Marsh

The Complexities of Managing Aggression and Violence in Healthcare

Session 1

November 9, 2021

1. Welcome
2. Speaker introductions
3. The problem of violence in healthcare
4. Defining the threat
5. Preparing for and managing aggression and violence
6. Closing

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

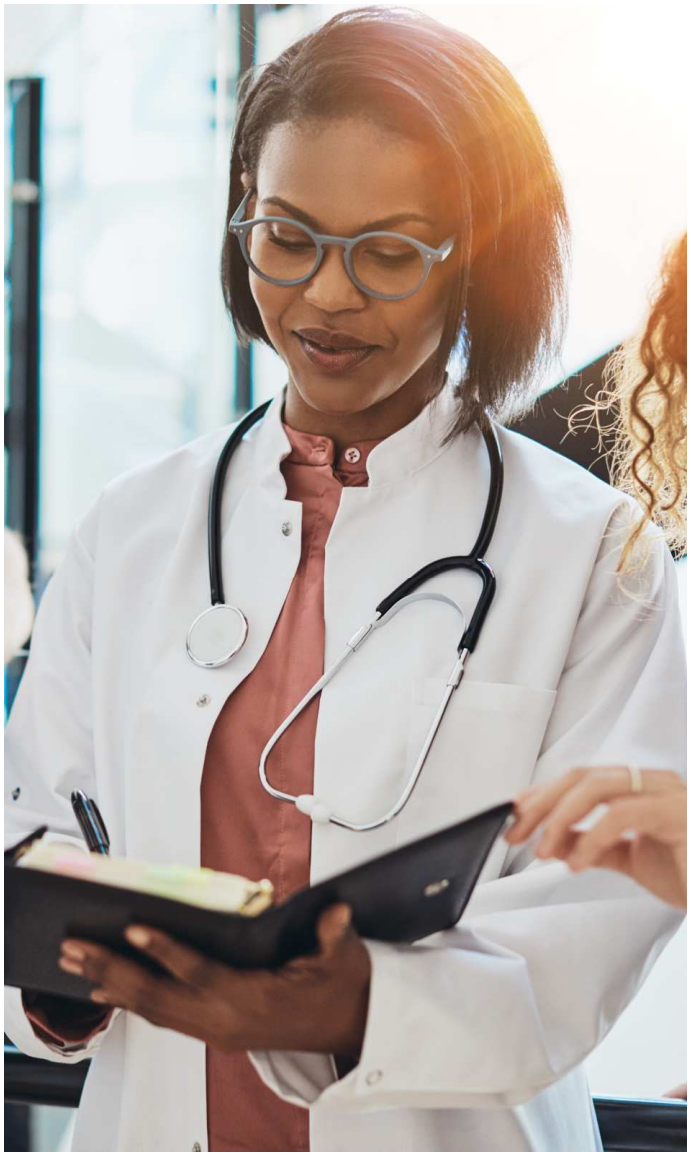
Session 2 — **Healthcare Security and the Role of Police and Security Response Forces**

- 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



Marsh

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

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

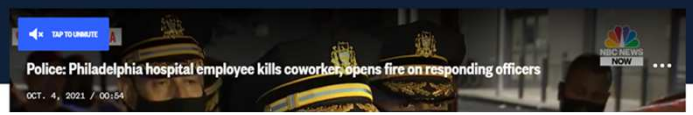
The problem of violence in healthcare

In the News

U.S. NEWS

Man accused of killing co-worker in Philadelphia hospital shooting, then opening fire on officers

After the deadly incident at Thomas Jefferson University Hospital, the suspected gunman took off in a U-Haul and was shot in a gunfire exchange that left two officers injured, police said.



HOSPITAL / SCHOOL / UNIVERSITY **Campus Safety**

News School University Hospital Technology Clery

News

Patient Brings Pipe Bomb into Pennsylvania Emergency Room

The pipe bomb was discovered by staff members who were logging the patient's belongings after his admission to the hospital.

The Washington Post
Democracy Dies in Darkness

A patient attacked a pregnant nurse at a Florida hospital, police say. Her unborn baby died.

Listen to article 2 min

Joseph Wuerz stands in court after being arrested on a homicide charge. Police say he attacked a nurse, causing the death of her unborn child.

Federal Judge Finds Florida Behavioral Healthcare Center Exposes Employees to More than 50 Attacks

UHS of Delaware Inc. and Premier Behavioral Health Solutions of Florida were both fined for not protecting workers.

By Shereen Hashem | May 06, 2021

Workplace violence exposure was determined by a federal administrative law judge at a Bradenton behavioral healthcare center. The center and its management company exposed

Who, what, where, when…….

All those caregivers working in the inpatient and outpatient environments including home health care, hospice, street medicine teams, etc. If you interact with patients and visitors, this applies to you.

