

**PROTOCOL FOR: Violence, Risk: Directed at Others: Care of the Patient**

**POLICY:** All patients admitted to inpatient psychiatric units will be evaluated on admission and at least every 8 hours (while patient is awake) for risk to others.

**DESIRED PATIENT**

- OUTCOMES:**
1. The safety of the patient and others will be maintained.
  2. The patient will verbalize feelings rather than acting upon impulses.
  3. The patient will identify stressors and/or triggers, which lead to violence, which is directed at others.
  4. The patient will begin to utilize more effective coping mechanisms.

**CLINICAL  
ASSESSMENT AND**

- CARE:**
1. The following criteria will be considered when assessing a patient for the potential to direct violence toward others:
    - a. violent ideation
    - b. plan; means of carrying out plan
    - c. intent
    - d. prior history of violence
    - e. specific persons who patient has identified as targets of violence
    - f. level of impulsivity
    - g. signs of heightened anxiety, fear, anger, aggression (i.e., pacing, clenched fists, verbal escalation)
  2. Assessment of a history of violent behavior will be completed upon admission.
  3. Based on the outcome of the risk assessment, an appropriate status level will be assigned by the admitting RN. The RN will review the status level with the admitting MD.
  4. For those patients with a history of violence or exhibiting associated behaviors, an assessment of violence potential will be conducted as frequently as indicated.
  5. Assess the need for immediate intervention (i.e., private room, constant observation or one to one observation) prior to initiating further interventions.
  6. Assess patient's ability to maintain behavioral control with support from staff. Assess patient's ability to notify staff of any escalation of violent ideation.
  7. Initiate 15-minute checks unless a higher-level status is clinically indicated.

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8. Encourage patient to verbalize feelings/stressors, which may lead to violent behavior.
9. Acknowledge changes in behavior (i.e., pacing, anxiety) and offer options to maintain behavioral control.
10. Provide patient with appropriate options/choices. Allow patient as much control as is safely indicated.
11. If patient continues to escalate or verbalizes difficulty maintaining control, institute appropriate safety measures. Begin with less restrictive measures:
  - a. sharps restrictions
  - b. confiscating potentially harmful items from patient's possession
  - c. use of own room to decrease stimulation and provide opportunity to de-escalate
  - d. time out in room 1035, 1036
  - e. use of private room
  - f. one-to-one or constant observation
  - g. locked door seclusion
  - h. restraints
12. As patient demonstrates improvement in symptoms, less restrictive measures will be utilized.

**PATIENT  
TEACHING:**

1. Educate patient to approach and utilize staff support when experiencing violent ideation/impulses.
2. Educate patient to the rationale for use of more supportive measures as appropriate to maintain safety.
3. Educate patient to expected behaviors within the milieu and to progress to less restrictive interventions.
4. Educate patient regarding the use of more effective coping mechanisms:
  - a. verbalizing feelings
  - b. journaling
  - c. distraction
  - d. relaxation

- DOCUMENTATION:**
1. Complete assessment of history of and/or potential for violent behavior on interdisciplinary database.

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2. Document as indicated in the progress notes an assessment of violence potential/behaviors and appropriate interventions utilized.
3. Document any safety interventions initiated and patient's response to interventions.
4. Document behaviors on 15-Minute Checklist.
5. Document on 1:1/CO/Restraint Flow sheet if initiated and in the Progress Notes.
6. Document patient/family education on Patient and Family Teaching Record and/or in Progress Note.

**APPROVAL:** Nursing Standards Committee

**EFFECTIVE DATE:** 11/97

**REVISION DATES:** 6/99, 10/00, 10/03, 6/06, 8/08