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Veterans Health Administration
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VHA DIRECTIVE 2010-053

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PATIENT RECORD FLAGS

1. PURPOSE: This Veterans Health Administration (VHA) Directive outlines policy and guidance for the proper use of Patient Record Flags (PRF) to enhance safety for patients, employees, and visitors.

2. BACKGROUND

a. VHA is committed to a safety program that is systems based and focused on prevention, not on punishment or retribution. Preventative methods that target root causes are favored.

b. A PRF alert, VHA employees to patients whose behavior, medical status, or characteristics may pose an immediate threat either to that patient's safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter. PRF enhance both the right of all patients to receive confidential, safe, and appropriate health care, as well as the right of employees to a safe work environment. PRF permit employees to develop strategies for offering health care to even the most behaviorally challenging patients who, in an earlier era, might have been excluded from receiving VHA health care.

c. PRF was originally developed for the specific purpose of improving safety in providing health care to patients who are identified as posing an unusual risk for violence. The use of PRF has expanded to address a limited number of additional safety vulnerabilities that present in the initial moments of a patient encounter. These PRFs are to be used very judiciously and approved either by appropriate local or VHA authorities.

d. The effectiveness of PRF is paradoxically based upon the degree to which their appearance on the computer screen is so unusual that it captures the attention of the user. Inappropriate use of any PRF reduces the effectiveness of all PRFs. Frequent training of busy clinic clerks, emergency department triage nurses, pharmacy technicians, and other typical PRF users is necessary to ensure appropriate use, and to maintain alertness to any PRF.

e. For ethical reasons, it is inappropriate to use a PRF in the absence of a clear risk to safety. The use of PRF can be ethically problematic for two reasons. First, a PRF stigmatizes patients, labeling them as difficult, whether for clinical or behavioral reasons. Second, a PRF compromises privacy because it reveals private patient information to anyone who opens the patient's chart, regardless of whether that person has the need to know that would normally justify revealing such information. Accordingly, a PRF must only be used for a compelling safety reason which outweighs these ethical concerns.

f. The use of PRF is limited to addressing immediate clinical safety issues. However, PRF are not an appropriate tool with which to alert employees to every potential safety issue. For example, a patient's human immunodeficiency virus status is not an immediate threat to the

safety of the patient or staff and thus is not appropriate as a PRF and additionally, would be in violation of the patient's privacy as all users of the Computerized Patient Record System (CPRS) would see the PRF. With the practice of universal precautions, such flags may be redundant.

g. The use of PRF for administrative or law enforcement purposes is strictly prohibited. Signaling a Veteran's theatre or era of service, unresolved felony warrants, or fee-basis eligibility would be examples of prohibited uses of PRF. Only safety issues of an immediate clinical nature (e.g., recurring violence, high risk for suicide, missing patient) are permitted.

h. A PRF is not the only tool available that may function as an alert for selected problems. Within CPRS some alert alternatives are: the patient problem list; Crisis Warning Allergies and Directives (CWAD) notes; and Veterans Heath Information Systems and Technology Architecture (VistA). However, only Category I PRF is to be used to signal high risk for seriously disruptive, threatening, or violent behavior.

i. Blanket program or facility-level access restrictions, based upon the mere presence of a Category I PRF, are prohibited by this Directive. Category I PRF is intended to make it possible for VHA to offer clinical services even to patients who present significant clinical (risk of danger to others) safety challenges. The presence of a Category I PRF on a patient's health record shall not, by itself, be grounds for refusing admission or services to a patient seeking care in a VHA facility or program. Nor should any PRF be automatic grounds for discharging a patient from a program to which the patient is entitled, and for which the patient is clinically appropriate. Each patient with a PRF is to be evaluated individually for appropriateness for any VHA service. The presence of any PRF should only be one factor in that calculation. Program managers or admission screeners may wish to seek consultation in assessing the suitability of a patient with a Category I PRF for entry into a program or use of a Department of Veterans Affairs (VA) service from the Disruptive Behavior Committee (DBC) or, depending upon the specific type of flag, the relevant body with responsibility for that flag.

j. **Category I PRF—Violent or Disruptive Behavior.** Category I PRF is nationally approved and is distributed by VHA as nationally released software for implementation in all VHA facilities. The Category I flag is shared across all known treating facilities for a given patient. Use of Category I PRF is not optional. Individual Category I PRF is assigned locally in accordance with standards developed nationally for the Category I PRF type in question. Category I PRF become national information as part of the Master Patient Index and is displayed at all VHA facilities where the patient is registered. As a result, patients with a Category I PRF who present an immediate safety risk for seriously disruptive, threatening, or violent behavior, may be safely treated within VHA wherever they are registered and seek care. A Text Integrated Utility (TIU) Progress Note in the CPRS describing the rational for the PRF assignment must accompany all Category I PRF.

