Huron Perth Healthcare Alliance		
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Scope

All staff, physicians, students and volunteers of Huron Perth Healthcare Alliance (HPHA) are required to comply with this policy and related policies and procedures.

Policy

Huron Perth Healthcare Alliance (HPHA) is committed to compliance with the *Occupational Health and Safety Act* (OHSA) to identify and address occupational health and safety hazards. This includes providing workers with information related to the risk of violence from a person with a history of and / or potential for violent, aggressive or responsive behaviours. These activities are not meant to stigmatize at-risk patients and will be conducted in a manner that respects ethical principles and aligns with the organization's duty to care.

HPHA is committed to providing a safe and respectful environment, and implementing measures and procedures to prevent, control and minimize the risk of violence. HPHA considers any violent behaviour unacceptable, and will provide the necessary measures to protect staff, including necessary training to understand and completely implement a flagging protocol, and to prevent and respond to incidents in a timely, efficient and safe manner. The organization acknowledges circumstances such as medical conditions or cognitive illness that may cause a patient to be violent and will seek to use information about violent incidents to improve patient care while protecting staff safety.

Definition:

Under the *Occupational Health and Safety Act*, **workplace violence** is defined as:

- the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
- an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or,
- a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Procedure:

A. Emergency Department – no History of Violence (HOV)

See Appendix A - ED - No HOV

1. Triage / Emergency Department

- Registration Clerk registers patient.
- Triage Nurse performs the observational Violence Assessment Tool (VAT) to determine the risk that patient poses to staff. Risk Score stratification as follows:

Risk Rating	Risk Score
Low	**Score = 0 (no observed behaviours)**
Moderate	**Score = 1-3**

High Risk	**Score = 4-6**
Very High Risk	**Score is greater than 6**

- Based on Risk Score, the nurse determines best treatment options with respect to room, nurse, etc.
- Will place purple clasp on patient ID wristband for Risk Score 4 or greater

Note: should the patient have any observed behaviours that meet the definition of violence (see Definitions), regardless of the Risk Score, Screen One of the VAT will need to be accessed and filled in with appropriate information. That patient will have purple clasp applied to wristband and STOP sign applied to room door.

2. ED Nurse

- Will receive HOV Risk information from Triage nurse
- If the HOV risk is 4 or more, a **STOP** sign and purple diamond magnet will be placed on room door indicating that staff and visitors are to check in for more information before proceeding.
- VAT can be repeated at any time prior to discharge/transfer.
- Should patient have a behavioural episode that meets the definition of violence, the VAT will be reassessed (see Definitions). On 'page one' query if the patient has a HOV, the nurse will check the box beside the violence behaviour that has been witnessed. The nurse shall then proceed to the behavioural assessment piece ('page two' of VAT) for further risk determination.

3. Unit Clerk

- Will print off ED Face Sheet, highlight the diamond symbol in purple highlighter. This diamond will appear for High or Very High Risk scores.
- Ensure Tracker Board is updated with the HOV information including manual entry of Risk level
- Will field any questions from service provider staff and visitors regarding STOP sign. The VAT risk score will populate on their Status Board and Tracker Board for quick reference.

B. Emergency Department – Known or Declared HOV

See Appendix B - ED Process for Patient with Documented HOV

1. Triage / Emergency Department

a. If the patient presenting has a documented HOV, the Registration Clerk will see initial Critical Care Indicator (CCI) screen when patient entered into system. Registration Clerk will communicate this CCI information to Triage nurse. The clerk will place purple clasp on patient ID wristband for patients with documented CCI.
b. Triage nurse will check the previous HOV flag on Meditech for history/context.
c. Triage Nurse will perform the observational VAT to determine the risk that patient poses to staff. Risk Score stratification as follows (automatic score of "1" with HOV therefore no Low Risk):

Risk Rating	Risk Score
Moderate	**Score = 1-3**
High Risk	**Score = 4-6**
Very High Risk	**Score is greater than 6**

Note: should the patient have any observed behaviours that meet the definition of violence (see Definitions), regardless of the Risk Score, "Screen 1" of the VAT is completed with appropriate information. That patient will have Purple clasp applied and STOP sign posted on room.

d. Based on Risk Score, the nurse determines best treatment options with respect to room, nurse, etc.
e. Ensure Tracker Board updates with the HOV information including manual entry of Risk level.
f. Place purple clasp on patient ID wristband if Risk is 4 or greater or if any violent behaviours are observed.

2. ED Nurse

a. Will receive HOV Risk information from Triage nurse
b. Will put STOP sign on room door alerting staff and visitors to check in for more information
c. VAT will be reassessed every shift and as required. VAT should be repeated at least once prior to discharge/transfer.
d. Should patient have a behavioural episode that meets the definition of violence, the VAT will be reassessed (see Definitions). On 'Screen 1' query if the patient has a HOV, the nurse will check the box beside the violence behaviour that has been witnessed. The nurse shall proceed to the behavioural assessment piece ('page two' of VAT).

