Workplace Violence Tabletop Toolkit

A Practical Readiness Roadmap Prepared for Montana's Community Health Centers

INSURICA HEALTHCARE

Table of Contents

Section 1: Facilitator's Guide

Purpose of this exercise

This tabletop guide was designed to help Community Health Centers approach workplace violence prevention in a practical, proactive way. It is structured to foster cross-functional dialogue, identify improvement opportunities, and build shared ownership of safety across your organization.

WHO SHOULD FACILITATE?

This exercise can be led by anyone with facilitation experience and a basic understanding of your organization's safety or emergency preparedness policies. Most often, this will be someone in:

- Risk management
- Human resources
- Compliance or quality improvement
- Operations or clinic leadership

DIVERSE PERSPECTIVES MATTER

Many workplace violence events unfold at the intersections—between programs, disciplines, and responsibilities.

WHO SHOULD BE INVOLVED?

A strong session includes perspectives from both leadership and front-line staff. Suggested participants:

Clinical Roles:

- Medical Assistants
- Nurses
- Behavioal Health Staff
- Dental Staff

Non-Clinical Roles:

- Reception/front desk
- Compliance/risk leadership
- Facilities/security
- Executive or operations leader

Tip: Consider co-facilitation with a clinical leader and non-clinical team member to relfect the diversity of roles impacted by violence in healthcare.

Choose a Format That Fits

Each organization will have different bandwidth and goals. Here's how to tailor facilitation based on session type:

HUDDLE (20-30 MINUTES)

Best For: Single departments, time-limited meetings

Suggested Focus:

- Brief framing (2-3 min)
- One key scenario or readiness question (10-15 min)
- Quick group reflection or "what stood out?" roundtable (5-10 min)

Facilitator Tips:

- Focus on one aspect of toolkit (front desk incident, de-escalation flags in EHR.
- Don't force a full action plan, capture ideas and follow up.

TABLETOP DISCUSSION (60 MINUTES)

Best For: Cross-department teams or leadership reviews

Suggested Agenda:

- Framing & purpose (5-10 min)
- Readiness questions OR role based scenario (20-30 min)
- Reporting & flowchart discussion (10-15 min)
- Group identifies & commits to 1-2 next steps (5-10 min)

Facilitator Tips:

- Use printed worksheets or shared screens
- Ask each participant to speak from their perspective - what would you do or need in this scenario?

FULL SIMULTATION (90-120 MINUTES)

Best For: All-hands planning or deeper strategic sessions

Suggested Agenda:

- Introduction, context, and shared goals (10 min)
- Full scenario walkthrough using stakeholder prompts (45-60 min)
- Response flowchart and readiness assessment (15-20 min)
- Post-incident trust, reporting, and action planning (15-30 min)

Facilitator Tips:

- Consider assigning roles in advance
- Use this format to rehearse policies, test systems, and simulate communication breakdowns
- This is also a great format for partnering with your risk consultant, trainer, or outside facilitator

Universal Guidance

PSYCHOLOGICAL SAFETY IS PRIORITY ONE:

Make it clear that this is a safe space to raise concerns; there are no bad ideas, there will be no consequences for sharing criticisms, and all feedback is valuable.

CAPTURE IDEAS AND GAPS:

Assign a note taker or use a whieboard/poster paper for everyone to see. Collaboration is crucial to uncovering all perspectives, opportunities for improvement, and conerns.

NO ONE IS EXPECTED TO HAVE ALL THE ANSWERS:

The goal is to reveal strengths, gaps, and next steps, not to assign blame. By focusing on collective growth and learning, we can create a foundation for innovative solutions and a stronger, more cohesive team.

Optional Opening Prompts

"We're here to explore how we respond to potential violence, not just what's on paper, but what actually happens. Let's focus on how we can support each other, close gaps, and strengthen trust across teams."

"This isn't about finding faults, it's about making sure everyone feels safe coming to work. We want to talk honestly about what happens during difficult situations and how we can support each other better."

