

Primary Care and Chronic Disease **High-Risk Behaviour Alert Procedures**

Purpose

The Health PEI policy regarding the utilization of high-risk behaviour alerts to communicate and alert Health PEI health care workers of a potential risk of violent or aggressive behaviour by patient/client/resident was updated in June 2024: [HIGH RISK BEHAVIOUR ALERT](#) (login to the Policy Document Management System is required). The updated 'High-Risk Behaviour Alert Procedures' incident procedures reflect these changes.

Violence Assessment Tool (VAT) Qnaire

Primary Care and Chronic Disease staff observing high risk patient behaviour that they assess as a potential risk to the patient, staff, other patients, or the public are to complete section A (Risk Indicators) of the Violence Assessment Tool (VAT) Qnaire in the provincial EMR system (see Appendix 1 – *Initiating a VAT Qnaire in Encounter in the Provincial EMR*) as soon as possible following the incident. Further action and risk reduction planning will be based on the outcome VAT Qnaire's total behaviour, section B (see Appendix 2 – *VAT Section B: Overall risk Rating*).

After completing the VAT Qnaire and documenting interaction in a clinical encounter in the provincial EMR (Appendix 3 – *Violence Assessment Tool Qnaire Output Sample*), the staff member notifies their clinical lead / administrative supervisor / network manager of the observed behaviour and of the completion of the VAT Qnaire. The staff member must notify the clinical lead / administrative supervisor / network manager of the incident via email but **not include any Personal Health Information (PHI) of the involved patient by email**. A provincial EMR message can also be shared with the clinical lead / administrative supervisor / network manager which can contain additional PHI information related to the involved person / incident.

Provincial Safety Management System (PSMS)

In a timely manner following the high-risk patient behaviour incident, the staff member is also to enter the incident as a 'Patient Safety Incident' into the Provincial Safety Management System (PSMS). If the observed behaviour was directed towards a staff member, the incident should also be logged as a separate 'Staff Event' in the PSMS as well.

The VAT Qnaire is to be first completed by the staff member before adding an incident in the PSMS, however the VAT Qnaire does not need to be uploaded and saved in the PSMS and will be saved within the provincial EMR.

VAT Qnaire Assessment

The VAT Qnaire is to be assessed by the clinical lead / administrative supervisor / network manager within the provincial EMR system based on the VAT Qnaire total behaviour score to determine the appropriate level of risk for the risk reduction plan. In any situation where a potential suicide was mentioned, presented, or implied by the involved patient or client, a provider or a staff member who

works in Collaborative Mental Health should be informed and immediately involved to assist in developing and actioning an appropriate risk reduction plan.

Risk Determination

The clinical lead / administrative supervisor / network manager determines how the observed patient's behaviour will be addressed. The mitigating steps chosen as appropriate for the incident event will be considered the risk reduction plan and upon review of section B (Overall Risk Rating) and section C (Contributing Factors) of the [Primary Care & Chronic Disease Community Care Violence Assessment Tool \(VAT\)](#). The VAT Qnaire total behaviour score is applied to section B of the VAT risk overall rating scale to determine the level of risk and risk reduction plan.

Mitigating risk reduction actions should be formulated based on the VAT Qnaire total behaviour score. If the involved staff member believes the risk rating does not adequately reflect the VAT Qnaire total behaviour score, the staff member should inform their clinical lead / administrative supervisor / network manager of their concerns.

Risk Reduction Plans

(See Appendix 2 – *VAT Section B: Overall risk Rating*)

A “low score” (zero) VAT Qnaire will not require an additional risk reduction plan. Continue to monitor and remain alert for any potential increase in risk. Communicate any change in behaviours that may put others at risk with the clinical lead / administrative supervisor / network manager.

A “moderate” (1-3) VAT Qnaire total behaviour score will necessitate what is known as a ‘simple’ risk reduction plan. A ‘simple’ risk reduction plan would be appropriate in situations where it is determined that future violence would be unlikely. A simple risk reduction plan should be expired after one week without further incidents. The simple risk reduction plan involves the appropriate time-specific instructions that involved staff will take. At the discretion of the manager / clinical lead / admin supervisor, a flag alert may be applied 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 suggested actions.

A “high” (4-5) to “very high” (6+) VAT Qnaire total behaviour score will require a more diligent response to the high-risk behaviour; therefore a ‘detailed’ risk reduction plan is appropriate. This is an event or situation where it has been determined that there is a risk of future violence. A detailed risk reduction plan should include a ‘note’ placed in the patient file in the provincial EMR. The provincial EMR ‘note’ should appear as a ‘pop-up’ for when any user accesses the patient file from within the system (which also must be acknowledged by the user to continue). No ‘detailed’ risk reduction plan should be permanently set in place, and all active ‘detailed’ risk reduction plans should be proactively reviewed for continuation monthly by the clinical lead / administrative supervisor / network manager.

