



Home > Policies & Procedures > Clinical Documents > Interdisciplinary Clinical Manual > Violence Risk Assessment and Identification of Patients at Risk for Violence in the Emergency Department and Inpatient Units

Disclaimer: the information contained in this document is for educational purposes only. Any PRINTED version of this document is only accurate up to the date of printing. Always refer to the Policies and Procedures Intranet site for the most current versions of documents in effect.

POLICY	Manual: Clinical	Section: Interdisciplinary Clinical	Code No.: I V005	Old Code No.: S V005
Title: Violence Risk Assessment and Identification of Patients at Risk for Violence in the Emergency Department and Inpatient Units			Original Effective Date: Nov 20, 2014	
			Review/Revised Effective Date: Feb 06, 2020	
			Next Review Date: Feb 01, 2021	
Cross Index: I V006	Authoring Committee/Program/Dept: Emergency Department, Risk Management		Approved By: SLT	

As an exception, SLT has approved the use of combined policy and procedure in this document, notwithstanding accepted practice to have policy and procedure as separate documents.

Preamble

In accordance with the [Ontario Occupational Health and Safety Act](#) (OHSA), Southlake and its supervisors/ managers/ directors must take every precaution reasonable in the circumstances for the protection of a worker. The [Health Care and Residential Facilities Regulation](#) requires the employer in consultation with the Joint Health and Safety Committee to develop, establish and put into effect measures and procedures for the health and safety of workers. Workers under the Act must work in compliance with the Act and the regulations. Southlake's [Occupational Health, Safety and Wellness](#) policy also requires staff to take all precautions to provide a safe environment for their patients, themselves and for other staff.

Refer to OHSA - 25 2.a), OHSA - 25 2.h) and OHSA - 32.0.5

POLICY

In order for Southlake to maintain safety, meet its requirements under the OHSA and for workers to comply with the Act and its regulations, it is important for any member of the health care team to follow this policy and procedure and also communicate to the rest of the team a patient's history of violent behaviour, triggers, or potential for violent behaviour in order that the appropriate measures and procedures for violence prevention or de-escalation can be implemented.

Refer to Southlake's [Workplace Violence Prevention](#) policy and procedure for issues of violence involving staff members. A staff member who personally observes or is aware of aggression and/or inappropriate behaviour will report it to Security and the most responsible nurse immediately.

Registration Staff

Registration staff will contact Security and ask Security to be on standby when a patient comes to the hospital who has a [Safety Indicator form](#) on their medical record or any recognized history of violent behaviour.

Emergency Department

At Triage

ALL patients are screened for history of violence and triggers for violence using the *VAT Screening* questions. These are found in the *ED Triage Screening* intervention in Meditech.

For patients who are determined to be at risk for violence during the above screening, the nurse will also complete the *Risk Indicators* section of the tool.

In the Main ED

A complete violence risk assessment must be completed on the following ED patients:

- All patients determined to be a violence risk during screening at ED triage (above)

- All patients for whom a *Safety Indicator* form prints during registration or the S-ABC is present on the ED Tracker
- All patients being admitted as inpatients
- Any patient who exhibits signs of violence or potential for violence

Inpatient Units

A violence risk assessment must be completed on **All** patients who present to inpatient units via routes other than ED (e.g. direct admissions, Same Day Surgery patients).

When patients are identified as potentially violent (i.e. moderate or highest risk), a Care Plan is developed that includes reducing/avoiding contributing factors or triggers as well as effective interventions to protect the staff and de-escalate the patient. A reassessment of risk for violence and effectiveness of care strategies must be completed each shift, and/or after any violent incident. The Care Plan will be updated as needed and communicated during shift or transfer reports.

Additional information about previous and current violence risk assessments and Care Plans can be found in the *Violence Risk Assessment* Clinical Panel within Meditech.

There is always the potential for any patient to become verbally or physically assaultive. Universal safety precautions (see Definitions) such as hourly rounding and the use of AIDET and HEARD principles (see Definitions) will be used wherever possible and may help reduce the risk. Additionally, staff trained in de-escalation techniques (such as non-violent crisis intervention (NVCi) and Gentle Persuasive Approaches (GPA) will use these skills when interacting with patients.