3. Unit Clerk

a. Will print off ED Face Sheet, highlight the diamond symbol in purple highlighter. This diamond will appear for HOV, High or Very High Risk scores.
b. Ensure Tracker Board is updated with the HOV information including manual entry of Risk level
c. Will field any questions from service provider staff and visitors regarding STOP sign. The VAT risk score will populate on their Status Board and Tracker Board for quick reference.

C. In-Patient – Known HOV (from previous encounter/admission)

See Appendix C - Inpatient-Documented HOV

1. In-patient Nurse receiving patient with known HOV

- Patient received to unit and HOV and most recent VAT score reported in the TOA

i. Current care plan related to VAT score will be part of TOA.
ii. Nursing assignment sheet, status board are updated with the VAT risk.

- On the Stratford IP MH unit, the safety binder will be updated as appropriate.

iii. Bed Board and face sheet indicate presence of HOV.

- Nurse will perform the observational VAT to reassess the risk that patient poses to staff. Risk Score stratification as follows (automatic score of "1" with HOV therefore no Low Risk):

Risk Rating	Risk Score
Moderate	**Score = 1-3**
High Risk	**Score = 4-6**
Very High Risk	**Score is greater than 6**

Note: The following flags are placed if Risk Score is 'High' or 'Very High'. They are also applied if the patient is currently demonstrating behaviours that meet the definition of violence (see Definitions) regardless of Risk Score:

1. STOP sign flag is placed on the patient's door
2. Purple clasp is placed on the patient's new ID wristband (old band removed)
3. Purple Diamond flag (magnet) is placed on the bedside whiteboard
4. Purple Diamond flag (magnet) is placed beside the patient's name on the Discharge Whiteboard
5. Purple Diamond flag (sticker) is placed on chart spine

Note: Certain exceptions to flagging apply on the Stratford IP MH unit. All staff are expected to check-in at the nursing station before entering the unit.

- Based on the VAT Score, the appropriate nursing care plan is initiated.

- When appropriate, nurse will explain flags to the patient, and work with patient and family on developing a plan to address the behaviours and strategies to reduce risk.
- VAT is reassessed at least q-shift and as needed.
- Screen 1 of the VAT is used to document the contributing and alleviating factors to the observed behaviours.

D. Newly Observed Behaviours including New HOV (i.e. If a patient with no previous observable behaviours has newly observed changes in behaviour)

See Appendix D - Inpatient - New Patient - No HOV

1. For any newly observed behaviours

- Patient's nurse performs the observational VAT to determine the risk that patient poses to staff. **(Note: Low Risk rating does not apply).** Risk Score stratification as follows:

Risk Rating	Risk Score
Low	Score = 0 (no observed behaviours)
Moderate	Score = 1-3
High Risk	Score = 4-6
Very High Risk	Score is greater than 6

- Patients with High or Very High Risk scores shall have:
- STOP Sign flag placed on the patient's door
- Purple clasp placed on the patient's ID wristband
- Purple Diamond flag is placed on the patient's whiteboard
- Purple Diamond is placed on Discharge Whiteboard, beside patient's name
- Purple diamond flag is placed on chart spine
- VAT is reassessed every 12 hour shift
- Investigate any medical reasons for demonstrated behaviour.

2. For Patients with newly observed HOV (any new behaviour that fits the definition of Violence (see Definitions, e.g. during a Code White)

See Appendix E - Inpatient - New Behaviours HOV

Assigned nurse will submit a RL6 (Safety/Security) if there is no personal injury / illness resulting from event. If personal injury occurs, the employee will submit an additional RL6 (Employee Event).

- VAT is used to assess/document further risk
- VAT "Screen 1" is filled in, appropriate type of violence is documented and contributing and alleviating factors documented.
- VAT "Screen 2" is filled and total risk determined
- Actions taken as per VAT dependent upon contributing factors determined and preventative measures understood and implemented (documented on VAT screen one).
- Regardless of overall Risk Score, patients with active HOV shall have:
    - STOP Sign flag placed on the patient's door
    - Purple clasp placed on the patient's ID wristband
    - Purple Diamond flag is placed on the patient's whiteboard
    - Purple Diamond is placed on Discharge Whiteboard, beside patient's name
    - Purple diamond flag is placed on chart spine

Note: Certain exceptions to flagging apply on the Stratford IP MH unit. All staff are expected to check-in at the nursing station before entering the unit.

- VAT is reassessed every 12 hour shift

- Investigate any medical reasons for demonstrated behaviour.