Includes patient as well as visitor on caregiver violence (and caregiver on caregiver violence, but this isn't the focus of this presentation)

Reduction in behavioral health treatment programs with exponential increase in acutely ill behavioral health patients presenting at ED and outpatient settings

Everyone needs to be paying attention to federal and state legislation as well as accrediting agency requirements surrounding workplace violence coming in January of 2022
(The Joint Commission)

If a complaint is submitted to OSHA, they are going to show up, and they are going to find fines

> "The U.S. Department of Labor will pursue all available legal actions to hold employers accountable and ensure they take all feasible steps to keep employees safe," *Regional Solicitor Tremelle Howard, Atlanta*

Extent of the problem

Statistics about workplace violence are often confusing and difficult to reconcile due to the different criteria and sampling methodologies used by the investigating agencies. Regardless of these differences, most studies show that health care workers, particularly nurses, are at a far higher risk of workplace violence compared to most other professions.

From 2006 to 2015 there were 186 workplace homicides in the health care and social assistance industry within the private sector (BLS, 2016).

In 2015, health care and social assistance workers overall had an incidence rate of 8.0 (out of 10,000 full-time workers) for injuries resulting from assaults and violent acts by other persons. The rate for nursing and personal care facility workers was 21.4 (BLS, 2016).

Data obtained from nurses (RNs/LPNs) in a major population-based study showed a rate of physical assaults at 13.2 per 100 nurses per year and at a rate of 38.8 per 100 nurses per year for non-physical violent events (threat, sexual harassment, verbal abuse) (Nachreiner, N.M. et al., 2007).

International Association for Healthcare Security and Safety (IAHSS) Foundation – 2020 Healthcare Crime Survey – “Type 2 Workplace Violence continues to dominate the other types of workplace violence and is increasing.” Patient/visitor on caregiver violence accounted for 78% of all aggravated assaults (weapon with intent for severe harm) and 85% of all assaults (no weapon with no obvious or serious bodily injury) in US hospitals. (IAHSS 2020)

Extent of the problem (cont.)

Healthcare is disproportionately impacted by WPV

Table 1. Incidence rate of nonfatal intentional injury by other person, by selected industries, 2018

Private Industry	NAICS code	Incidence rate of nonfatal intentional injury by other person, per 10,000 full-time workers
All Industry		2.1
Health care and social assistance	62	10.4
Ambulatory health care services	621	3.1
Hospitals	622	12.8
Psychiatric and substance abuse hospitals	6222	124.9
Nursing and residential care facilities	623	21.1
Social Assistance	624	12.4
Child day care services	6244	7.8

Source: https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm

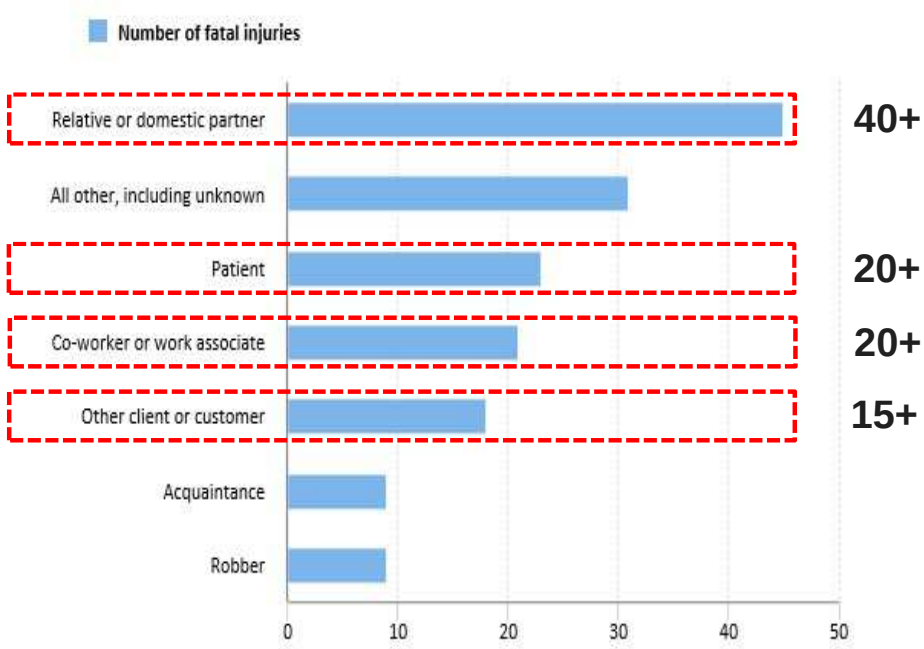
Extent of the problem (cont.)

Healthcare is disproportionately impacted by WPV

Fatal Data

From 2011 to 2018, there were 156 workplace homicides to private healthcare workers, averaging about 20 each year. The most common assailant in workplace homicides to healthcare workers was a relative or domestic partner of the injured worker (see Chart 3).

Chart 3. Workplace homicides to healthcare workers, by assailant, 2011-18



Source: https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm

Defining the threat

What is workplace violence?

The Occupational Safety & Health Administration (OSHA) defines Workplace Violence (WPV) as: Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors.

