



Team Name: Public Health-Healthy Living	Reference Number: CLI.6210.PR.002
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Approved by: Executive Director North	Policy Section: General
Issue Date: February 1, 2019	Subject: Violence Prevention Program in Public Health-Healthy Living Office Setting
Review Date:	
Revision Date:	

PROCEDURE SUBJECT:

Violence Prevention Program in Public Health-Healthy Living Office 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 Public Health-Healthy Living Program is outlined in this procedure.

DEFINITIONS:

Client – For the purpose of this procedure 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 client seeking health care services.

Episode of Care – All services provided to a client with a health concern for the duration of the client’s interaction with Southern Health-Santé Sud regarding the health concern (i.e. client 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 Public Health-Healthy Living 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 six 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 right of the form, and then completes Section #1 A and Section #1 B, placing a check mark next 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 completes Section #2 to determine whether the criteria for an Alert are met or not met.
 - If an Alert IS required based on the further assessment:
 - In Section #2: Screening Tool Outcome, check “Alert required”. This may include:
 - At least one (1) “yes” in Section 1 A or 1 B; **OR**
 - Two (2) or more “yes” in Section 1 C.
 - 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 the client’s paper chart.
 - Communicate the Alert to staff in the area who need to know, communicating both 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 Provider's 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 "Alert not required" in Section #2: Screening Tool Outcome and documents in the client's chart.
 - Adds a purple flag to indicate VPPN, Violence Prevention Plan - No to the task window in the EMR or 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 designate 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 program or site:

1. When a clinical handoff to another program or 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).
 - Communicates 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.FORM.01).
 - Communicates the deactivated alert as applicable such as removal, discontinuation or update of:

- Documents in the Progress Notes.
 - Removes the Violence Prevention Program Use CARE Environment Alert (ORG.1513.SG.001.SD.03) from the EMR, stroke out the symbol on the paper chart, date and sign.
 - Communicates the deactivation of the Alert to any other 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