"We're here to talk about the realities of workplace violence, not just what's in the policy, but what actually happens, and what we wish would happen. This isn't a test. It's a chance to learn and improve together."

"This session is about strengthening our culture of safety. Not just physical safety, but psychological and emotional safety too. If we can spot where we're vulnerable now, we can prevent harm later."

"For many of us, workplace violence isn't just a policy issue, it's personal. If you've experienced something difficult, know that you're not alone, and your insight today could help shape a safer environment for everyone."

"We want this to be a conversation, not a presentation. The most valuable insights usually come from the people doing the work, so please speak up. Your voice is part of the solution."

Section 2: Stakeholder Role Prompts

Purpose of this section

Workplace violence rarely impacts just one department. Effective prevention and response require insight from across the organization, from clinical staff to front desk to facilities.

This section is designed to:

- Encourage empathy across roles
- Highlight communication gaps
- Prompt discussion around role clarity, training, and support
- Capture improvement opportunities that would otherwise be missed in leadership-only planning

HOW TO USE THIS SECTION

- Choose 3-5 roles to focus on during the session.
- Read the prompt aloud and invite participants to reflect: *What would I need in this moment? What would I do? What don't I know?*
- If time allows, ask people to respond from a role that is not their own.

Variation: Write the roles on cards, pass them out, and ask each participant to represent that role during the tabletop walkthrough.

Sample Role Prompts

FRONT DESK / RECEPTIONIST

“A visibly agitated patient is raising their voice in the waiting area. You’re the first person they see. What training or tools do you have to de-escalate? Who would you call first? Is the panic button within reach, and does everyone know what happens when it's pressed?”

MEDICAL ASSSISTANT / PRIMARY CARE PROVIDER

“You're with the patient when they become verbally abusive or threatening. How do you alert others? What support do you expect, and what happens next? Have you practiced this scenario before?”

BEHAVIORAL HEALTH CLINICIAN

“You’re meeting with a client who has a known history of aggression and begins to escalate. What early warning signs do you rely on? Do you have a clear plan for exiting or calling for help? Does your EHR system flag prior incidents?”

DENTAL ASSISTANT / HYGIENIST

“The patient in your chair begins to lash out physically. You have sharp instruments, limited mobility, and no one else in the room. What is your response plan? Are you trained in safe disengagement or does another staff member check in regularly?”

FACILITIES / MAINTENANCE / SECURITY

“You’re called to assist with an incident involving a disruptive patient. Do you know what level of intervention is expected? Have you been trained in trauma-informed approaches, or only physical response protocols? Who debriefs with you afterward?”

CLINIC DIRECTOR / OPERATIONS LEADER

"You're informed of a violent incident hours later. What reporting process is in place? Do you trust it? Are you confident the affected staff member received support? How do you balance patient care continuity with staff protection?"

CALL CENTER / SCHEDULING STAFF

"A patient makes repeated, threatening phone calls after being denied a same-day appointment. What are you empowered to do? Who do you report to, and how do you know your concerns were taken seriously?"

