

# Foundational – Initiating and Updating Violence Risk

Violence risk screening is an important part of maintaining the safety of all care areas. This should be done on an ongoing basis for each patient.

# **Initial Screening**

Violence risk screening begins at the first point of care for all nurses.

- In inpatient settings, the section is part of admission forms
- If done at a time other than admission, the form can be found in the Ad Hoc folder
  - 1. Locate your patient.
  - 2. Access your admission documentation or access the Violence Risk Alert Screening form from the Ad Hoc folder.
  - 3. Navigate to and complete the Violence and Aggression Screening section.

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*Performed on: 27-Feb-2018	✓ 1409  PST		By: TestUser, Nurse-MH
General Information	General Informat	ion	^
Barriers to Communication			
Appearance and Behaviour	Barriers to Communication	Reason Unable to Obtain Information	
Speech, Affect, Mood	O Yes O No	None Language barrier	
Thought Process and Content		Cinical condition     Physical impairment     Connitive impairment	
Cognition, Insight, Judgment	Answer "Yes" if the patient has		
Violence and Aggression Screening	language barriers, requires interpreter support, or has sensory		_
Review Violence Risk Alert	deficits.		
Medication History			
Delirium Screen	Information Given By	Information Given By (Name)	
* Weight	Patient		
Allergy	Family     Community Care/Case Manager		
	Dther:		

Select the appropriate response as per your assessment from the yellow required Violence and Aggression Screening box.



- If **No risk assessed at this time** is selected, no further steps are necessary. Proceed to complete the rest of your documentation
- If any of the other choices are selected, further screening options become available



4. Complete the remaining questions as necessary.

These questions identify the patient's current presentation, stressors and risk factors.

Current Patient Presentation		Current Presentation Additional Information
Attack on object		
Instrument of harm/weapon     Physical harm (e.g. strikes, grabs)		
Physical threat		
Unwanted sexual touch		
Verbal aggression with another beha	viour or history of violence	
Verbal or written threat of physical vi	olence	
C Other:		
[		
Perceived Staff Approach Str	essors	Perceived Staff Stressors Additional Information
Enforcing or authoritative		
Denial or delay of request, action or i	item	
Sudden or unanticipated approach		
Task focus		
Unwelcome touch		
C Other:		
Risk Factors		Behavioural Early Warning Signs
Brain injury	🗖 Pain	
	Pauchasia	
Cognitive impairment		
Cognitive impairment	Sensory deficits	
Cognitive impairment     Communication impairment/barriers     Delirium     Fear crief anxietu	response     response     Sensory definits     Sleep deprivation     Substance introduction or withdrawal	
Cognitive impairment     Communication impairment/barriers     Delirium     Fear, grief, anxiety     History of abuse or trauma	Psychosis     Sensory deficits     Sleep deprivation     Substance intoxication or withdrawal     Other:	
Cognitive impairment     Communication impairment/barriers     Defirium     Fear, grief, anxiety     History of abuse or trauma     Hunger	Psychosis     Sensory deficits     Sleep deprivation     Substance intoxication or withdrawal     Other:	

5. The **Support and Intervention** information is meant to supplement care plan information that may be documented within an Interdisciplinary Care Plan document or on paper depending on your unit processes.

Support and Intervention		
<ul> <li>✓ Use verbal de-escalation</li> <li>Call police</li> <li>Comfort measures</li> <li>✓ Clear patient area of potential weapons/other patients</li> <li>Distraction (safe topics, redirection)</li> <li>Leave alone, give space</li> </ul>	Locate near nursing station     Medication     Protective measures     Security stand-by     Team response or partnered care     Other:	
Support and Intervention Detail	メ 陶 ඬ 吊 U 7 5 三 三 三	
Responsive to medication. Seclusion also had go	ood effect.	



6. Choose Done for **Risk Alert Activated** to identify that you will be activating the Violence Risk Process Alert.

<b>Risk Alert Activated</b>	
Done	
Place Violence Risk Alert on Electro	onic Medical Record

- 7. If accessed through admission documentation, complete the rest of the PowerForm as necessary.
- 8. Activate the Violence Risk Process Alert if there is an identified violence risk (see steps 1-4 in Managing the Violence Risk Process Alert section below).
- 9. Place a Violence Risk order.



**NOTE**: Like other nurse-initiated risk alerts, a Violence Risk alert can be entered as a **No-Cosignature Required** order.

PRODBCTES PRODBCTEST,		
PRODBCTEST PRODBCTEST,	P	P Ordering Physician ×
Allergies: Peanuts, Citrus, No Known	PRODBCTEST, TEST, DOB:3	
Menu 7	Age:3	Order
, Patient Summary	Allergies. Peanuts, Citr Genue	O Proposal
Orders 🕂 Add	Search violence	*Physician name
Single Patient Task List	Violence Risk	l 🔍
MAR	Enter to Search	*Order Date/Time
MAR Summary	Cardiology Orders	08-Mar-2018 🗘 🗸 1346 🗭 PST
Interactive View and I&O	Dermatology Orders	*Communication type
Results Review	Endocrinology Orders	Phone
Documentation 🕂 Add	General Medicine Orders	No Cosignature Required
Medication Request	Geriatric Orders	Cosignature Required Paper/Fax
Histories	Mental Health Orders	Electronic
Allergies 🛉 Add	Nephrology Orders	
		OK Cancel

10. This order will appear in CareCompass and Clinical Leader Organizer (CLO) as an alert icon.



11. Click the alert icon to view all high risk alerts for the patient. This order appears in CareCompass as an alert icon.