Types of WPV defined:

- Type 1: Criminal Intent (criminals with no connection to the workplace)
- Type 2: Customer/Client (violence directed at caregivers by patients and visitors)
- Type 3: Worker on Worker (current or former employee on employee)
- Type 4: Personal Relationship (assailant has personal relationship with caregiver, i.e. domestic disputes)

Type 2 is the most common form of WPV in healthcare. Research shows that this type of violence occurs most frequently in emergency and psychiatric treatment settings, waiting rooms, and geriatric settings, but is by no means limited to these (cdc.gov).

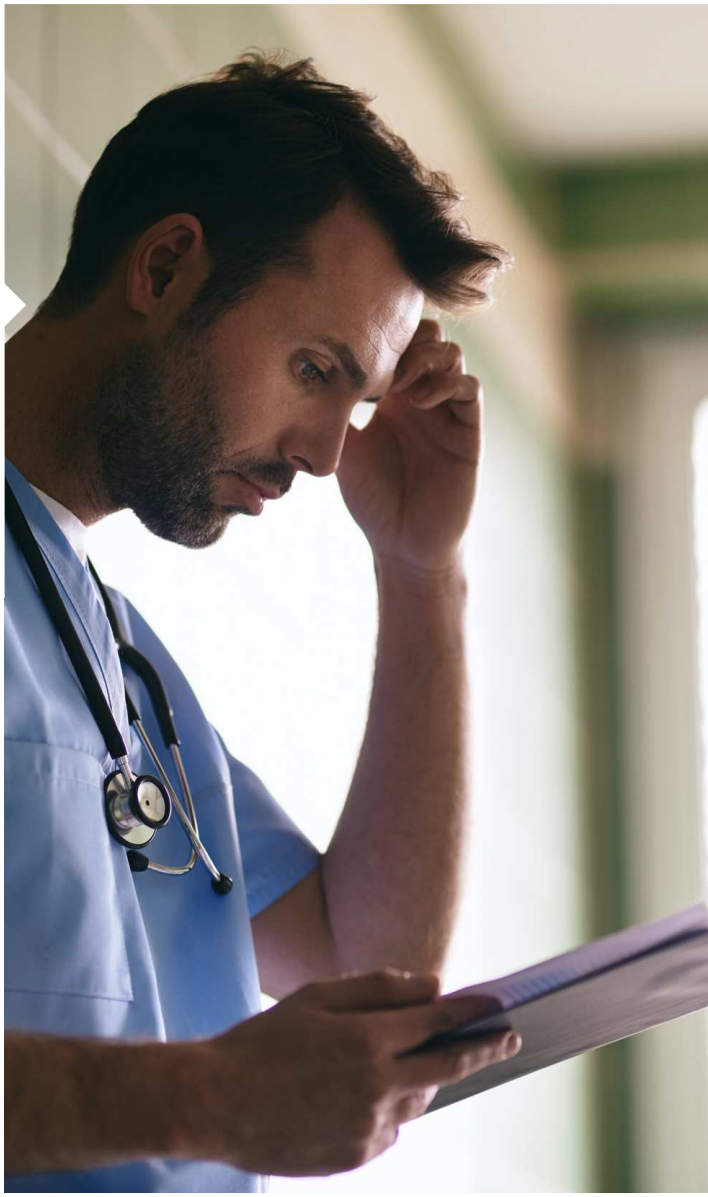
Type 3 and Type 4 are also a concern for healthcare occupancies, but not our primary focus for this presentation.

We're also seeing a significant increase in WPV in outpatient clinic settings.

Facilitating a change in the narrative

Prevention of the ongoing threat of WPV must come from within and requires a cultural paradigm shift

- Avoid the acceptance of violence and aggressive behavior as being a part of the job
  - Top down commitment to address violence and not let it become a part of the culture of the organization
  - Commitment to providing the necessary tools for caregivers to manage violence, aggressive behavior, and higher acuity patient populations (i.e. behavioral health, neuro/TBI, memory care, substance abuse, med-surge, cardiac care, ICU, etc.)
- Documentation of incidents and tracking of statistics
  - If we do not know when, where, why, how, who, and how we responded, then we cannot track and trend the issues, apply appropriate mitigation measures, and ask for appropriate funding
    - By location within the facility
    - By type of violence/aggression
    - If weapon used and type
    - If security intervened
    - If restraints had to be deployed
    - Caregiver injuries
    - Caregiver lost time
    - Caregiver cost of injuries and treatment



Facilitating a change in the narrative (cont.)

Prevention of the ongoing threat of WPV must come from within and requires a cultural paradigm shift

Avoiding complacency surrounding violence and aggressive behaviors. We need to change our terms and considerations surrounding violence.

- “Active Violence”, not “Active Shooter” or “Active Assailant”
- Includes non-physical aggressive behavioral as well as verbal abuse (these are gateways to physical violence)
- Weapons include but aren’t limited to stabbing objects, cutting objects, firearms, vehicles, blunt objects, explosive devices/fire, chemicals, etc.