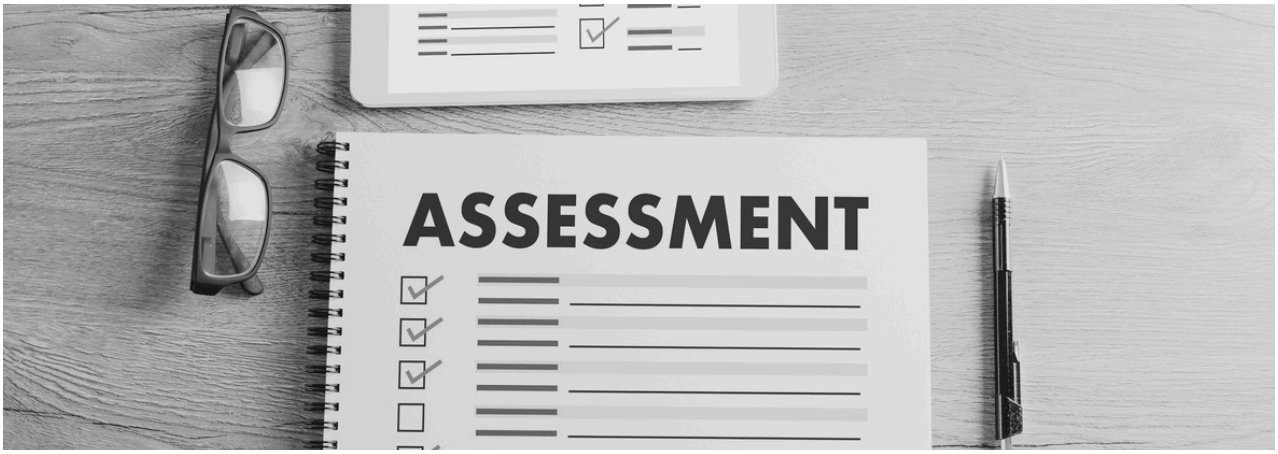
Suggested Discussion Questions

To ask after each prompt:

- What feels unclear or unsafe in this situation?
- How would we know if someone in this role needed help?
- What systems or policies should support this person, but maybe don't today?
- What would make this role feel more prepared?

Remember: violence looks different from every vantage point. Real safety starts with real understanding.

Section 3: Readiness Self Assessment



Purpose of this section

This section is designed to help your team identify strengths, gaps, and blind spots in your current approach to workplace violence. It's not a scored checklist, it's a conversation tool.

HOW TO USE THIS SECTION

- Choose a facilitator to read each queation aloud.
- Discuss each item briefly and rate your readiness:

🟥 = High Risk / Not in Place
🟨 = In Progress or Inconsistent
🟩 = Confident / Consistently in Place

💡

You can use this as a standalone exercise or as a primer before walking through the response planning sections.

Assessment Questions

A. FOUNDATIONAL CULTURE & LEADERSHIP

- Do frontline and leadership staff feel safe speaking up about concerns?

- Is workplace violence prevention treated as a strategic priority, not just a compliance issue?

- Has leadership communicated a clear, consistent commitment to staff safety?

- Is there regular communication with staff about progress, actions taken, and unresolved issues?

- Is respectful, trauma informed behavior modeled by leadership?

B. EARLY DETECTION & PREVENTION

- Do we have behavioral screening or intake questions that assess risk for violence?

- Are there mechanisms in our EHR to flag high-risk individuals or incidents?

- Have we identified early warning signs and built them into our de-escalation training?

- Are staff confident in recognizing and responding to signs of escalation?

- Is de-escalation training specific to our care settings?

C. ENVIRONMENT & PROCEDURES

- Have we identified high-risk areas?

- Do we have panic buttons or emergency alerts, and does staff know how to use them?

- Are policies and responsibilities clear for staff who are working along or after hours?

- Have we assessed and adapted our layout or furniture to minize risk?

- Do we have secure processes for home visits, transporation, and field based care (if applicable)?

D. REPORTING & RESPONSE

- Is it easy to report all incidents including physical assaults, verbal threats and near misses?

- Are reports reviewed consistently by a multidisciplinary team?

- Is there consistent follow up with staff including informing what actions were taken when they report concerns?

- Have we ever reviewed pas incidents or near misses to identify preventable patterns?

- Are post-incident supports in place?

E. RESPONSE INFRASTRUCTURE & DECISION PROTOCOLS

- Have we developed coordinated response frameworks that outline who responds, how, and when in a disruptive or violent event?

- Have we established multidisciplinary response teams by shift and location?

- Do all staff understand the incident hierarchy - what types of incidents to manage internally vs. external escalation (law enforcement)?

- Are there clear and consistent guidelines for terminating patient relationships after an incident?

- Is there a centralized communication protocol for ensuring leadership is aware of incidents immediately?

- Are staff trained on how to secure their environment, remove themselves safely, and engage support during an active event?

- Are post-incident roles clearly defined?

F. DATA & ACCOUNTABILITY

- Do we review workplace violence data regularly (monthly, quarterly)?

