# NURSING SERVICE GUIDELINES
# INPATIENT BEHAVIORAL HEALTH

**Guideline**: **Violence risk assessment**

**Policy Number Superseded**:

**Responsibility:** All trained inpatient behavioral health staff

**Purpose of Guideline**:
Inpatient behavioral health strives to maintain a safe and therapeutic environment for patients, visitors and staff. In order to achieve this, a review of patient's history to look for medical conditions or other problems that may trigger aggressive behavior is completed.

**Effective Date:**
November 2025

**Initial Effective Date**:
January 2020

**Procedure:**

(A) Complete violence risk assessment in electronic health record. Risk level determined as a result of completed risk assessment.

(B) Anticipating aggressive behavior, and planning for it, may prevent injury and/or violent aggression. Identification of patients at high risk for aggressive behavior is crucial in the management of aggression in individuals admitted to inpatient facilities.

(1) Low risk: Patient is at low risk for violence. Has not had established pattern of violence in the past. However, still pay attention to changes in the patient that would show signs of potential violence. Look for pacing, restlessness, increasing anxiety and tension or change in voice tone.

(2) Medium risk: Patient has a history of violence. Violence may not be recent and may be directed at property vs. person.

(3) High risk: Patient at high risk for violence with recent attempts, may be reason for admission. Patient aggressive towards self, others, or property and may have had involvement with the court.

(C) Interventions for low risk may include:

(1) Completion of individual crisis plan/treatment plan.
(2) Continued evaluation.
(3) Be aware of factors that signify a buildup of agitation.
(4) Be aware of triggers that may increase the likelihood of aggressive behaviors.
(5) Provide an outlet for patient's feelings.

(D) Interventions for medium risk may include:

(1) Completion of individual crisis plan/treatment plan.
(2) Continued evaluation.
(3) Be aware of factors that signify a buildup of agitation.
(4) Exploration of triggers at home.
(5) Activities that allow the patient to feel useful and/or allow patient to self-calm.
(6) Provide an outlet for patient's feelings.
(7) Possible medication changes and addition of PRN medications.

(E) Interventions for high risk may include:

(1) Completion of individual crisis plan/treatment plan.
(2) Continued evaluation.
(3) Be aware of factors that signify a buildup of agitation.
(4) Exploration of triggers at home.
(5) Activities that allow the patient to feel useful and/or allow patient to self-calm.
(6) Provide an outlet for patient's feelings.
(7) Possible medication changes and addition of PRN medications.
(8) Increase in observation levels to be considered; 1:1 sitter or Line of Sight.
(9) Staff and patient to complete Anger-style worksheets to assess for triggers and ways to help.
(10) Two staff interactions and direct patient care.
(11) Maintain de-escalation training principles.
(12) Removal of items and persons from area.
(13) 383-2600 to reach security and panic button education and reminder to staff.

(F) Documentation may include:

(1) Any precipitating events.
(2) Progression of changes of patient's behavior.
(3) Staff interventions and patient's response to each.
(4) Attempts to process after incident, including patient's behavior.
(5) Any persons that were communicated with for aggressive situations (e.g., family, guardian, manager, security, physicians).
(6) Any property damages.
(7) Harm to self or others.
(8) Medication rationale.
(9) Updated treatment plan with interventions used.

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