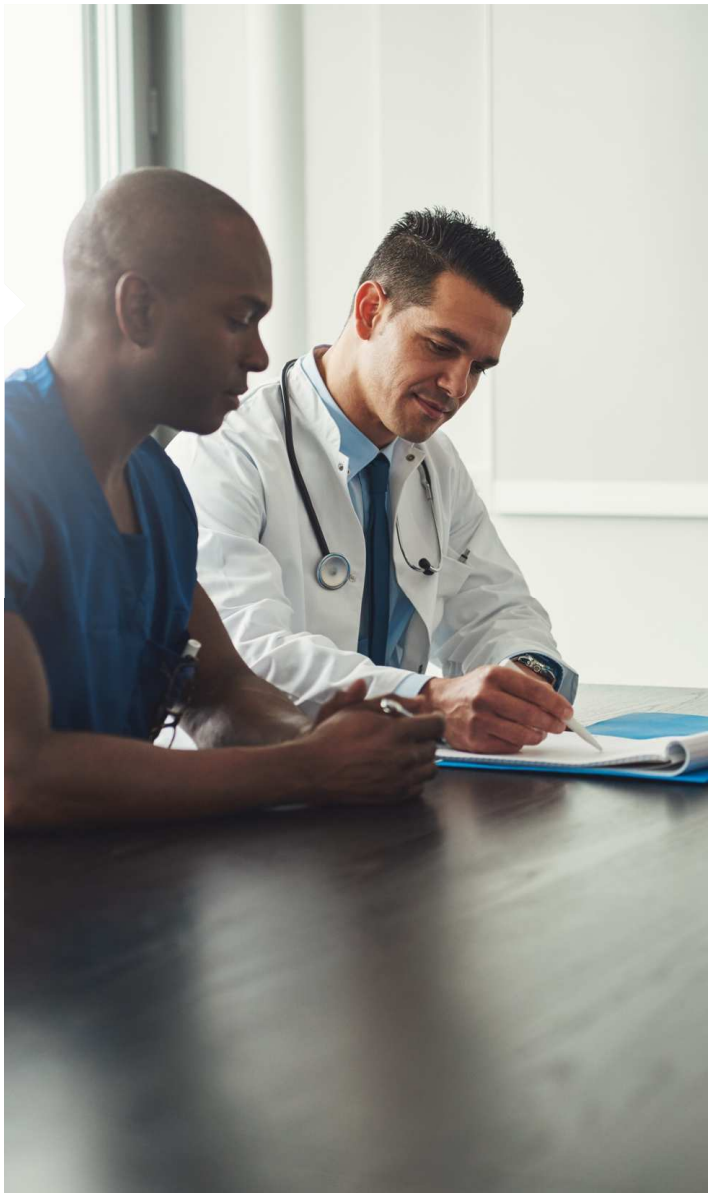
Preparing for and managing aggression and violence

Developing a strategy

Developing a WPV prevention strategy

Violence prevention is WAY more than physical security

- Ownership and Accountability
- Communication
- De-escalation Training
- Reporting/Tracking
- Response
- Screening
- Environment of Care - Security
- Zero Tolerance Policy
- Active Violence Planning and Response



Ownership and accountability

The Creation of an interdisciplinary team comprised of frontline staff and senior leadership

This Team will:

- Own the WPV prevention program and act as the steering committee on the local level
- Work to implement the best practices, as well as tracking incident data and reporting to regulatory bodies and other stakeholders
- Meet monthly to enact the best practices, as well as, to review incident data, trends, interventions success/failure, and opportunities
- Be comprised of an interdisciplinary team based on the organization's resources. Membership representation should include, but is not limited to:
  - Senior leadership
  - Nursing leadership
  - Security
  - Employee health
  - Risk Management
  - Human Resources
  - Legal Counsel (possibly)

Communication

Make WPV prevention a priority and discuss it openly and regularly

- Caregivers have to know that their safety is the number 1 priority of senior leadership and front line managers
- Shared learning during daily safety briefing, department huddles, and shift change reports
- Data Sharing: Create dashboards to make WPV data accessible to leaders
- Weekly review of all WPV incidents
- Discuss policies, procedures, and expectations during new hire onboarding and annually thereafter
- Share near misses and close calls

De-escalation training

WPV can impact anyone at any time. Everyone needs training.

The use of evidence-based education will improve colleague proficiency in identifying escalating behavior, understanding what interventions or strategies can be utilized in a variety of circumstances, and gain a better understanding of resources within their organization to assist them in responding to and resolving aggression or violence when they encounter it. Early and regular training presented in multiple modalities solidifies learned skills and approaches that will result in greater competence and confidence in our colleague's ability to manage such encounters.

- Training during onboarding and annually thereafter
- Caregivers identified as medium and high risk have to be given time during shifts to practice skills, at a minimum of monthly, to build muscle memory
- Using a Tiered training approach

In accordance with The Joint Commission, State, and local regulatory and accrediting body's best practice recommendations as part of its workplace violence prevention program, that provides training, education, and resources for the prevention of workplace violence to leadership, staff, and licensed practitioners as appropriate to their roles and responsibilities.

De-escalation training (cont.)

Identifying colleagues at risk of exposure should be assessed on historical data of reported incidents of violence by evaluating incident rates based on report documentation and security calls for service. Training levels and frequency should be based on this assessment.