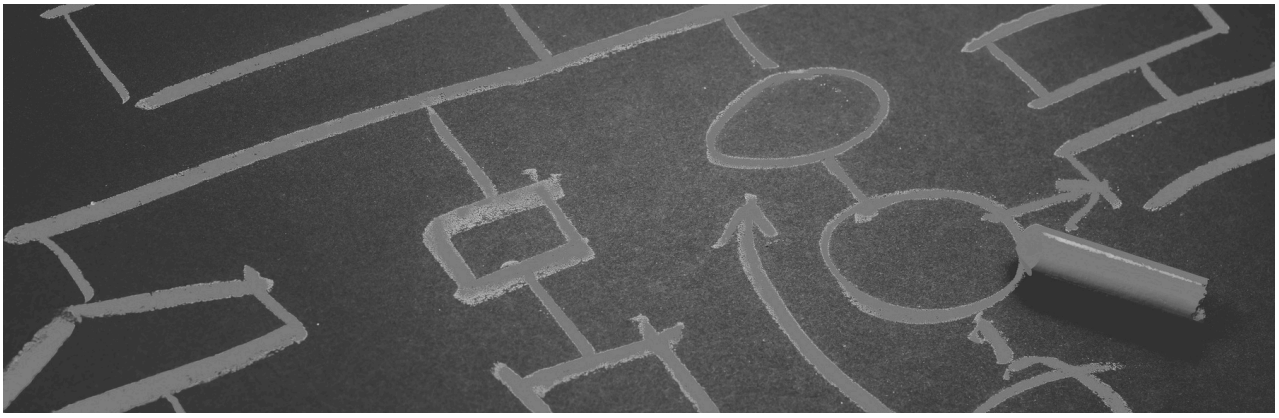
- Are we tracking trends across locations, departments, or times of day?

- Are specific individuals or teams accountable for follow up and improvements?

- Have we built staff feedback into our improvement plans?

- Do we close the loop with staff and communicate what's changing, and why?

Section 4: Response & Recovery Flowchart



Purpose of this section

Even the best policies mean little without clarity in the moment. This section provides a step-by-step visual of what an ideal response to workplace violence looks like, from early warning through recovery, so staff and leadership can identify gaps, clarify roles, and improve coordination.

This flowchart is broken into five distinct phases for clarity and to prompt discussion:

1. Early Warning & Escalation
2. Active Incident Response
3. Incident Containment & Communication
4. Post-Incident Support & Debrief
5. Long-Term Recovery & Learning

Use this as a conversation guide, drill template, or quick reference in emergency planning sessions.

Early Warning & Escalation

Objective: Recognize and respond to risk before it escalates into an incident.

Key Questions:

- Are staff trained to identify verbal, behavioral, or physical warning signs?
- Is there an alert system (verbal code, button, signal) that everyone understands?
- Is the person showing early signs already flagged in the EHR?
- Do staff know who to notify, and how?

🛠️ Tools/Considerations:

- Behavior alert protocols
- EHR flags / high-risk care plans
- De-escalation scripts / verbal diffusion skills
- Panic buttons or code calls (e.g., “Code Gray”)

💡

Quick Tip:

Escalation rarely begins with violence, it begins with missed signals. Train your team to spot early changes in tone, body language, or behavior.

Front desk staff and behavioral health teams often detect warning signs first. Make sure they’re trained and empowered to speak up without hesitation, even if others aren’t yet concerned.

Active Incident Response

Objective: Minimize harm, activate help, and maintain safety.

Key Questions:

- Who takes lead in this moment, frontline, supervisor, clinical, or security?
- What are the steps for containment or withdrawal?
- Do staff have clear exit options or shelter-in-place guidance?
- Has 911 or external response been notified if appropriate?

🛠️ Tools/Considerations:

- Incident response team protocols
- Physical safety actions (room lockdowns, evacuations)
- External escalation (law enforcement, EMS)
- Documentation: capture facts, not opinions

💡

Quick Tip:
In a moment of crisis, confusion is the enemy. Everyone should know their role before an incident ever occurs.