All staff will:

Check for alerts and triggers prior to interacting with a patient (e.g. Meditech status board, red safety sign on door, purple wristband, [Safety Indicator form](#), chart stickers, MPV board, ED tracking board etc.). If an alert is present, the staff member will check with the nurse for guidance before proceeding into the patient room.

Deciding to Call Security/Code White:

Staff members will deploy their staff assist safety pendant to call a [Code White](#) when they feel threatened or at risk for harm by another individual. Following a code white, a reassessment with the Violence Assessment Tool (VAT) is to be completed.

Applying a Continuing Special Indicator:

All patients who were at Highest Risk and any patient at Moderate Risk who had aggressive behaviour (e.g. verbal or physical threats, attacking objects, physical or sexual assault etc.) shall have a continuing Special Indicator added to their electronic documentation to indicate this for future visits. Patients, or their substitute decision makers (in the case of incapable patients), have the right to appeal the continuing Special Indicator (refer to [Appeal Process](#) procedure).

PROCEDURE

Purpose:

- To outline the process to assess all patients in the Emergency Department and upon inpatient admission for the risk of violence.
- To outline the process for reassessing patients who have been identified as a Moderate or Highest Risk for violence.
- To outline the process of providing a visible and electronic warning system that will alert and protect patients, visitors, and staff from patients who have behaved or are at risk of behaving in a manner that causes harm or are deemed to be a moderate or high risk threat to the safety of others.

Definitions:

- Aggression - hostile, injurious or destructive behaviour. Examples from the VAT include verbal or physical threats, attacking objects and physical or sexual assault.
- AIDET- Acronym for: A-Acknowledge your patient, I-Identify yourself, D-Duration, E-Explain what is happening, and T-Thank you.
- Alerts - visible and electronic tool(s) to communicate that there is a risk of violence. These include the "VAT" icon in the Safety column on the ED tracking board and inpatient Primary Status Board, the "S-ABC" icon in the "SI" column of the ED tracking board and inpatient Primary Status Board, the purple wristband, the red warning signage for patient doorways, the white bell symbol on the McKesson Visibility Board (MPV), white bell stickers for the spine and front of the patient chart and the ["Safety Indicator" form](#) printed at registration.
- Care Plan - A plan to address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers.
- Continuing Special Indicator: a permanent alert that is added to a patient's electronic record to indicate a possible risk of violence for future visits. This alert triggers the printing of the ["Safety Indicator" form](#) upon registration and also appears in the "SI" (for "Special Indicator") column of the ED tracking board and inpatient Status Board in the electronic record. ABC is an acronym indicating an Alert for Behavioural Care.
 - S-ABC indicates a continuing Special Indicator initiated at Southlake Regional Health Centre;
 - M-ABC indicates a continuing Special Indicator initiated at Markham Stouffville Hospital;
 - H-ABC indicates a continuing Special Indicator initiated at Stevenson Memorial Hospital;
 - X-ABC indicates a continuing Special Indicator initiated at Uxbridge Cottage Hospital.
- HEARD - Acronym for: H-Hear them out, E-Empathize with their feelings, A-Acknowledge the concerns; Apologize for their experience where appropriate, R - Respond to their concerns, D-Document the interaction.

- Potential violent behaviour - refers to behaviours exhibited by individuals who show signs of potentially escalating towards violence. These behaviours are assessed using the Violence Assessment Tool (VAT).
- Safety Indicator form - a form automatically printed at each time of registration for patients previously determined to be at high risk for violence. The form is placed on the chart for the patients current hospital visit and all subsequent visits (see [Appendix D](#)).
- Security Standby - may include being ready to respond if called or actually being posted to a location or near a patient and depends on the risk assessment.
- Staff - includes employees, medical staff, midwives, volunteers, students and all others who have a working relationship with the hospital.
- Universal Safety Precautions - precautions staff should take with all patients regardless of assessed level of risk. E.g. maintaining a safe distance between patient and caregiver, wearing staff assist pendants at all times, hourly rounding, use of AIDET & HEARD principles.
- Violence Assessment Tool (VAT). The assessment tool used at Southlake to evaluate a patient's risk for violence or behaviours that may indicate a risk for impending violence. Also the symbol for Violence Risk alerts within Meditech:
 - VAT in the "Safety" column on the ED tracking board and inpatient Status Board indicates an alert for the current visit;
- Violence Risk Assessment - Levels of Risk:
 - *Low Risk* - the patient has received a score of 0 on the Violence Assessment Tool (VAT)
 - *Moderate Risk* - the patient has received a score of 1-3 on the Violence Assessment Tool (VAT) - note patients with a history of violence will always score at least 1, so will remain a Moderate Risk for violence.
 - *Highest Risk* - the patient has received a score of 4 or higher on the Violence Assessment Tool (VAT)
- Violent behaviour - refers to behaviours with actual acts of violence including, but not limited to, acts of physical attack, assault, threats, stalking, or harassment. This violence may or may not occur on hospital premises. For example, if a patient is brought to the hospital by police, staff may ask about a history of violence and/or the police may advise staff that the patient has been violent.