Flagging the ‘Pop-up’ Risk Reduction Plans Alerts in the Provincial EMR

(see Appendix 4 – *High-risk Behaviour Alerts in the provincial EMR*)

VAT Qnaires and any risk reduction plans become part of the patient's chart once completed and the risk reduction plan should be added electronically to the patient's provincial EMR record as a 'note'. The provincial EMR will flag all users who access the involved patient's chart with a 'pop-up' as long as a risk reduction plan remains active.

The 'pop-up' provincial EMR note will:

- Briefly detail the history of the observed high-risk behaviour and the mitigating actions previously taken to manage the situation.
- List the suggested future actions expected from staff who will encounter the patient involved while the risk reduction plan is active.
- Include information about whether the patient is aware of the risk reduction plan in place.
- Be shared with the patient's primary provider so that they are promptly notified and can be consulted regarding the risk reduction plan in place involving their patient.

Duration of 'detailed' risk reduction plans

The 'detailed' risk reduction plans are put in place in response to identified high / very high-risk behaviours, and they remain in place until a decision is made to remove them. This decision should be made with consultation with the patient's primary care provider (and any involved Collaborative Mental Health staff if the situation involved a risk of suicidality).

When it is decided that the level of risk has been sufficiently reduced and a 'detailed' risk reduction plan should be expired, a summary note detailing the review and consultations completed resulting in the ending of the 'detailed' risk reduction plan is to be placed in the patient's chart in CHR. The alerting CHR 'pop-up' note is also to be immediately deactivated for all those accessing the CHR file but will remain as a part of the patient chart.

Informing Patients of Risk Reduction Plans

No patient notification is required for 'simple' risk reduction plans.

When a 'detailed' risk reduction plan is set in place, every reasonable effort should be made to inform the patient of the plan, along with the details and purpose of the plan. This notification should be done safely in agreement and in partnership with the patient's primary care provider. In cases where informing the involved patient of a 'detailed' risk reduction plan may elevate the potential risk to themselves, the staff, or others, then such notification can be delayed or withheld. This decision requires the agreement of their primary care provider.

Information Sharing

Even in situations of high-risk behaviours, patient privacy remains important and held in confidence. Communication of any risk reduction plan should be made with staff who are likely to have contact with the patient or those who are required to assist in the development and implementation of a risk reduction plan. Staff should be reminded that risk reduction plans remain as a part of the patient's chart, even after expiry, and that documentation of the high-risk behaviour incidents should only be comprised of factual details and observations.

High-Risk Behaviour Alert Tools and Resources

- [High-Risk Behaviour Alert Tools and Resources | Health PEI | Staff Resource Centre](#)
- Flowchart for the PCCD High-Risk Behaviour Alert Procedures (See Appendix 5 - *Flowchart for the Primary Care and Chronic Disease High-Risk Behaviour Alert Procedures*)
- Health PEI High-Risk Behaviour (Flag) Alert Policy (see Health PEI Policy Document Management System)
- High-Risk Behaviour Alert Policy FAQ (see Health PEI Staff Resource Centre)

Appendix 1 – Initiating a VAT Qnaire in an Encounter in the Provincial EMR



Violence Assessment Tool Qnaire within an Encounter in Prov EMR

- 1) Document the interaction had with the patient/client in an Encounter.
- 2) Click on the button “Collect Data” to attach Violence Assessment Tool (VAT) Qnaire to your Encounter and complete.
- 3) Once Qnaire is completed, your answers should be brought into the Encounter at the Top of the History Section.

+Collect Data

Auto-Populate Encounter

We've found 1 natural language paragraph from your selection.
Please assign an encounter section to fill.