Don’t rely on policy binders during an emergency. Use color-coded cheat sheets, code cards, or badge reference tools to support rapid decision-making.

Incident Containment & Communication

Objective: Secure the environment and initiate leadership notification.

Key Questions:

- Has the situation been stabilized?
- Has leadership been notified using the designated communication path?
- Are patient/staff movements being adjusted to avoid further escalation?
- Is media involvement a possibility?

🛠️ Tools/Considerations:

- Chain of command / admin-on-call list
- Multisite coordination (if patient or event moves across departments)
- Communication templates (internal and external)
- Early documentation of injury, exposure, and actions taken

💡

Quick Tip:
Containment isn't just about physical control, it's about stabilizing the environment, calming those nearby, and initiating trusted communication lines.

Ensure communication plans include who notifies leadership, how other patients are informed (if necessary), and how confidentiality is maintained during and after the event.

Post-Incident Support & Debrief

Objective: Support those affected and evaluate immediate needs.

Key Questions:

- Have affected staff been offered time off, peer support, or EAP access?
- Has a debrief been scheduled with those involved (nonpunitive)?
- Has the team reviewed whether policy was followed, and whether it worked?
- Is the patient relationship under review or needing termination?

🛠️ Tools/Considerations:

- Peer support network / manager check-in
- EAP / trauma-informed follow-up
- Temporary work reassignments if needed
- Root cause analysis (RCA) initiation if warranted
- Documentation: emotional, physical, and operational impact

💡

Quick Tip:
Support staff like you'd support a patient. Recovery from workplace violence includes emotional safety, not just physical care.

Many staff won't ask for support. Normalize check-ins, peer support programs, and low-friction pathways to EAP or trauma-informed follow-up care.

Long-Term Recovery & Learning

Objective: Capture trends, close loops, and build resilience.

Key Questions:

- Was a formal review held to analyze the response system?
- Have lessons been shared across departments?
- Were trends in time, place, or people identified?
- Has leadership communicated outcomes and next steps?

🛠️Tools/Considerations:

- Incident tracking database or dashboard
- Cross-departmental review team
- Policy or workflow changes based on findings
- Staff newsletter / all-hands communication follow-up

Quick Tip:

The biggest missed opportunity is failing to learn. Review every incident, even the ‘near misses.’ They tell you what’s still vulnerable.

Trend tracking isn’t just for data analysts. Use a dry-erase calendar or a private tracking log to surface patterns. Time of day, staffing levels, and locations often reveal weak points.

Workplace violence isn’t just a one-day event. It’s a system-level challenge, and the strength of your response plan is only as strong as your staff’s confidence in it.

Regular reviews, clear roles, and honest debriefs create a culture where safety isn’t just reactive, it’s expected.

Section 5: Reporting Systems & Practices

Purpose of this section

Many organizations struggle not because staff don't witness incidents, but because they don't report them. This section helps your team evaluate how effective, accessible, and responsive your reporting process truly is.

Reports are valuable not just as records, but as signals. They tell you where to intervene, how to improve, and when your team may need more support.
Use this section to evaluate whether your reporting structure closes the loop,from awareness to action to accountability.

💡

Use this as a conversation guide, drill template, or quick reference in emergency planning sessions.

Core Components of a Healthy Reporting System

ACCESSIBILITY

- Do all staff know how to report an incident, concern, or near miss?
- Can staff report anonymously or without fear of retaliation?
- Is there a mobile-friendly or simplified pathway (e.g., quick form, hotline, QR code)?
- Is the process available in multiple languages if needed?
- Are informal verbal reports captured in any structured way?

 *Quick Tip*: If it takes more than 5 minutes or 3 clicks to report, most staff won't do it after a long shift.

CLARITY

- Do staff understand what qualifies as a reportable incident (including threats, intimidation, or verbal abuse)?
- Is there a shared vocabulary or behavior matrix to reduce ambiguity?
- Are policies clearly defined for reporting violence by patients, visitors, coworkers, and external actors?

 *Quick Tip:* A shared language, like the use of the term 'disruptive behavior', helps reduce reporting hesitancy and increases consistency.