k. **Category II Local PRF—Patient at Risk**

(1) Category II PRF may be locally established by individual Veterans Integrated Service Networks (VISN) or facilities. Category II PRF is used in various VHA facilities for a range of purposes. Appropriate uses include:

(a) Flagging patients who are enrolled in research trials involving potentially risky investigatory pharmaceuticals;

(b) Flagging patients with a documented history of narcotics diversion or theft;

(c) Flagging patients at high risk for suicidal behavior;

(d) Flagging patients with spinal cord injuries;

(e) Flagging homeless Veterans who have urgent medical test results pending; and

(f) Flagging missing and wandering patients.

(2) The use of Category II PRF, like Category I PRF, must be strictly limited to information that is immediately needed for the delivery of safe and appropriate health care. A TIU Progress Note in the CPRS describing the rationale for the PRF assignment must also accompany all Category II PRFs.

l. **Inappropriate Use of PRF.** PRF must never be used for law enforcement or administrative purposes. An inappropriate use of PRF for law enforcement might include flagging of fugitive felon status. An inappropriate use of PRF for administrative purposes might include name changes, Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) status, etc.

3. POLICY: It is VHA's policy that all VHA facilities must install all PRF related patches by the mandatory installation date and initiate facility-wide use of PRF.

4. ACTION

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for providing oversight to the VISNs to ensure that PRF is appropriately implemented by each VISN.

b. **VISN Director.** The VISN Director, or designee (e.g., the Network Mental Health Committee or other comparable VISN group), is responsible for oversight and implementation of this Directive at the VISN level.

c. **Medical Facility Director.** The medical facility Director, or designee, is responsible for:

(1) Ensuring that Category I PRF is originated and accessible. Individual Networks and facilities determine whether optional Category II PRF is to be used. ***NOTE:*** *Attachment B, Standards for PRF, defines the standards for the origination of, and access to, both Category I and Category II PRF.*

(2) Establishing a process for requesting, assigning, reviewing, and evaluating PRF.

(3) Establishing a plan to transition previous VistA, CPRS, local Class III Advisories, and any other behavioral alerts or warnings system in use, to VHA's nationally released PRF software. ***NOTE:*** *As of September 25, 2003, only PRF computerized advisories as described in Attachment B are approved for use in the identification of patients who are at significant risk for violence.*

(4) Ensuring that each Category I PRF assigned to a patient is reviewed at least every 2 years; however, reviews may be appropriate anytime a patient's violence risk factors change significantly, the patient requests a review, or for other appropriate reasons.

(5) Training appropriate staff in determining when a PRF is to be entered, how PRFs are entered, and how PRF and PRF-related documents are to be maintained and reviewed.

(6) Evaluating the facility process to ensure that PRF is assigned appropriately.

(7) Ensuring that each PRF in a patient's record is accompanied by a TIU Progress Note. The TIU titles utilized must be:

(a) PRF Category I, or

(b) PRF Category II.

d. **Clinical Executives: Chief of Staff (COS) and Nurse Executive.** The COS and Nurse Executive are responsible for:

(1) Instituting procedures to ensure that the utilization of PRF and the associated processes for recommending PRF are ethical, clinically appropriate, supported by adequate resources, and used in accordance with this Directive.

(2) Ensuring that patients are notified that a PRF has been placed in their health record and that they are informed of its contents.

(3) Establishing a DBC or a Disruptive Behavior Board (DBB).

(a) The DBC or DBB is responsible for:

1. Coordinating, when possible and appropriate, with the clinicians responsible for the patient's medical care, and recommending amendments to the treatment plan that may address factors that may reduce the patient's risk of violence.

2. Implementing the standards in Attachments A and B.

3. Collecting and analyzing incidents of patient disruptive, threatening, or violent behavior.

4. Assessing the risk of violence in individual patients.

5. Informing patients they have a right to request amendment to the contents of a PRF, and providing the information for contacting the facility privacy officer in the event the patient wants to pursue an amendment.

6. Identifying system problems.

7. Identifying training needs relating to the prevention and management of disruptive behavior.

8. Recommending to the COS other actions related to the problem of patient violence.

(b) The DBC or DBB must be comprised of:

1. A senior clinician chair that has knowledge of, and experience in, assessment of violence;

2. A representative of the Prevention Management of Disruptive Behavior Program in the facility (see subpar. 5i);

3. VA Police;

4. Health Information Management Service and/or Privacy Officer (ad hoc);

5. Patient Safety and/or Risk Management official;

6. Regional Counsel (ad hoc);

7. Patient Advocate;

8. Other members as needed, with special attention to representatives of facility areas that are at high risk for violence, (e.g., emergency department, nursing home, inpatient psychiatry, and community-based outpatient clinics).

