Community Care Violence Assessment Tool (VAT) (Modified)

Primary Care and Chronic Disease High Risk Behaviour (Flag) Alert Procedure

This form is to be completed by clinical healthcare worker or manager/supervisor.

Health PEI

Client's Name: _____

Identification #:_____

☐ **Initial Assessment** ☐ **Reassessment**

Section A: Risk Indicators

Read the list of behaviours below and identify behaviours that will require specific care interventions. A score of 1 is applied for past occurrence of any of the History of Violence behaviours; and additional scores of 1 are applied for each observed behavior. Add the scores — **the maximum is 12**.

HISTORY OF VIOLENCE: **Score 1 for past occurrence of any of the following:**	**SCORE**
▪ Exercising physical force, in any setting, towards any person including a caregiver that caused or could have caused injury ▪ Attempting to exercise physical force, in any setting, towards any person including a caregiver that could cause injury ▪ Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury	
OBSERVED BEHAVIORS: **Score 1 for each of the observed behaviour categories below.**	**SCORE**
Confused (Disoriented – e.g., unaware of time, place, or person)	
Irritable (Easily annoyed or angered; Unable to tolerate the presence of others; Unwilling to follow instructions)	
Boisterous (Overtly loud or noisy – e.g., slamming doors, shouting etc.)	
Verbal Threats (Raises voice in an intimidating or threatening way; Shouts angrily, insulting others or swearing; Makes aggressive sounds)	
Physical Threats (Raises arms / legs in an aggressive or agitated way; Makes a fist; Takes an aggressive stance; Moves / lunges forcefully towards others)	
Attacking Objects (Throws objects; Bangs or breaks windows; Kicks object; Smashes furniture)	
Agitate/Impulsive (Unable to remain composed; Quick to overreact to real and imagined disappointments; Troubled, nervous, restless or upset; Spontaneous, hasty, or emotional)	
Paranoid / suspicious (Unreasonably or obsessively anxious; Overly suspicious or mistrustful – e.g., belief of being spied on or someone conspiring to hurt them)	
Substance intoxication / withdrawal (Intoxicated or in withdrawal from alcohol or drugs)	
Socially inappropriate / disruptive behaviour (Makes disruptive noises; Screams; Engages in self-abusive acts, sexual behaviour or inappropriate behaviour – e.g., hoarding, smearing feces / food, etc.)	
Body Language (Torso shield – arms / objects acting as a barrier; Puffed up chest – territorial dominance; Deep breathing / panting; Arm dominance – arms spread, behind head, on hips; Eyes – pupil dilation / constriction, rapid blinking, gazing; Lips – compression, sneering, blushing / blanching)	
TOTAL SCORE	
Client's Risk Rating: ☐ Low (0) ☐ Moderate (1-3) ☐ High (4-5) ☐ Very High (6+)	

Completed By (Name/ Designation)_____ **Date:** _____

Section B: Overall Risk Rating

Apply the total behaviour score to the Risk Rating Scale to determine whether the client's risk level is low, moderate, high or very high. Each level provides cues for further action to consider. If moderate or high / very high risk is determined, complete Section C to identify factors that may trigger or escalate violent, aggressive, or responsive behaviour and ensure the care plan includes measures to avoid or reduce risk behaviours identified.