LGH MIU					
M018 - 01	CSTPRODBC, CSTPRODBC; Dam Elis No COD Concerning Concerning Concerning High Risks Display: Violence Risk	Patient is a 17 year old female wh LOS: 5m 1w	Plsvcj, Linwood, MD Business (199)240-9204	PRN/Continuous 56	ED Trauma (Validated) MH Psychiatric Admission (Validated) Restraints Adult (Module) (Validated)
Activity Timeline	Details: 08-Mar-2018 12:31 PST Date/Time: Today 12:31				
	Display: Suicide Risk (Suicide Precautions) Details: 2017-Sep-28 15:48 PDT Date/Time: Sep 28, 2017 15:48	_	_	_	

12. Click the alert icon. This order appears in the Clinical Leader Organizer (CLO) as a high risk alert icon.

<b>Clinical Le</b>	ader Organi:	zer																(D)	Full scree
A .		100% 🔹   🌑 🌑 🚮																	
Clinical Lea	ader Organizer	∺ +																	
Patient Lis	t: LGH MIU M	ental Health Inpatient Unit 🗸 🛛	List Mainten	ance	Establish Relationship	s													
Location		Patient			Care Team	Hi	Re	Central	Ox	Ve	Air	No	Diet	Sui	Fall	Ski	Dis	Elo	Iso
LGH MIU	M020 - 02	*CSTPROD, MHSUND	56 yrs	м	No Relatio	//////////////////////////////////////	273111111	-											
LGH MIU	M010 - 01	*CSTPROD, MHTHUR	57 yrs	м	No Relatic Violen	<sup>sk</sup> ce Risk		-											
LGH MIU	M002 - 01	*CSTPROD, MHTUES	56 yrs	F	No Relatic 08-Ma	r-2018 12:3	PST												
LGH MIU	M005 - 01	*CSTPROD, MHWED	51 yrs	м	No Relatic	ed at: 03/08	/2018 12::	31 PM											
LGH MIU	M018 - 01	CSTPRODBC, PRODBC,	29 yrs	F		A	8					-	τf		15		<b>F</b>		
LGH MIU	M008 - 01	*CSTPRODBCMH, CH	23 yrs	м	No Relationship Ex	asts													
LGH MIU	M021 - 01	*CSTPRODBCMH, CH	31 yrs	F	No Relationship Ex	asts													



**NOTE**: This order will also appear on in the orders profile and alerts widget if applicable to communicate risk to staff that do not have CareCompass or CLO, such as allied health.

- 13. Update any paper copies of care plans as necessary with details from the Support and Intervention information.
- 14. Communicate the patient's violence risk to the healthcare team as per your site-specific workflows.

## **Updating the Violence Risk Alert Screening**

A patient's violence risk profile may change during his or her admission. Ongoing assessment is necessary to monitor the patient situation and plan care appropriately.

If the patient's violence risk profile has changed, document this in the Violence Risk Alert Screen PowerForm.



- 1. From the Ad Hoc folder in the toolbar, select the Violence Risk Alert Screen PowerForm.
  - If there was no previous violence risk documentation, this PowerForm will be empty. Fill in the fields as appropriate (see step 3 of the Initial Screening section).
  - If there was previous violence risk documentation, this PowerForm will be pre-populated with the most recent information. Revise the information as appropriate.
- 2. Navigate to the **Review Violence Risk Alert** section to document changes in the patient's violence risk profile.
- 3. Click radio button **Alert will be maintained until next review** if the patient continues to have violence risks
- 4. Select **Recommend alert be discontinued** if there is no longer any violence risks and provide a reason for discontinuation

Alert Maintained or Discontinued	Alert MUST be maintained if any of the three points occurred:	Alert Discontinued Reason			
<ul> <li>Alert will be maintained until the next review</li> <li>Recommend that alert be discontinued</li> </ul>	Patient was physically threatening or physically violent towards staff. Patient made specific and executable threats of physical harm/sexual harm. There is an existing history of serious violence in healthcare, or received from documented credible source.	Medical condition changed     Risk behaviour did not escalate to violence (e.g. attack on object)			

- 5. Update the patient's Process Alert if necessary.
  - To activate a Violence Risk Process Alert, see steps 1-4 of the Managing the Violence Risk Process Alert section below
  - To remove a Violence Risk Process Alert, follow steps 5-7 of the Managing the Violence Risk Process Alert section below