9. Representative of the Union Safety Committee; and

10. Clerical and administrative support staff to accomplish the required tasks.

(c) The DBC or DBB, whose primary focus is upon reducing the risk of patient violence toward employees and others, will offer technical advice to other PRF software users as appropriate.

(4) Identifying a Suicide Prevention Coordinator who will be responsible for entering, maintaining, and deactivating Category II Suicide PRFs in accordance with VHA policy regarding the use of PRFs to identify patients at high risk for suicide.

(5) Identifying an employee or employees who will be responsible for entering, reviewing, maintaining, and deactivating Category II PRFs for missing or wandering patients in accordance with VHA policy regarding management of wandering and missing patient events.

e. **Facility Privacy Officer.** The facility privacy officer is responsible for:

(1) Receiving requests from patients regarding an amendment to a PRF that has been placed in the patient's health record.

(2) Amending the health record, as appropriate, according to VHA Handbook 1907.01.

5. REFERENCES

a. Appelbaum PS, Dimieri RJ. "Protecting Staff from Assaults by Patients: OSHA Steps In," Psychiatric Services. 46(4): 333-338, 1995.

b. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers; U.S. Department of Labor, Occupational Safety and Health Administration, OSHA 3148, 1996.

c. Environment of Care Guidebook, JCAHO, 1997.

d. VA Suicide and Assaultive Behavior Task Force. Report of a Survey on Assaultive Behavior in VA Health Care Facilities; Feb. 15, 1995.

e. Blow, FC; Barry, KL; et al. "Repeated Assaults by Patients in VA Hospital and Clinic Settings," Psychiatric Services. 50(3): 390-394: 1999.

f. OIG Evaluation of VHA's Policies and Procedures for Managing Violent and Potentially Violent Psychiatric Patients (Report No. 6HI-A28-038).

g. Drummond, D, et al., "Hospital Violence Reduction in High-risk Patients," Journal of the American Medical Association (JAMA). 261(17) 531-34, 1989.

h. United States Postal Commission. Report of the Commission on a Safe and Secure Workplace. National Center on Addiction and Substance Abuse at Columbia University, New York 2000.(Goldstein N et al) Columbia University, August 2000.

i. Hodgson MJ, Reed R, Craig T, Belton L, Lehman L, Warren N. Violence in healthcare facilities: lessons from VHA. J Occup Environ Med. 2004 ;46:1158-1165.

j. Secretary's Letter to All VA Employees October 19, 2001
http://vaww1.va.gov/VASAFETY/DashoLetters/AllVAEmployeesAndVolunteersLett.pdf
NOTE: *This is an internal VA Web site not available to the public.*

k. VA Office of Occupational Safety and Health Intranet Site: http://vaww.va.gov/vasafety .
NOTE: *This is an internal VA Web site not available to the public.* Includes links to the Prevention and Management of Disruptive Behavior, VA training program.

l. Public Law 105-220, Section 508.

m. Calhoun, FS, Weston, S.W. (2003). Contemporary threat Management: A Practical guide for Identifying, Assessing, and Managing Individuals of Violent Intent. Sand Diego, CA: Specialized Training Services.

n. Employee Education System, US Dept. of Veterans Affairs Training DVD: Preventing Violence in Healthcare: Identifying, assessing, and Managing Violence-Prone Patients, 2005.

o. Meloy, J.R. (2000). Violence risk & threat Assessment: A Practical Guide for Mental Health & Criminal Justice Professionals. San Diego, CA: Specialized Training Services.

p. Elbogen, EB; Beckham, JC;Butterfield, MI; Swartz, M; Swanson, J. "Assessing Risk of Violent Behavior Among Veterans with Severe Mental Illness." Journal of Traumatic Stress, Vol. 21. February 2008, pp. 113-117.

q. Association of Threat Assessment Professionals (ATAP) http://www.atapworldwide.org/ .

r. RAGE-V, Risk Assessment Guideline Elements for Violence (2006). May be downloaded at no cost from http://www.atapworldwide.org/associations/8976/files/documents/RAGE-V.pdf .

s. White, SG, Meloy, JR. (2007) WAVR-21, A Structured Professional Guide for the Workplace Assessment of Violence Risk. San Diego, CA: Specialized Training Services.