Overall Score	Risk Reduction Planning Actions to take
Low Score of 0	▪ Continue to monitor and remain alert for any potential increase in risk ▪ Communicate any change in behaviours, that may put others at risk, to the manager / clinical lead/ admin supervisor ▪ Ensure communication device / processes are in place – (e.g., phone, personal safety / "panic button" alarms, check-in protocol; respectfully terminate patient engagement / visit if concerns arise)
Moderate Score of 1-3 Risk Reduction Plan	▪ Apply flag alert by inserting an admin note in the patient's chart in CHR that every staff member entering the patient chart will see as a pop-up window; this note should include a very brief summary of the concerns and a brief listing of suggested actions ▪ Promptly notify the manager / clinical lead/ admin supervisor so they can inform relevant staff and coordinate appropriate staffing, workflow ▪ Alert back-up staff / security / police and request assistance when needed ▪ Scan environment for potential risks and remove if possible ▪ Arrange to meet patient in a public location as needed ▪ Ensure section c is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for patients and workers ▪ Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care ▪ Be prepared to apply behaviour management and self-protection teachings appropriate for the situation in accordance to organizational policy, including non-violent crisis intervention (NVCI) techniques ▪ Ensure communication device / processes are in place – (e.g., phone, personal safety / "Panic button" alarm, check-in protocol and / or global positioning tracking system) ▪ Notify the primary care provider via a message from the patient's chart in CHR ▪ Communicate any change in behaviours, that may put others at risk, to manager / clinical lead/ admin supervisor. ▪ Inform patient or SDM of VAT results, when safe to do so (consult with primary care provider) ▪ Other: _____
High Score of 4-5 OR **Very High Score of** **6+** Detailed Risk Reduction Plan	▪ Apply flag alert by inserting an admin note in the patient's chart in CHR that every staff member entering the patient chart will see as a pop-up window; this note should include a very brief summary of the concerns and a brief listing of suggested actions ▪ Promptly notify manager / clinical lead/ admin supervisor so they can ensure relevant staff are on high alert and prepared to respond ▪ Alert back-up staff / security / police and request assistance when needed ▪ Scan environment for potential risks and remove if possible ▪ Arrange to meet patient in a public location as needed ▪ Ensure section c on VAT is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers, including non-violent crisis intervention techniques. ▪ Notify patient's primary care provider directly and via a note from the patient's chart in CHR; Initiate applicable referrals ▪ Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care ▪ Be prepared to apply behaviour management and self-protection teachings appropriate for the situation in accordance to organizational policy, including non-violent crisis intervention (NVCI) techniques. ▪ Ensure communication device / process is in place – (e.g., phone, personal safety / "panic button" alarm, check-in protocol and / or global positioning tracking system) ▪ Communicate any change in behaviours, that may put others at risk, to the program manager / supervisor ▪ Call 911 as necessary ▪ Inform patient of VAT results, when safe to do so (consult with primary care provider) ▪ Other:

Section C: Contributing Factors

Physical, psychological, environmental, and activity triggers can lead to or escalate violent, aggressive or responsive behaviours. Documenting known triggers and behaviours and asking your client or substitute decision maker (SDM) to help identify them can help you manage them more effectively and safely. Use the information collected and the intervention resources listed on p.2 and p.11 of the PSHSA Individual Client Risk Tool to develop an individualized violence prevention care plan and a safety plan to protect workers at risk.

QUESTION FOR CLIENT:	CONSIDERATIONS – Select any that Apply			
	PHYSICAL	**PSYCHOLOGIAL**	**ENVIRONMENTAL**	**ACTIVITY**
To help us provide the best care possible, please describe if there is anything during your stay that could cause you to become agitated, upset or angry e.g., I am agitated when…	☐ hunger ☐ pain ☐ infection ☐ new medication ☐ other_____	☐ fear ☐ uncertainty ☐ feeling neglected ☐ loss of control ☐ being told to calm down ☐ being lectured ☐ other_____	☐ noise ☐ lighting ☐ temperature ☐ scents ☐ privacy ☐ time of day ☐ days of the week ☐visitors ☐ small spaces/ overcrowding ☐ other_____	☐ bathing ☐medication ☐ past experiences ☐ toileting ☐ changes in routine ☐ resistance to care ☐ other_____
What works to prevent or reduce the behaviour(s) e.g., When I am agitated, it helps if I…	☐ Go for a walk ☐Listen to music ☐ Watch TV ☐Draw ☐ Read (Bible/Book) ☐ Have space and time alone ☐ Talk 1:1 with _____(who?) ☐ Participate in activities ☐ Consult a family member or friend	**POTENTIAL DE-ESCALATION TECHNIQUES** Identify potential de-escalation strategies using above information such as respect personal space, actively listen, offer choices, give eye contact, use humor		