6. Discontinue the patient's Violence Risk order from the Orders Profile

P			CSTPRODBC, ALBINAT	EST - 700006940 Opened by TestCD, Nurse	
Task Edit View Patient Chart Lin	ks Options Current Add Help				
🗄 🎬 CareCompass 📲 Clinical Leader Organi	izer   Patient List 🔐 Multi-Patient Task List	t 🔐 Staff Assignment 🎬	LearningLIVE 📮		
👯 🕄 CareConnect 🕄 PHSA PACS 🔇 VCH a	and PHC PACS 🔇 FormFast WFI 🝦				
👯 🕄 Patient Health Education Materials 🕄 S	HOP Guidelines and DSTs 🕄 UpToDate 🚊			Renew	
Tear Off 📶 Exit 🎦 AdHoc IIIII Medica	tion Administration 🔒 PM Conversation 👻	Medical Record Request	🕂 Add 👻 🗐 Do	Modify	ern
				Copy	
CSTPRODEC CSTPRODEC	DOB:07-Sep-1988	MRNI-700006940	Code Status:1	Cancel and Reorder	
CSTPRODUC, CSTPRODUC	Age:29 years	Enc:7000000010937	Code Status	Suspend	2:
Allergies: amoxicillin, Peanuts	Gender:Female	PHN:9876569013	Dosing Wt:50	Complete	n:
Menu 7	< 🗧 🕇 🛉 Orders			Cancel/Discontinue	
Patient Summary	+ Add   🖓 Document Medication by Hx	♦ Check Interactions		Void	
Orders 🕂 Add		_		Pershadula Task Timas	
Single Patient Task List	Orders Medication List Document In Pla	n		Add/Modify Compliance	-
MAR	K			Add/ Modily compliance	_
MAR Summary	View	Displayed: All Active Order:	rs   All Inactive Order	Order Information	
Interactive View and I&O	Suggested Plans (0)	<i>№</i> 7 0	)rde <b>r</b> Name	Comments	. [
Results Review	Admit/Transfer/Discharge	△ Admit/Transfer/Dise	charge	Results	
	- Status	A Status	Discharge Patient	Reference information	2
	Patient Care	M N	/IHA. Form 4 x2 Inv	Finit	F
Medication Request		🗹 🖻 見 🛛 C	Code Status	Advanced Filters	1
Histories	Continuous Infusions	A Patient Care	/HA. Form 4 x1 Inv	Customize View	F
Allergies 🕂 Add	- Medications		iolence Risk	Disable Order Information Hyperlink	
Diagnoses and Problems	Blood Products	🗹 🛃 R	estraints Initiation	Ordered	2

- 7. Update any paper copies of care plans as applicable.
- 8. Communicate the change in the patient's violence risk to the healthcare team as per your sitespecific workflows.

## Managing the Violence Risk Process Alert

1. Open the dropdown on the **PM Conversation** in the Organizer toolbar.



- 2. Select the Process Alert conversation.
- 3. Select your location in the Organization window.
- 4. Click --- icon.



<b>(</b> )	Organization	×						
Please select the facility where you want to view person aliases.								
Facility N LGH LGH Joi I GH Lat LGH Lio LGH Ne	ame Facility Alias	]						
Facility:								
	0K Cancel							

- 5. Click **OK** to confirm your selection.
- 6. Click on **Violence Alert** window to turn it green in the available alerts in the Process Alert window.



- 7. Click **Move** to select the Process Alert for activation.
- 8. Click Complete to activate the Process Alert.



NOTE: You can select multiple Process Alerts and activate them all at once.

9. Refresh the page.



You see the Violence Risk Process Alert on the banner bar of the patient's chart.

own Aller	DOB:29/Apr/	MRN:740000 Code Status:	Process:Violence Risk		Location:LGH Chemo Hold				
	Age:91 years	Enc:74000000	Disease:		Enc Type:Inpatient				
	Gender:Male	PHN:9876272 Dosing Wt:61 kg	kg Isolation:		Attending:TestUser, Psychiatr				
A Orde	rs			[므] Full screen	Print	ninutes ago 🕈			

- 10. To de-activate a Process Alert, navigate to the Process Alert PM Conversation.
- 11. Select your location then land on the Process Alert window.
- 12. Select the activated Violence Risk Process Alert.
- 13. Click **Move** to remove it from the active Process Alerts list.
- 14. Click **Complete** to confirm Process Alert deactivation.

٩		P	Process Alert		- 🗆 🗙
Medical Record Number: 700020900	Encounter Number:	Last Name: CSTTEST	First Name: MHADMISSION	Middle Name:	Preferred Name:
Previous Last Name:	Date of Birth: 01-Jan-2001	Age: 17Y	Gender: Undifferentiated V	BC PHN: 9876296361	]
ALEMIS Process Alert: To Available: Communication Barrier Cytotoxic Difficult Intubation/Airway Falls Risk Family Development No Ceiling Lift	< Move Viole	Selected: Innce Risk			

#### 15. Refresh the page.

The Violence Risk Process Alert is removed from the banner bar.

## **Related Topics**

- Foundational Process Alert
- Foundational High Risk Alert

## **Related Positions**

- Nurse/Mental Health Nurse
- Nurse Supervisor/Mental Health Nurse Supervisor



# **Key Words**

- Violence and aggression screening
- Violence risk
- Process alert
- High risk alert