High risk of violence; Colleagues who are directly patient facing who interact with HROV (high risk of violence) patients, i.e. security staff, behavioral health units, ED staff, psychiatric clinicians, etc.

- These colleagues will receive the highest level of WPV prevention training to include but not limited to, in person de-escalation training, limit setting skills, personal nonviolent physical safety techniques and nonviolent physical restraint techniques provided upon hire and annually. Additional online curriculum focusing on WPV prevention should be assigned quarterly.

Medium risk of violence: Colleagues who are directly patient facing or public facing. This includes ancillary teams that perform work in patient care areas or within the residence of patients; i.e. acute care nursing, PT, OT, respiratory therapy, imaging, pharmacy, food service, housekeeping, environmental services, etc.

- These Colleagues will receive the same training as the High-risk colleagues apart from the restraint techniques.

Low risk of violence: Colleagues who do not interface with patients or the public during their normal day to day work, i.e. administrative colleagues, IT services, facilities, etc.

- These colleagues will receive initial verbal de-escalation training upon hire and eLearning/online curriculum assigned quarterly.

Example programs include Crisis Prevention Institute (CPI), MOAB Training International, and KLA Risk Consulting

Reporting and tracking incidents

Any time that an incident of workplace violence occurs within the organization that impacts a colleague, that incident must be documented and reported. Accurate documentation data helps to ensure that colleagues get the support that they need, risk mitigation is enacted, and meaningful preventative actions toward future incidents can be applied.

Create a clear and streamlined reporting process for colleagues

- If the reporting process is perceived as burdensome, then incidents will go unreported
- Use of a standardized reporting document that is readily available/online
- Identify a sole repository for all incidents. “Don’t keep multiple books.”
- Normalize the culture of reporting, make it the expectation
- Document the who, what, when, where, but also include the contributing factors and preventative actions taken
- Track various pertinent metrics to determine trends: site location, department, unit, physical location on unit, colleague involved, aggressor involved, type of violence, severity of injury, etc.

Response to WPV

Providing a 24/7 real-time response beyond security

The purpose of this real-time response to colleague safety incidents is to provide more consistent and timely support to the colleague impacted by WPV, as well as mitigating ongoing safety concerns, fostering improved communication and notification to stakeholders of when colleague safety incidents occur, and prevention of future safety incidents.

- Identify the response team: Business hours vs. Off hours/weekends/holidays
  - Security
  - Clinical Coordinator/House Supervisor
  - Administrator on call
- Leadership training in response process
  - Use of scripting to ensure consistent response
- Mitigate ongoing risk
- Provide care/support to impacted colleague
- Investigate causes and contributing factors
- Initiate preventative actions
- Complete documentation
- Communicate findings

Response to WPV (cont.)

Providing a 24/7 real-time response beyond security

“Code Grey” response procedures

- There needs to be a clear delineation between a Code Grey and criminal activity
- Caregivers need to know what it says and who has what roles
- Needs to be reviewed a minimum of annually

“Code Grey” training and drilling

- Are clinical and security teams training together?
- Is security considered part of the patient care team?

Do “Code Grey” responses create vulnerabilities in facility security and patient care?

Screening for High Risk of Violence (HROV) Patients

If you can predict it, you can prevent it.

The inclusion of a violence screening tool early in the care plan process, ideally during triage or initial assessment of a patient, paired with clear documentation in the electronic medical record (EMR) will aid in ensuring that all members of the care team are aware of patients that pose a heightened risk of violence or aggression. The violence screening should be standard work in the triage or intake process to establish a violence acuity score. This score will be documented in a specified location within the EMR. Patients who meet criteria of an elevated risk or violence or aggression will automatically have predetermined precautionary interventions implemented to their care plan based on their acuity score. This may include:

- A highly visible alert in the EMR (similar to isolation precaution alerts)
- A door flag /tag to the patient's room to alert care team members and ancillary staff to check with the attending RN prior to entry so that relevant information to the risk of violence or aggression maybe shared
- Staffing a patient safety attendant for 1:1 observation or the use of video remote monitoring
- Notifying security of the patient's elevated risk of violence or aggression

Screening tools include the Brøset Violence Checklist and Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument

Environment of care — Security

Accrediting agency requirements

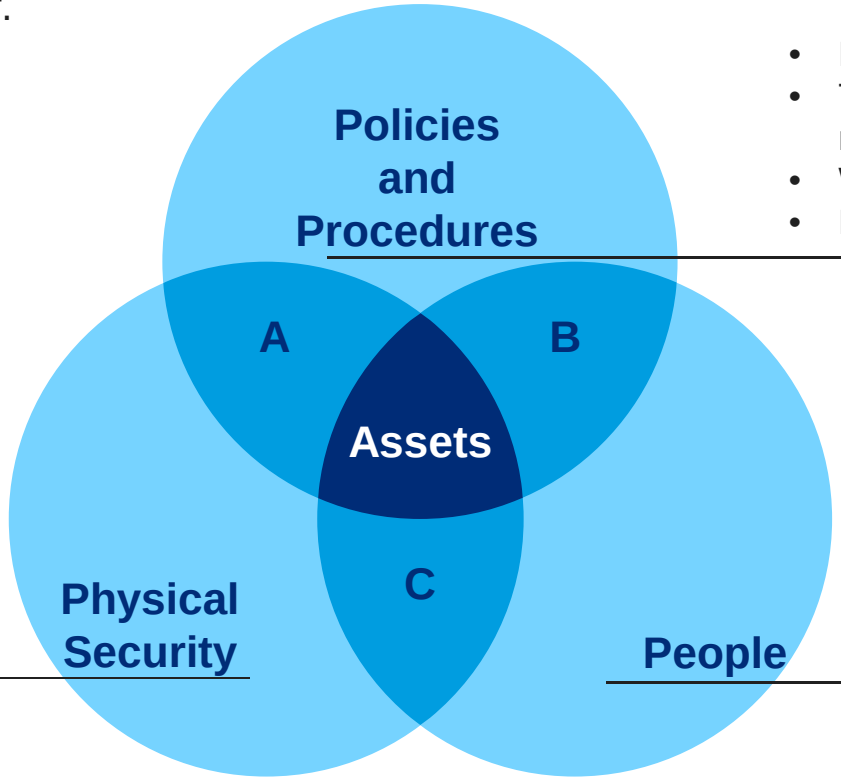
Requirements are pretty loose and open to interpretation:

- EC.02.01.01/EC.04.01.01
  - The facility manages safety and security risks
- Identify security risks and high risk areas
- Minimize or eliminate identified security risks
  - Identify individuals entering facilities
  - Control access to and from areas it identifies as “security sensitive”
  - Written procedure(s) in place for responding to a security incident
  - When a security incident occurs, identified procedures are followed
  - Continually monitors, reports, and investigates security incidents involving patients, staff, or others within its facilities

Environment of care – Security (cont.)

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

The use of polices/procedures/guidelines, personnel, and environmental monitors/controls regarding Workplace Violence is another tool in our toolbox in preventing, responding to, and recovering from a Workplace Violence Incident. Healthcare organizations must commit to providing a safe Environment of Care for patients, visitors, and staff.



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

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

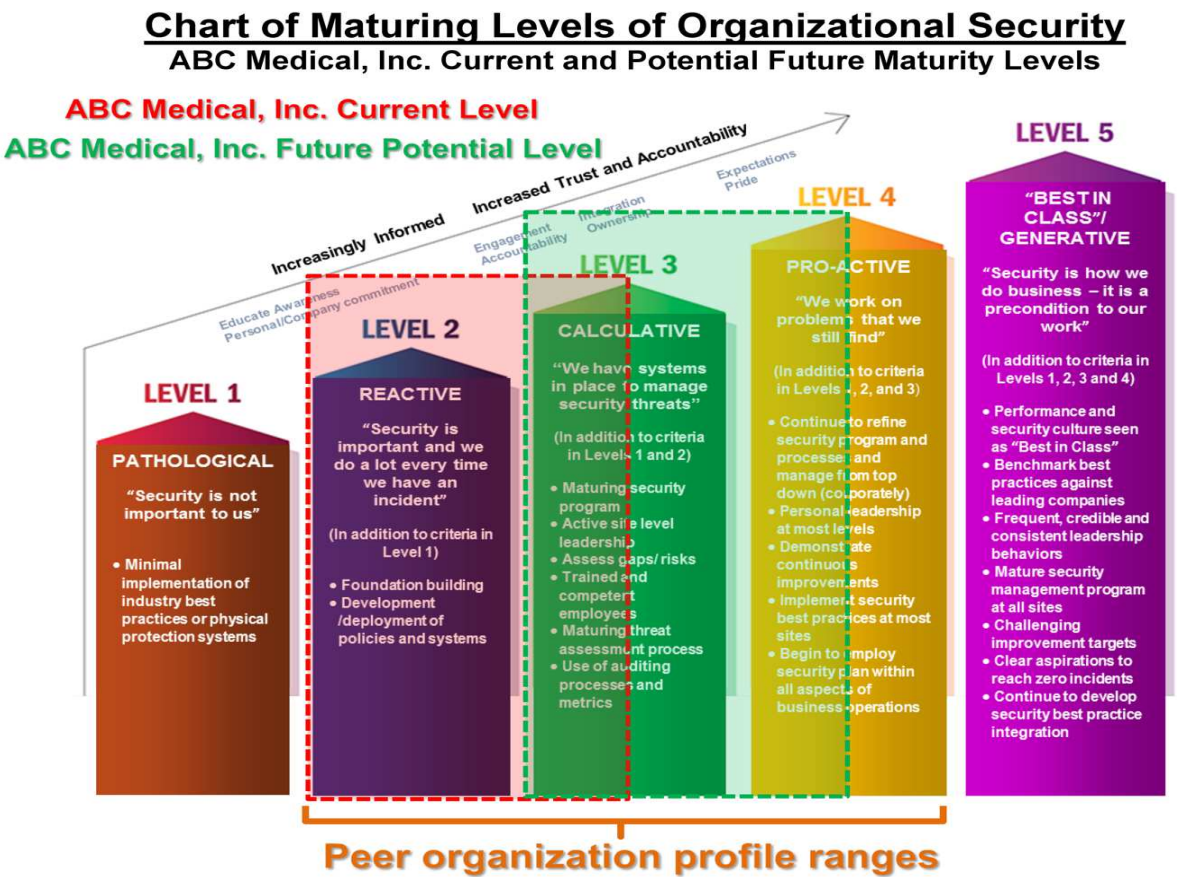
- Facility security oversight (who owns it?)
- Training
- Drilling
- Security personnel staffing, qualifications/credentialing, outfitting, and deployment

Environment of care – Security (cont.)

