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PROCEDURE SUBJECT:

Violence Prevention Program in Primary Health Care Setting

PURPOSE:

This procedure complements the Violence Prevention Program for Health Care Workers Policy (ORG.1513.PL.001) and the Violence Prevention Program for Health Care Workers - Patient Risk Screening and Alert System Standard Guideline (ORG.1513.SG.001).

The process for screening, alert implementation and communication, reassessment, communication of alerts on transfer, and alert deactivation for the Primary Health Care Program is outlined in this procedure

DEFINITIONS:

Client – For the purpose of this policy and its supporting documents, the terms Client, Patient and Resident, are synonymous.

First Point of Contact – The initial interaction between a designated staff person and a patient seeking health care services.

Episode of Care – All services provided to a patient with a health concern for the duration of the patient’s interaction with Southern Health-Santé Sud regarding the health concern (i.e. outpatient IV therapy, patient receiving home care, mental health, public health etc. services over a period of time).

Past Active Violence or Aggression – Evidence of violent or aggressive behavior within the past 2-4 weeks that may present again.

Violence – Any act that results in injury or threat of injury, real or perceived, by an individual, including but not limited to:

- Act of aggression (whether intentional or not)
- Verbal or written threats
- Vandalism of personal property

IMPORTANT POINTS TO CONSIDER:

- Screening for potential violence and aggression is an ongoing process during an episode of care.
- Identified risks of violence and aggression and actions to mitigate or eliminate the risk must be communicated at points of transition across the health care system. Information shared must adhere to PHIA legislation

PROCEDURE:

Screening:

1. On arrival to a Primary Health Care setting reception staff or designated staff, as the first point of contact, uses the laminated Violence Prevention Quick Screen for Violence or Aggression Reference Sheet (ORG.1513.SG.001.SD.01) to screen all Clients over the age of 6 to determine risk factors for violence and aggression.
2. If an Alert IS required based on the initial screen, the reception staff or designate:
 - Marks the intake form with the provincial alert symbol for that episode of care.
 - Completes the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01) entering the date and time of the screening at the top left of the form and then Complete Section #1 A & B, placing a check mark to all criteria that apply.
 - Communicates the Alert to the Health Care Provider with primary responsibility.
3. The Health Care Provider with primary responsibility for the client:
 - Completes Section #1 C, checking all that apply.
 - Assesses further to determine the need for an Alert then complete Section #2 to determine if the criteria for an Alert are met or not met.
 - If an Alert IS required based on the further assessment:
 - Check off Section #2: Screening Tool Outcome, Alert required. This may include:
 - At least one (1) yes in Section 1A or 1B; **OR**
 - Two (2) or more yes in Section 1C.
 - Complete Section #3 of the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01).
 - Document the Alert in Client Progress Notes in the Electronic Medical Record (EMR) or paper chart.
 - Place the Violence Prevention Program Use CARE Environment Alert (ORG.1513.SG.001.SD.03) in the Demographic Area of the EMR or on the front cover of a client's paper chart.
 - Communicate the Alert to staff in the area who need to know verbally and in writing; using the provincial standardized symbol, as appropriate.

- The Health Care Provider with primary responsibility creates a safety care plan to eliminate or minimize the risk of violence, aggression and/or responsive behaviours. Document interventions in the Violence Prevention Program Care Plan (ORG.1513.SG.001.FORM.02).
 - At the Health Care Providers discretion, the Client and/or his/her representative/designate is given the handout Violence Aggression and Responsive Behaviour Information for Patients and Families Bilingual (ORG.1513.SG.001.SD.02).
4. If an Alert is NOT required based on the initial screening, using the laminated Violence Prevention Quick Screen for Violence or Aggression Reference Sheet (ORG.1513.SG.001.SD.01) at first point of contact the Health Care Provider with primary responsibility:
- Completes the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01).
 - Checks off Section #2: Screening Tool Outcome, Alert not required and document in the client's chart.
 - Adds a purple flag to indicate VPPN, Violence Prevention Plan - No to the task window in the EMR and add 'VPPN' to the front of a paper chart to indicate that the client has been screened and is negative for violence.

Reassessment:

1. Re-screening of the Client is determined by the Health Care Provider or delegate based on the behavioural presentation of the Client, or upon receiving new information about the Client's behaviour.
2. Any re-screening is conducted using the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01).
3. The re-screen is documented on the Client Progress notes.
4. The Alert must remain active until the risk of violence, aggression or responsive behaviour is reasonably mitigated or eliminated, as determined by the health care team.

Transfer to another facility:

1. When a clinical handoff to another site occurs the health care professional with responsibility for the Client communicates an active Alert by noting the Alert on the Referral form. The Health Care Provider with primary responsibility:
 - Communicates an active Alert by providing a copy of the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01).
 - Any other known information to reasonably mitigate or eliminate potential for violence, aggression and /or responsive behaviours.

Deactivation of Alert:

1. Deactivation of an Alert may occur at any time and is at the discretion of the health care team once the potential or actual violent behaviour of the Client has been reasonably mitigated or eliminated. Once the Alert is deactivated, the Health Care Provider with responsibility for the Client:
 - Completes Section 4 of the Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.SD.02).
 - Communicates the deactivated alert as applicable such as removal, discontinuation or update of:

- Documentation in the Progress Notes.
 - Removal of the Violence Prevention Program Use CARE Environment Alert (ORG.1513.SG.001.SD.03) from the EMR and stroke out the symbol on the paper chart, date and sign.
 - Communicate the deactivation of the Alert to all Health Care Providers as appropriate.
2. At time of discharge where the potential or actual violence has not been reasonably mitigated or eliminated and risk factors remain, the Alert is to remain activated. The Alert is communicated in the Health Record, EMR or paper chart, by remaining an active notation on the Progress Notes.

Screening Filing:

1. The Screening Tool and Alert for Violence and Aggression Tool (ORG.1513.SG.001.FORM.01) is filed in the client's health record, EMR or paper chart. The original and current are retained on the active health record.

REFERENCES:

[ORG.1513.PL.001](#) Violence Prevention Program for Health Care Workers

[ORG.1513.SG.001](#) Violence Prevention Program for Health Care Workers - Patient Risk Screening and Alert System

[ORG.1513.SG.001.FORM.01](#) Screening Tool and Alert for Violence and Aggression Tool

[ORG.1513.SG.001.SD.01](#) Violence Prevention Quick Screen for Violence or Aggression Reference Sheet

[ORG.1513.SG.001.SD.02](#) Violence Aggression and Responsive Behaviour Information for Patients and Families Bilingual

[ORG.1513.SG.001.SD.03](#) Violence Prevention Program Use CARE Environment Alert