RESPONSIVENESS

- Are reports reviewed by a designated team with clinical, HR, operations, and safety representation?
- Is there an established timeline for reviewing reports and closing the loop?
- Do staff receive acknowledgement and, when appropriate, feedback on what was done in response?
- Is the system proactive, does it suggest follow-up actions or supports?

 *Quick Tip:* Silence after a report sends a louder message than a policy ever could.

TREND ANALYSIS & USE OF DATA

- Are reports tracked over time to identify:
  - Repeat offenders or patients?
  - High-risk locations?
  - Shifts or seasons with increased incidents?
- Does leadership review data regularly, and make it transparent when possible?
- Is reporting data shared with staff in a way that informs and motivates, rather than blames?

 *Quick Tip*: Use "stoplight summaries" (Red = concerning trend, Yellow = stable, Green = improvement) to share digestible insights in team meetings.

REVIEW FREQUENCY & FOLLOW-UP

- Are report review meetings held weekly, monthly, or quarterly depending on volume and severity?
- Is there a formal mechanism for using report data to influence policy, training, or environment changes?
- Are results of report trends discussed with all-staff or department meetings?
- Are successes shared—e.g., "after implementing panic buttons, response times improved by 40%"?

 *Quick Tip:* Reporting systems should help staff feel protected, not punished. If no one trusts it, it doesn't matter what's on paper.

If you're only hearing about the worst incidents, your system isn't working, it's missing the warning shots.

Section 6: Reporting Reviews, Staff Trust & Accountability

Purpose of this section

This section addresses the “last mile” of prevention: whether staff believe that leadership is truly committed to their safety, not just on paper, but in practice. It emphasizes that transparency, consistency, and follow-through are what transform good policies into safe cultures.

Staff don’t leave because of incidents, they leave because of how those incidents are handled.

Trust Building Mechanisms to Review

MULTIDISCIPLINARY REVIEW TEAMS

- Do you have a dedicated team that reviews all workplace violence reports?
- Is it truly multidisciplinary (e.g., risk, HR, nursing, operations, BH, security)?
- Are team members trained in trauma-informed review processes?
- Does this group meet on a reliable schedule with documented outcomes?

 *Quick Tip*: Staff are more likely to report if they believe someone like them is part of the review process.

LEADERSHIP COMMUNICATION

- After an incident or reporting trend, has leadership:
  - Acknowledged the issue publicly (where appropriate)?
  - Shared what's changing or being evaluated?
  - Thanked staff for speaking up?
- Is there a recurring "You Said / We Did" communication method (e.g., short updates, town halls, newsletters)?

 *Quick Tip:* Transparency builds trust, even when the answers aren't perfect. Silence creates doubt, even when the process is working.

CONSISTENT FOLLOW-UP & CLOSURE

- Are staff informed of the outcomes of reports they submit (when possible and appropriate)?
- Is there a defined timeline for closing the loop on incidents or investigations?
- Do staff know what to expect after submitting a report (e.g., when they'll hear back, who will follow up)?
- Is there documentation of completed actions tied to each review?

 *Quick Tip*: Closure doesn't just mean the paperwork is done. It means the person who was impacted knows they weren't forgotten.

ACCOUNTABILITY STRUCTURES

- Who is ultimately accountable for improvements after an incident?
- Are safety-related metrics reported up to executive leadership or the board?
- Is accountability shared, or does it fall only on risk or HR?
- Is performance around violence prevention part of leadership evaluations or quality dashboards?

 *Quick Tip:* Consider publishing a quarterly "safety snapshot" that includes updates, metrics, and highlights from improvements tied to staff-reported incidents.

Every time a staff member reports an incident, they're taking a risk. What you do next determines whether they ever take it again.

Section 7: Next Steps & Planning Template

Purpose of this section

This section helps leadership teams take the insights from the toolkit and turn them into actionable commitments. It reinforces that progress matters more than perfection, and gives teams a way to track, prioritize, and assign ownership for safety-related goals.