Aspects to consider and steps to identify security risks and high risk areas

The security vulnerability assessment (SVA):

- What are your critical vulnerabilities to manage and what is your current security posture?
- Have you ranked your risks of relevant threats?



Environment of care – Security (cont.)

Aspects to consider and steps to identify security risks and high risk areas

Consider where there is the highest volume of high acuity patients. This will often be in critical care areas, such as the Emergency Department, Intensive Care units, Psychiatric units, and visitor/patient COVID-19 screening stations. These areas can be highly stressful for patients and their families and emotions can run high. Other areas of consideration for elevated emotional duress may include pain clinics, cardiac/intensive care units, oncology units, and labor and delivery/pediatrics.

Identify areas of care or locations within a facility that have historically had elevated rates of acts of violence or aggression. Organizations should track historical data through incident reports or other employee health records to identify frequency trends of incidents of aggression or violence.

Coordinating between clinical staff and security resources to track trend which areas of a facility receive the most calls for security service and utilizing security focused rounding to these higher risk areas.

Patients that have been identified as having a higher risk of violence (HROV) need a safer physical environment. These HROV patient's environment of care must mirror the steps taken for patients that demonstrating active suicidal ideation. Any non-essential furniture or equipment should be removed from the environment, limiting personal items that might be used as weapon, and removing ligature risk items from the environment. Do "safe rooms" exist in the ED as well as inpatient floors? If not, can they be made to be safe?

Environment of care– Security (cont.)

Deploying policies/procedures, personnel, and systems to secure the facility and respond to threats:

Identification of individuals entering facilities:

- “Be on the lookout” (BOLO) procedures/postings? Are video analytics deployed?
- Limited number of public entrances/exits
- Logging of visitors
- Identification badge policies and enforcement
- Contraband screening

Access control into and through the facility:

- Healthcare occupancies are typically a leaky sieve.
- Organizations must assess their visitation policies to determine what areas of the facility and during what hours visitation is permitted. Then criteria must be established for exceptions to these policies for emergent or extenuating circumstances.
- Assessment of access control mechanisms from most secure to least secure. i.e. Lock and key access only, use of intercom/telephone outside of area to be granted access from staff by calling in upon arrival, badge access, keypad, staffed entry checkpoint, non-staffed entry point. Facilities will determine the degree of access control based on risk to a given area or facility.
- Ability to initiate automated soft and hard “lock downs” of areas or the entire facility

Environment of care– Security (cont.)

Deploying policies/procedures, personnel, and systems to secure the facility and respond to threats:

Use of video surveillance

- Full coverage video surveillance utilizing analytics as a force multiplier (loitering detection, tail gate detection, facial feature, crowd density, object, video trip line, etc.)
- Security command center and dispatching staff
- Well positioned mirrors in hallway intersections and blind spots
- Adequate lighting in hallways, corridors, patient rooms, facility entry points, parking lots/garages, and cross walks

Use of duress alarms

- Fixed or mobile (wearable badge buddy) panic devices with geospatial tracking, interfaced with nurse call (examples include ASR Alert Systems, Midmark, and Strongline)
- Emergency intercoms and bluelight telephones throughout the site integrated with site video surveillance
- Gunshot detection systems integrated with video surveillance and mass notification.
- Inspection and testing program

Environment of care– Security (cont.)

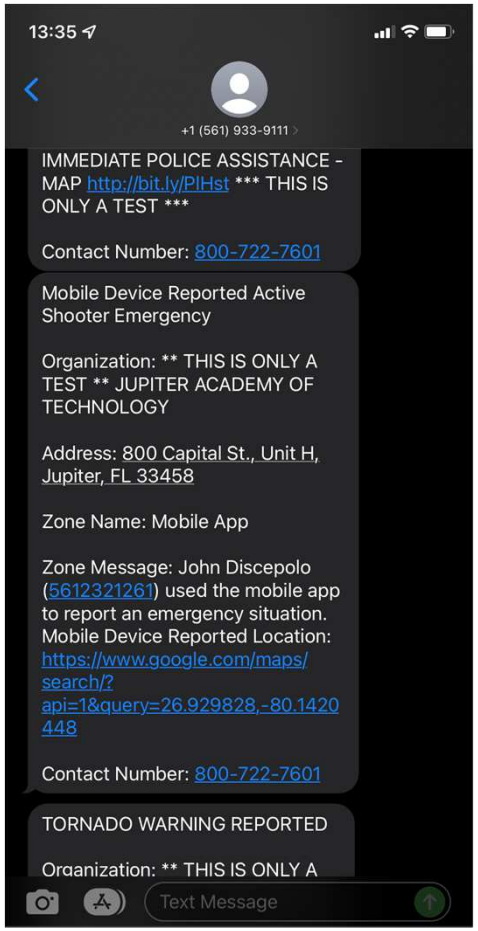
Deploying policies/procedures, personnel, and systems to secure the facility and respond to threats:

Use of notification systems

- Companion wireless telephone/communications solutions (i.e. Vocera, mobile radios, etc.)
- Intelligible facility-wide overhead paging system
- Multi-faceted mass notification solution (Examples include Everbridge, Single-wire - InformaCast, and OnSolve) integrated with as many communications systems and mediums as possible
- Intelligence gathering and active threat management (ONTIC and Sigma)

Response to security related incidents

- Can site guard force be scaled up within an hour?
- Emergency response plan needs to account for a myriad of incident types including patient/visitor violence, bomb threats, suspicious package threats, as well as active violence
- Incident command system and emergency operations center
- After action reviews



Zero tolerance policy

Aggressive and violent behavior are simply not acceptable from anyone

Caregivers cannot be the escalating factor

- Assessing for this needs to be a part of the incident review process and after action reviews
- There needs to be progressive and swift disciplinary action
- Hiring process of security and peace/police officers needs to account for this “fitness for duty”

Proactive patient and visitor campaigns surrounding expectations regarding unacceptable behaviors and repercussions

Patient and visitor contraband screening for both inpatient and outpatient settings

Written warnings and/or off boarding a patient from an outpatient practice (letter examples)

Emergency Medical Treatment and Labor Act (EMTALA)

Criminal charges, no trespass, and restraining orders

Continual threat assessment and management after discharge (increase in caregiver stalking incidents nationally)

Active violence planning and response

We’re beyond prevention at this point

Know your codes and when to call what (why’re we still seeing codes out there?)

An active violence incident is beyond a patient or visitor acting out. An active violence incident involves an individual attempting to actively cause bodily harm to or kill individuals in their vicinity.

All employees have to be provided with hands on training to active violence following the United States Department of Homeland Security Run, Hide, Fight methodology. Watching a video annually does not constitute training.

Program needs to include annual table top exercises and full scale drills for
ALL employees.

No one can prevent these incidents, but a balanced and measured response can help to limit loss of life.

Review of 2020 outpatient clinic shooting incident

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

Thank you!

We enjoyed our time with you today

Coming soon: Invitation for Session #2 - Healthcare security and the role of police and security response forces

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Coming up:

MarshMcLennan

the schwartz center
FOR COMPASSIONATE HEALTHCARE

Register now

Wednesday,
December 8, 2021

3:00 – 4:30 EST

Supporting the mental health and wellbeing of healthcare workers is a pressing imperative for healthcare organizations and it has only grown more urgent throughout the COVID pandemic. Marsh McLennan, in partnership with the Schwartz Center for Compassionate Healthcare, invites you to join an interactive webinar on December 8 to discuss this important topic with your healthcare executive peers.

Q&A

Who do you see leading the WPV prevention committee?
This will vary from health system to health system depending upon the size, resources, & organizational structure. Having senior leadership involvement is essential to drive change, but that may not be the best person to lead the committee. The organization's Safety Officer or Emergency Manager would be good candidates, but so would a VP of Operations or CNO. The best answer would be the person with the passion for the work, bandwidth to take it on so that the program does not wilt on the vine, and the expertise or understanding to manage such a program.

What de-escalation training do you recommend?
There are numerous options in the market, and the decision will need to be based on the needs of your organization. Many of these programs can be expensive, though selecting a reputable and evidence based training program will result in better results in the form of improved colleague competence and confidence as well as a reduction of injuries and potential liability. The Crisis Prevention Institute is probably one of the most well know programs. The beauty of this option (as well as other commercially available solutions), is that they provide "train the trainer" programs so that candidates can go back to their organizations and train their own staff. In this case, we recommend security response force leadership and senior officers receive the training as well as a cadre of clinicians so that the training is taught on site in a tag team effort by security and clinicians so that both aspects of response to escalation incidents is considered in the training. The absolute key to de-escalation training is that it include the hands on physical skills for those that are patient facing. The other key is providing caregivers time on the job to practice these skills throughout the course of a year so that muscle memory is built and fresh.

We are seeing many more vague phone threats towards providers. What steps can we take in these instances?
Documentation is essential. Gather as much information about the caller, use direct quotes as to what is said, and notify the appropriate stakeholders (i.e. security, risk management, legal council, and up to and including local law enforcement). All threats must be taken seriously by using a team approach to navigate threat mitigation and response to reduce potential harm to staff or the organization. Use of a threat management platform to receive inputs from geospatial intelligence resources as well as to document the course of and timeline of an investigation is also a very important tool. In the case where an established organizational threat assessment and management team does not exist or is in its infancy, consideration should be given to hiring an reputable/credentialed threat management firm to conduct these investigations and determine risk of violence potential.

A business of Marsh McLennan