Qnaire Name

Attach Paragraph to



Violence Assessment Tool

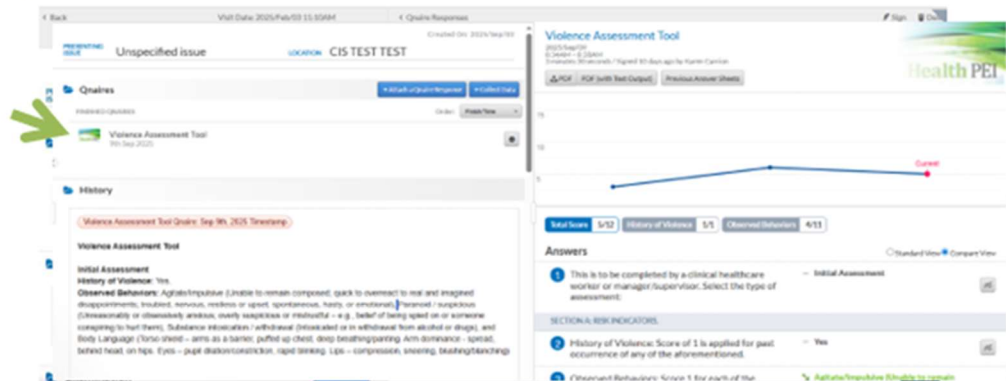
History

Add To: ☒ Top ☐ Bottom

Close

Attach

- 4) Click on the completed Qnaire tab and your screen will split for you to visualize the SCORE.



Appendix 2 – VAT Section B: Overall Risk Rating

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	▪ Promptly notify the manager / clinical lead/ admin supervisor so they can inform relevant staff and coordinate appropriate staffing, workflow ▪ At the discretion of the manager / clinical lead / admin supervisor a flag alert <u>may</u> be applied 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 ▪ 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 with 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	▪ A flag alert <u>should</u> be applied 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 with 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 if necessary ▪ Inform patient of VAT results, when safe to do so (consult with primary care provider) ▪ Other:

Appendix 3 – Violence Assessment Tool Qnaire Output Sample

Violence Assessment Tool

Questionnaire last updated at: 03:52 PM ADT / 11 July 2025

Kristy Mirella Testing
PE: 77715451

PATIENT INFORMATION				12:50 PM ADT / 02 September 2025	
FIRST NAME	M.I.	LAST NAME	GENDER	DATE OF BIRTH	
Kristy	Mirella	Testing	Male	4th May 1967	
STREET ADDRESS			CITY	STATE/PROVINCE	COUNTRY
#1400 - 207 W Patienty St			Patientyville	Prince Edward Island	
PHONE		EMERGENCY CONTACT		Spouse	
+1 902 303 2477		9823236598			
EMAIL			PE		
kmcarrion@ihis.org			77715451		

QNAIRE RESPONSE		Score: 5.0	08:40 AM ADT / 09 September 2025
1.	This is to be completed by a clinical healthcare worker or manager/supervisor. Select the type of assessment:	☒ Initial Assessment ☐ Reassessment	
SECTION A: RISK INDICATORS.			
2.	History of Violence: Score of 1 is applied for past occurrence of any of the aforementioned.	☒ Yes ☐ No	
3.	Observed Behaviors: Score 1 for each of the observed behavior categories below.	☐ 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 (Overly 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 behavior (Makes disruptive noises; screams; engages in self-abusive acts, sexual behavior or inappropriate behavior – e.g., hoarding, smearing feces / food, etc.) ☒ Body Language (Torso shield – arms as a barrier, puffed up chest, deep breathing/panting. Arm dominance - spread, behind head, on hips. Eyes – pupil dilation/constriction, rapid blinking. Lips – compression, sneering, blushing/blanching) ☐ No Observed Behaviors	

SCORING BREAKDOWN
History of Violence: 1/1 Observed Behaviors: 4/11



Appendix 4 – High-Risk Behaviour Alerts in the Provincial EMR



Risk Behavior Alerts in the Provincial EMR

Low Risk Behaviour

VAT Qnaire Scores of 0 indicates **Low Risk Behaviour**. Continue to monitor situation and communicate any changes in behaviours. No risk reduction plan is required.

Moderate Risk Behaviour

VAT Qnaire Scores of 1–3 indicates **Moderate Risk Behavior**. As part of a “simple” risk reduction plan, an **Important Admin Note** (pop-up) may optionally be created at the discretion of the clinical lead, manager, or administrative supervisor.

High and Very High-Risk Behaviour

VAT Qnaire Scores of 4–5 indicates **High Risk Behavior**, and scores of 6 or higher indicate **Very High-Risk Behavior**. As part of a “detailed” risk reduction plan, an **Important Admin Note** (pop-up) should be created in the patient chart.

All **Important Admin notes must be **reviewed monthly** by the clinical lead, manager, or administrative supervisor and should remain active until a formal decision is made to remove them. **

The Important Admin Note

Title the note: “VAT Score [insert score] (Moderate, High or Very High-Risk Behaviour Alert)” and include a hyperlink to the provincial EMR “Encounter” along with a brief summary of the incident.

Hyperlink Setup

1. Click the Hyperlink Button and insert the URL of the Encounter.
2. Tick the box: “Open link in New Tab”
3. Set the hyperlink text to: “Violence Assessment”.

Appendix 5 – Flowchart for the Primary Care and Chronic Disease High-Risk Behaviour Alert Procedures