DON'T LET PERFECT BE THE ENEMY OF THE SAFE

Your plan doesn't have to be perfect to make a difference. Even small shifts in how you listen, train, or follow up can prevent harm and rebuild trust.

💡

The most common failure isn't lack of concern, it's the lack of a clear next step.

STEP 1: IDENTIFY YOUR TOP 3 PRIORITIES

Based on your tabletop discussion or internal review, what are the most pressing gaps, risks, or opportunities?

Priority Area	Why It Matters	Supporting Evidence	Initial Ideas
Example: Improve staff reporting rates	Staff don't feel safe or heard	Anonymous survey, underreported incidents	Redesign report form, offer anonymous hotline

STEP 2: ASSIGN INITIAL OWNERSHIP

Who will lead the charge on each priority? Who will support them? Consider cross-functional teams, not just leadership roles.

Priority Area	Lead Contact	Support Team	First Check-in Date
Improve staff reporting	HR Manager	Clinic Manager, Front Desk Supervisor	1 Aug 2025

STEP 3: DEFINE YOUR TIMELINE FOR ACTION

Use this space to outline what you'll aim to accomplish in the next:

Time Frame	Goals or Milestones
Next 30 days	e.g., Conduct reporting system review, distribute survey
Next 90 days	e.g., Pilot de-escalation training, launch reporting awareness campaign
Next 6 months	e.g., Full policy update, annual drill, reporting dashboard review process in place

Section 8: Training, Templates & Trusted Resources

Practical Tools to Deepen Your Violence Prevention Strategy

BEHAVIORAL THREAT ASSESSMENTS

Explore adding behavioral threat assessments into your patient intake/check-in process and integrating with EHR for early warnings.

- Broset Violence Checklist
- Dynamic Appraisal of Situational Aggression (DASA)
- STAMP

INCIDENT DEBRIEF & STAFF SUPPORT MODELS

Frameworks for supporting staff post incident.

- Well-Being Debriefings
- Critical Incident Stress Debriefing
- TeamSTEPPS Debriefing Toolkit

DE-ESCALATION & BEHAVIORAL INTERVENTION

- Crisis Prevention Institute (CPI)
  - Widely used curriculum for nonviolent crisis intervention.
- Safewards Model
  - Evidence-based strategies for reducing conflict in inpatient care.
- NIOSH Violence Prevention Training for Nurses
  - Free, interactive eLearning modules.
- Trauma-Informed De-escalation Education for Safety and Self-Protection (TIDES)
  - Collaborative strategies for managing disruptive situations.

SIMULATION & DRILL PLANNING

- AHRQ TeamSTEPPS Simulation Guide
  - Guidance on structuring simulations for healthcare teams.
- FEMA Tabletop Exercise Toolkit
  - Customizable scenarios and templates for emergency response.
- OSHA Worker Safety in Hospitals
  - Variety of resources for healthcare organizations.

POLICY & PLANNING FRAMEWORKS

- OSHA Workplace Violence Guidelines (2023)
  - Comprehensive strategies and expectations.
- Joint Commission Sentinel Event Alert #59
  - Alert on physical and verbal violence against healthcare workers.
- ASHRM Workplace Violence Self-Assessment Toolkit
  - PDF tool for evaluating risk posture.

Closing Thoughts

Workplace violence is complex, emotional, and often overwhelming, but it's not immovable. The greatest progress happens when organizations go beyond policies and procedures to ask: *What kind of culture are we building? And how do we protect it?*

This guide was designed not to give you all the answers, but to help you start deeper, more meaningful conversations. To spark alignment, clarify roles, and ensure everyone, from leadership to the front lines, feels seen, heard, and safe.

Whether the topic is workplace violence or any of the other challenges you face, INSURICA's model is built to be proactice and strategic. If you'd like help going through this guide with your team, want to explore what our risk consultants can do for your organization, or are simply ready to talk more about the ripple effects of risk, don't hesitate to reach out.

Broker: Drew Colwell
Phone: 406-333-6309
Email: Drew.Colwell@INSURICA.com

INSURICA
HEALTHCARE