Responsibility for Risk Assessment and Alerts:

- All members of the interprofessional health care team including members of the management team, crisis workers, security, and medical staff
- Anyone may alert the clinical team when they observe a patient acting out and request that they initiate the violence risk assessment process
- Staff are responsible to know how to access the various alert tools and equipment as required (see "Equipment" below)

All staff who interact with patients have the responsibility to check for alerts prior to interacting with a patient (e.g. Meditech status board, red safety sign on door, purple wristband, [Safety Indicator form](#), chart stickers, MPV board, ED tracking board etc.). If an alert is present, the staff member will check with the nurse for guidance before proceeding into the patient room.

Equipment/Alert Tools:

- *Violence Assessment Tool (VAT) #SL2559*: used for assessment of violence risk during downtime in all areas.
- Electronic documentation system (Meditech)
 - *ED Triage Screening* intervention - for ED patients during Triage
 - *Violence Assessment Tool (VAT) Intervention* - for Inpatients as well as ED Patients in the Main ED
 - Personalized Safety Program: Information For Patients and Their Families #SL1851 information sheet

Alerts include:

- Meditech ED Tracker and Patient Status Boards
- Red Warning Sign
- McKesson Performance Visibility (MPV) White Bell symbol
- White Bell sticker for spine and front of patient chart
- Purple wristband
- [Safety Indicator form](#)

Method:

All patients will have a risk assessment for violence completed in Meditech as follows:

Note: During downtime, the paper *Violence Assessment Tool (VAT) #SL2559*: is used for all screening and assessments. If a continuing special indicator is required, this form is signed by the Manager, Coordinator or Educator and faxed to the number at the bottom of the form.

Note: If patients are unable or unwilling to answer questions related to violence risk, information from a SDM, caregivers and police can be used to assist with the risk assessment.

Note: Previous violence risk assessments can be reviewed in Meditech using the Clinical Panel titled *SRCH ABC/Violence Risk*

1. ED Patients

- At ED triage the patient will be assessed using the *VAT Screening* section within the *ED Triage Screening* intervention

- A "yes" answer to either of the screening questions within the *VAT Screening* section will automatically populate the violence risk "VAT" into the Safety column of the ED Tracker; and the MPV board ([see Appendix A](#)) will be automatically updated with the white bell icon
- If there is a "yes" answer to either of the screening questions, the *VAT Assessment* within the *ED Triage Screening* intervention must also be completed
- Complete documentation of the *VAT Assessment* section will determine the level of risk, Low, Moderate, or Highest.
- If the Risk Level is assessed as Moderate or Highest, the *VAT Care Plan* section must be completed by the primary nurse
- Any time new aggressive behaviours by patients are observed after Triage is complete - even if the initial violence risk assessment was determined to be Low Risk, the *Violence Assessment Tool (VAT)* intervention will be completed

2. If the [Safety Indicator form](#) prints at registration or the *S-ABC* icon is noted on the ED Tracker or inpatient Primary Status Board. This indicates that the patient has had a history of violence.

- The *Violence Assessment Tool (VAT)* intervention will be completed if not already done;
- The "History of Violence" question will be answered as "yes" regardless of current behaviours.