3. Assigned individuals including the Program Manager or Team Leader will enter the HOV in the CCI module on Meditech as per standard work.

E. Outpatient Mental Health (Crisis Team, ACTT, Day Programs etc.)

1. All patients will have a VAT assessment completed upon intake
2. Patients identified as having current violent behaviours and/or a VAT score of 4 or greater, will require ongoing monitoring and behavioural assessment using the VAT as required (prn). Patients with stable behaviours but with a HOV, will be reassessed every 6 months.
3. All patients will regularly be reviewed for behaviours. This may take place during patient Rounds.
4. Meditech's "History of Violence Report" will be accessed and run as outlined in the Standard Work document:

- Any individual identified on the History of Violence Report requires a charting review:
    - Enter PCI, locate most recent VAT documentation and check for accuracy, check addition of scores as well as documentation of contributing and alleviating factors.
- Access the Admission Module in Meditech and enter the CCI for HOV using date of incident. Utilize the text box for pertinent information only

5. When patients are identified as having concerning behaviours, a staff member will open Meditech and complete the Violence Assessment Tool (VAT).

- Check the electronic chart for CCI documentation and the reason patient has a flag on their record
- Select the VAT on the Process Intervention (PI) screen to document.
- Page 1: view for historical information:
- If blank, the patient has had no prior VAT assessments at HPHA
- If completed, a previous documentation has pulled forward regarding this patient's history
- Document current findings; entry will default into this screen for future providers/reference
- Page 2: document current behaviours, noting the following queries are required since they are considered red flag behaviours

- Verbal threats
- Physical threats
- Attacking objects

6. Transfer of accountability regarding a patient newly identified as having a history of violence or exhibiting any concerning observable behaviours, should occur at Rounds.

VAT score will be auto-tallied once entered into the Total Score and Risk Rating lines **Note:** changes to these fields from' Y' back to 'N' will cause errors in the addition. Manual entry of the correct value may be required.

Next Steps based on VAT Risk Rating:
VAT=1-2:
o Continue to monitor,
o Communicate any changes in behaviour to team affected
o Ensure communication devices are on hand for visit
o Arrange check-in call where appropriate
VAT =3:
o Scan environment for potential risks,
o Alert shift manager/ point of contact, co-workers (weekends) and manager
o Request assistance for visit
o Ensure section C is completed and document in client's care plan. Known triggers and safety measures should be addressed

o Use effective therapeutic communication
o Be prepared to use NVCI de-escalation techniques, GPA, P.I.E.C.E.S
o Communicate any changes in behaviour to team affected
o Inform client of VAT results when appropriate
o Ensure communication devices are in place for visit

VAT 4 or more:

***The wide array of interventions that can be utilized to ensure or achieve patient and staff safety in high risk situations is listed in the Violence Risk Strategies Assessment, which is a mandatory assessment to be completed whenever a patient scores a VAT of 4 or more**

- Staff member to remove self from any situation that is escalating to a level 5-6
- Promptly notify manager/ shift manager/ point of contact
    - Scan environment for potential risks
- Employee will submit a RL6 under “Safety/Security” if there is no personal injury / illness resulting from situation. However, if personal injury occurs, employee will submit an additional RL6 under “Employee Event”.
- If any of the 3 starred behaviours on page 2 is demonstrated, ensure that page 1 of the VAT now lists a history of violence with triggers/de-escalation
- Request assistance for visit – 2nd staff,
    - 911 call when appropriate
    - Ensure section C is completed and document in client’s care plan. Known triggers and safety measures should be addressed
    - Use effective therapeutic communication
    - Be prepared to use Non-Violent Crisis Intervention (NVCI) de-escalation techniques, Gentle Persuasion Approach (GPA), P.I.E.C.E.S strategies
    - Communicate any changes in behaviour to team affected
    - Inform client of VAT results when appropriate
    - Ensure communication devices are in place for visit
- Ensure VAT is documented on each encounter and as the patient’s condition changes

VAT-HOV Audits will be completed regularly to:

- Ensure each patient is assessed appropriately for violence/aggression
- Ensure documentation is consistent between pages 1 and 2 of the VAT
- Send reminder notifications to staff when documentation is incomplete or misaligned
- Evaluate indications to and adding CCI flags to the patient’s electronic health record

See Appendix F – Outpatient Mental Health Pathway

Resources:

- Violence Prevention - Patient and Family FAQ.pdf
- Violence Prevention - Staff FAQ.pdf

Appendices:

Appendix A - ED - No HOV

Appendix B - ED Process for Patient with Documented HOV

Appendix C - Inpatient-Documented HOV

Appendix D - Inpatient - New Patient - No HOV

Appendix E - Inpatient - New Behaviours HOV

Appendix F – Outpatient Mental Health Pathway