-Certificate-Program.htm
* https://www.iahss.org/page/hcsindustryguidelines

American Society for Healthcare Risk Management (ASHRM)

* https://www.ashrm.org/resources/workplace_violence

American Hospital Association

* https://www.aha.org/websites/2015-12-17-workplace-violence-prevention-resources
* https://www.aha.org/system/files/media/file/2021/10/creating-safer-workplaces-guide-to-mitigating-violence-in-health-care-settings-f.pdf

The Joint Commission

* https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/

Occupational Safety and Health Administration

* https://www.osha.gov/healthcare/workplace-violence

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Thank you!

We enjoyed our time with you today

Coming soon: Invitation for Session #3 – Care for the Caregiver

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