3. Inpatients

- All inpatients who have not already been assessed for violence in the ED will be assessed using the *Violence Assessment Tool (VAT)* intervention upon admission.
- If the Risk Level is assessed as Moderate or Highest, Meditech will automatically populate the violence risk "VAT" into the "Safety" column of the Primary Status Board, and the MPV board ([see Appendix A](#)) will be automatically updated with the white bell icon.
- Any time new aggressive behaviours by patients are observed - even if the initial violence risk assessment was determined to be Low Risk, the *Violence Assessment Tool (VAT)* intervention will be completed.
- If the Risk Level is assessed as Moderate or Highest risk, the *Care Plan* section of the *Violence Assessment Tool (VAT)* intervention must also be completed.

For all patients who are determined to be at risk for violence (i.e. Moderate or Highest Risk), the following steps will be taken:

1. If printed at registration, the "Safety Indicator form" is placed on the patient chart.
2. The nurse places a Red Warning sign on the patient's door. Where the patient only has a curtain, the sign will be placed over his/her bed.
3. The nurse places a white bell sticker on the front and spine of the patient chart. In areas where charts are kept in a binder the sticker is placed on the front page of the chart.
4. The nurse places a purple wristband on the patient **when it is safe to do so (this will be in addition to the white patient identifier band)**. Assistance may be requested from Security and/or management if the nurse does not feel comfortable placing the purple wristband on the patient independently. Application of the purple wristband may be done in conjunction with the care planning discussion (see #11 below).
5. The staff member who completed the *Violence Assessment Tool (VAT)* informs the charge nurse as well as the educator or management team member that they have a patient with a moderate or highest risk. Together the staff member and the educator or management team member review the risk assessment and Care Plan.
6. If restraints are required for patient or staff safety, refer to the following Standards of Care: [Restraint\(s\) - Use of for Patients Not Admitted Under the Mental Health Act](#) and [Restraint\(s\) - Use of for Patients Admitted Under the Mental Health Act \(MHA\)](#).
7. If there is no previous Special Indicator, the staff member and the educator or management team member work together to determine if a continuing Special Indicator is necessary.
8. All patients who were assessed as being at Highest Risk should have a continuing Special Indicator added to their electronic documentation to indicate this for future visits.
9. Any patient assessed as Moderate Risk who had aggressive behaviour (e.g. verbal or physical threats, attacking objects, physical or sexual assault etc.) during their hospitalization should have a continuing Special Indicator added to their electronic documentation to indicate this for future visits.
10. Only selected individuals (CSM, Manager, Coordinator or Educator) have access to add to the Special Indicator list.
 - From the patient's chart on the Summary tab, select the [Edit] button beside the Special Indicators heading
 - Select "S-Alert for Behavioural Care"
 - Click [Save] in the footer to add the special indicator permanently.
11. Entering the Special Indicator will automatically add the "S-ABC" icon to the Primary Status Board and/or ED Tracker in the Special Indicator "SI" Column. **Note:** when using the *Acute Care Violence Assessment Tool (VAT)* #SL2559 downtime form, scan it as instructed in order to have the Special Indicator applied.
12. Entering the Special Indicator will also automatically trigger the Safety Indicator Form to print for all future visits.
13. When there is disagreement on whether to place a Special Indicator onto the patient chart, always default to the highest level of safety, i.e. apply the S-ABC. The educator or management team member will escalate the disagreement/concern to the Director of the program. Resources available to assist with further discussions include members of the Appeals Committee, Manager/Director of Risk, Patient Relations, the staff member that completed the initial Violence Assessment (VAT) and the Ethicist.
14. Once the patient can engage in care planning, the patient and/or substitute decision maker (SDM) is informed of the reasons why she/he has been identified as a risk for violence, provided with the *Personalized Safety Program: Information for Patients and Their Families information sheet*. The Care Plan is created in partnership with the patient/SDM to obtain information regarding contributing factors, soothing strategies and approaches for de-escalation.

