Vermont Psychiatric Care Hospital Policy and Procedure		
Violence Risk Assessment		
Effective: December 2018	Revised: July 2024	Due to Review: July 2026

POLICY

The Vermont Psychiatric Care Hospital (VPCH) recognizes that healthcare workers are at high risk for workplace violence, including physical assault and verbal aggression by hospitalized individuals. To identify and mitigate this risk, VPCH will utilize a frequent and dynamic process for the assessment and management of risk of harm to others that aims to balance individual autonomy and the need to protect others from acts of violence.

PROCEDURE

The Broset Violence Checklist (BVC, see APPENDIX A) is an evidence-based tool used at VPCH to predict the likelihood of an acute episode(s) of other-directed violence among psychiatrically hospitalized individuals within the 24-hour period following assessment. The BVC aims to improve risk identification and prediction, to standardize how clinical staff quantify and articulate risk, to prompt early risk-mitigation interventions, and to ultimately prevent and reduce the frequency and severity of other-directed violence.

Upon admission, the admitting provider shall conduct a violence risk assessment and document the assessment and level of risk on the *Physician Admission Assessment*. The risk of violence shall also be assessed on an ongoing basis by the treating provider and documented in the *Comprehensive Physician Progress Notes*.

Registered Nurses (RNs) shall assess the individuals they are assigned to work with for violence risk using the BVC upon admission, and at a minimum of once per shift thereafter. BVC assessment scores shall be communicated to direct care staff and other members of the individual's multidisciplinary treatment team. Information obtained from the BVC may inform the plan of care and implementation of interventions to eliminate and reduce the occurrence of violence.

Violence risk assessment shall again be completed by the treating provider prior to discharge.

References:

- https://www.frenzs.org/bvc-broset-violence-checklist/

Approved by	Signature	Date
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	7/9/2024

Appendix A: Broset Violence Checklist

•bvc

Client Data Label

Score the patient based on the highest score they would achieve based on your assessment of his/her behavior throughout your shift. Absence of a behavior gives a score of 0. Presence of a behavior gives a score of 1. Maximum score (SUM) is 6. If behavior is normal for a well-known client, only an increase in behavior should score a 1. For example, if a well-known client is confused at baseline his/her score for this item would be 0. If an increase in confusion is observed than you would score a 1.

Tuesday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Saturday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Wednesday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Sunday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Thursday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Monday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

Friday / /	DAY	NIGHT
Confused		
Irritable		
Boisterous		
Verbal Threats		
Physical Threats		
Attacking Objects		
SUM		
RN Initials		

VPCH Form #AS-08-05
File In: Assessments
Last updated: 9/29/19

Days=0630-1900 Nights=1830-0700

bvc

Client Data Label

Behavior Definitions:

Confused	Appears obviously confused and disoriented. May be unaware of time, place, or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behavior is overtly loud, energetic, and unruly. For example, slams doors, shouts out, etc.
Physically Threatening	Where there is a definite intent to physically threaten another person. For example, the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbally Threatening	A verbal outburst which is more that just a raised voice; and where there is a definite intent to intimidate or directly threaten another person. For example, verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking objects	An attack directed at an object and not an individual. For example, the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting and object; or the smashing of furniture.

Score Interpretations:

Score	Violence Risk and possible risk mitigation interventions
0	Risk is nominal.
1-2	Risk is minimal. o Proactive, preventative, trauma-informed crisis planning (include plan on Coping Partnership board and/or individual treatment plan as indicated). o Identify triggers and appropriate coping strategies, provide alternatives and choices. o Educate about communication and the appropriate way to outlet and express anger. o Encourage use of stress reduction and relaxation techniques. o Praise efforts made to manage anger and/or hostility towards others and provide feedback and positive reinforcement when appropriate and effective communication is used. o Use assertive communication to provide structure, clearly define expectations, and prevent further escalation. o Provide reality-based reorientation. o Reduce milieu stimulation/noise or offer quiet alternative. o Offer PRN medication and medication education.
3-4	Risk is moderate. o Listen. o Work to engage client in redirection and proactive crisis prevention. o Identify trigger/need/conflict and work to meet or resolve. o Maintain a consistent environment, schedules, and routines. o Offer cathartic activities to help appropriately manage anger and agitation - engage in some form of physical activity or sensory modulation to diffuse anxiety, anger, and hostility. o Offer alternatives, complementary strategies, and choices. o Promote appropriate socialization and leisure time activities. o Assertive communication and limit setting. (present a calm appearance, speak softly, speak in a non-provocative and nonjudgmental manner, speak in a neutral and concrete way put space between yourself and patient, show respect to the patient, avoid intense direct eye contact, etc.) o Offer voluntary time out on or off unit. o Consider area restrictions. o Consider adjusting level of supervision to meet need for safety and individual's sense of safety.
5-6	Risk is high: o Utilize a team approach. o Engage in crisis communication and rapid de-escalation. o Remove other patients from the immediate area. o Provide clear and concise ways to cease the behavior using a calm voice and demeanor. o Provide positive reinforcements when efforts are made to follow direction and independently manage behavior. o Offer clear, concise, and simple choices. o Set and adhere to behavioral limits – safety is the priority. o Offer medications. o Seclusion or restraint as a last resort when all other measures have failed, and the client remains an imminent risk of serious harm to self and/or others o (Debrief with client to review triggers, review alternative interventions, and modify care plan.)

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