15. Patients who are receiving a continuing Special Indicator applied to their EMR are informed of the appeal process if they have concerns (refer to [Appeal Process](#) procedure). Assistance may be requested from Security or management in communicating this information to the patient and/or SDM as deemed necessary.
16. The *Violence Assessment Tool (VAT)* intervention is reviewed and completed every shift considering Patients who have a history of violence will remain at least Moderate Risk for their entire stay.
 - o At the **beginning of the shift** – review the care plan to prepare for interacting with the patient
 - o **Throughout the shift** – assess the patient for observed behaviours as well as noting what upsets and calms the patient
 - o Toward the **end of each shift** - determine which behaviours the patient has exhibited during your shift. Consider behaviours that were reported to you by family or other staff (e.g. the physiotherapist tells you the patient attempted to bite her, the family tells you the patient is more agitated than usual, etc.) Each behavior will receive a score of 1 to get a total score for the shift
17. The Care Plan is reviewed to assess effectiveness at the end of shift. As new triggers, coping strategies or useful interventions are discovered, incorporate these into the Care Plan.
18. Risk Level and Care Planning information will be passed on during shift and transfer reports.
19. As part of the discharge planning for patients who have been assessed as Moderate Risk, reassess the need for a continuing special indicator for future visits. If this alert has not been previously added to the EMR and is required, ensure that it is added prior to discharging the patient.

Algorithms

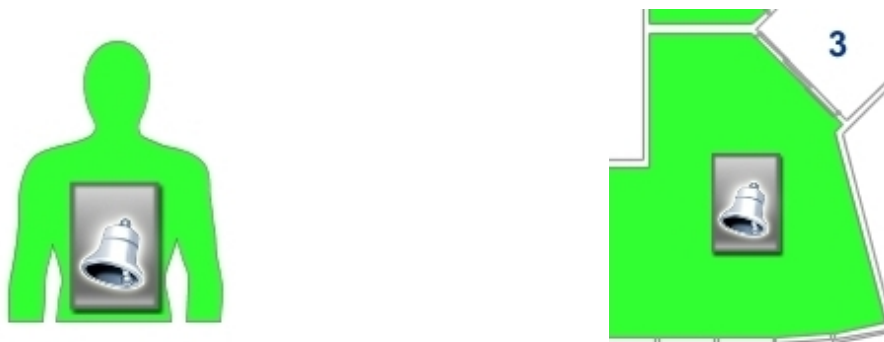
Refer to algorithms below for Identification of Potentially Violent Patients in the Emergency Department ([Appendix B](#)) and Identification of Potentially Violent Patients - Process for Inpatient Units ([Appendix C](#)).

Also see [Appendix A - McKesson Performance Visibility \(MPV\) Screen](#) and [Appendix D - Safety Indicator form](#).

Special Considerations:

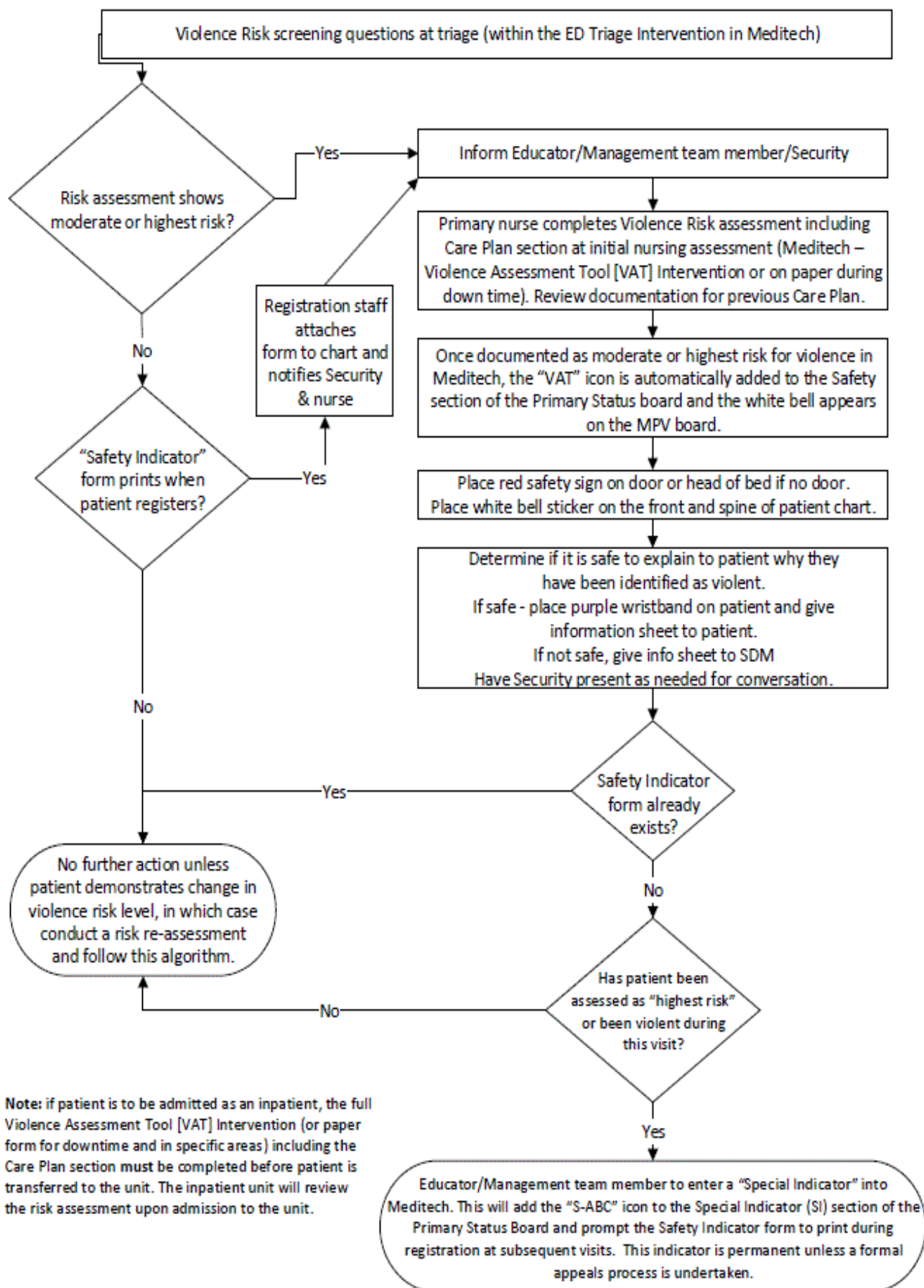
- Once the Special Indicator "S-ABC" has been placed on a patient record, it is permanent unless successfully appealed. An appeal can be made by contacting a member of the management team or the Patient Relations office. Quality and Risk Management will be contacted. If the appeal is successful, the S-ABC will be removed from the patient record, and staff will be notified. The outcome of the request for an appeal will be indicated in the patient chart (refer to [Appeal Process](#) procedure).
- Secure inpatient mental health units will post a large red safety warning sign outside the unit rather than on individual room doors. When staff from other areas enter the mental health unit, if an alert is present, she/he will check with the nurse for guidance before proceeding to patient rooms.

Appendix A - McKesson Performance Visibility (MPV) Screen:



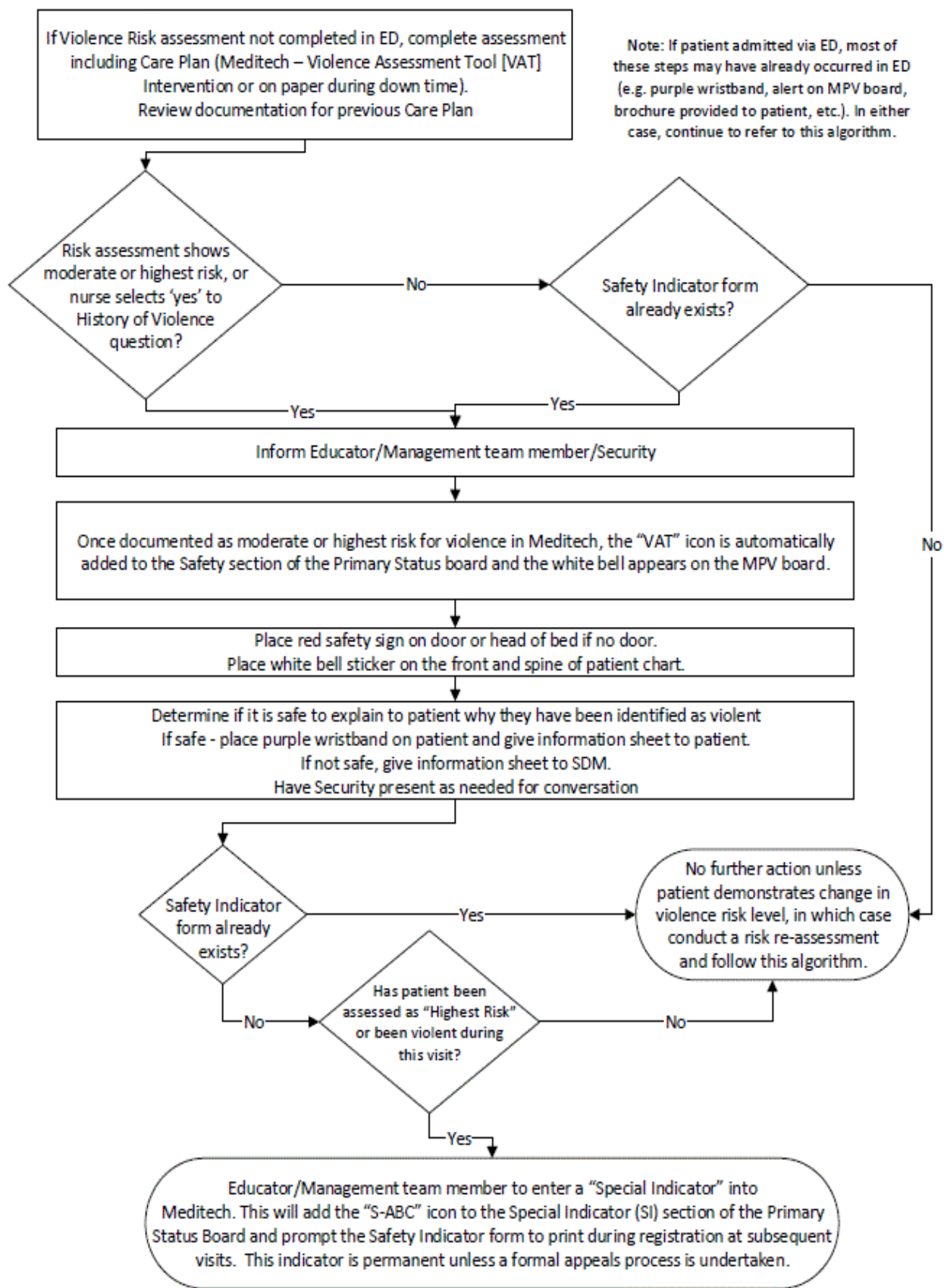
Appendix B - ALGORITHM FOR PATIENTS ADMITTED THROUGH THE EMERGENCY DEPT:

Violence Risk Assessment of Patients and Process for Identifying Patients as Moderate or Highest Risk ADMITTED THROUGH THE EMERGENCY DEPARTMENT (Jan. 2020)



Appendix C - ALGORITHM FOR PATIENTS ON THE INPATIENT UNITS

Violence Risk Assessment of Patients and Process for Identifying Patients as Moderate or Highest Risk PROCESS FOR INPATIENT UNITS (Jan. 2020)





SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #:	Complete or place barcoded patient label here		
Patient Name:	Patient last, first		
DOB: mm / dd / yy	Age:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
ONIP #:	Version Code:		
Account #:	Date of Admission: mm / dd / yy		

This form is NOT part of the permanent patient record – please shred once acted upon

Safety Indicator



SL1750_05 (01/14) "Emergency Department" Review (01/17)

Additional Resources:

- [Getting the Most out of Your VAT Assessment](#)
- [Viewing the Risk Assessment and Care Plan in Meditech - Tip Sheet](#)
- [Identifying Patients who are At Risk for Violence - Tip Sheet](#)
- [Violence Assessment Tool for Managers & Coordinators - Tip Sheet](#)
- [Violence Assessment Tool - Use of in the ED - Tip Sheet](#)

- [Violence Assessment Tool - Use of for Inpatient Units - Tip Sheet](#)

References:

- [Ontario Occupational Health and Safety Act](#)
- [Health Care and Residential Facilities Regulation](#)
- [Incident Reporting \(Staff\) procedure](#)
- <http://pshsa.ca/>
- <http://www.precautionaryprinciple.eu/>
- RNAO Best Practice Guideline: Preventing Violence, Harassment and Bullying against Health Workers. <https://rnao.ca/bpg/guidelines/preventing-violence-harassment-and-bullying-against-health-workers>
- Merriam-Webster Dictionary: <https://www.merriam-webster.com/dictionary/aggression>