t. Mental Health Initiatives memo, Deputy Undersecretary for Health Operations and Management, June 1, 2007.

u. Department of Veterans Affairs Office of the Inspector General. Implementing VHA Mental Health Initiatives for Suicide Prevention; May 10, 2007.

v. Suicide Risk Assessment Guide Reference Manual, which can be found at:
http://vaww.mentalhealth.va.gov/files/suicideprevention/SuicideRiskGuide.doc ***NOTE:*** *This is an internal VA Web site not available to the public.*

6. RESPONSIBLE OFFICE: The Office of Patient Care Services, Office of Mental Health (116) is responsible for the contents of this VHA Directive. Questions may be referred to (202) 461-7364.

7. RESCISSIONS: VHA Directive 2003-048, dated August 28, 2003 is rescinded. This Directive expires on December 31, 2015.

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Attachments

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 12/8/2010

ATTACHMENT A

STANDARDS FOR CATEGORY I AND CATEGORY II PATIENT RECORD FLAGS

1. BACKGROUND: A diverse group of patients present with certain behavioral or clinical risk factors that place special demands upon the health care system. It is both a privilege and a challenge for the Department of Veterans Affairs (VA) health care employees and facilities to offer safe and appropriate care to all patients. The safety of patients and the safety of staff who treat them, can be enhanced when carefully designed Patient Record Flags (PRF) immediately alert care providers to the presence of risk factors *that must be made known in the initial moments of a patient encounter*.

a. Because some of the most challenging patients may be nomadic, and because a patient's electronic health record is increasingly available to other facilities, it is essential that conventions for creating, supporting, and maintaining computerized advisories be made uniform throughout VA's health care system.

b. PRFs should never be used to punish or to discriminate against patients, nor should they be constructed merely for staff convenience. The effectiveness of PRFs depends upon limiting their use to those unusual risks that threaten the safe delivery of health care. Threats to the effective use of PRFs are their misuse and overuse.

c. Providing an environment that is safe for patients, visitors, and employees is a critical factor in health care. The safety of patients and staff, as well as the effectiveness of care and patients' right to privacy and dignity, need not be compromised by threats of violence or other clinical safety risk factors. Risks associated with a history of violence or other risk factors can be limited when those risks are recognized and reported. Risks need to be addressed by an interdisciplinary group under senior clinical leadership and documented, when appropriate, in the patient's treatment plan. They must also be communicated in a standardized manner to those most at risk in an encounter with a "flagged" patient.

2. PROCEDURES: Each facility must demonstrate its readiness to use PRF in a manner which is consistent with the standards and protocols outlined in this Directive.

a. As part of the patient health record, all PRFs are entered under the authority of the Chief of Staff (COS) or designee at each facility. ***NOTE:*** *PRF must be accorded the same confidentiality and security as any other part of the health record.*

b. The COS, or designee, at each facility is responsible for identifying those employees authorized to initiate, enter, and access PRF. The COS, or designee, must ensure that only those employees with a demonstrated need to know are permitted access to PRF menu options.

c. Access to viewing PRFs is recommended for employees who are likely to be the first to encounter a "flagged" patient, prior to or at the time of the patient's visit. Access includes viewing the type of PRF and the narrative associated with it. Those who access a PRF are

responsible for communicating the PRF advisory to doctors, nurses, and others who have a need to know. The following are examples of medical center staff who have direct patient contact needing to view, or be made aware of PRF:

(1) Emergency room clerks and receptionists;

(2) Administrative Officer of the Day;

(3) Pharmacists and pharmacy technicians;

(4) VA police officers;

(5) Enrollment clerks;

(6) Social Work staff;

(7) Triage and telephone care staff;

(8) Ward and clinic clerks;

(9) Insurance and billing staff;

(10) Receptionists;

(11) Travel clerks;

(12) Laboratory clerks and technicians;

(13) All medical staff;

(14) Patient advocates;

(15) All Nursing staff;

(16) Decedent Affairs Clerk;

(17) Scheduling staff;

(18) Fee clerks; and

(19) Release of Information Clerks.

d. PRF software is in place. Although facilities may respond appropriately to PRF transmitted from other facilities, only facilities that employ the criteria in this Directive may enter new Category I PRFs.

e. A Text Integration Utility (TIU) Progress Note must be entered at the same time as the entry of any PRF. This note must provide general guidance to PRF users, and should include a brief summary of the rationale for the existence of the specific PRF. The progress note, however, is not the same narrative as the PRF itself.

f. A process exists for the review of each flag for risk of violent behavior at least every 2 years. A review may be appropriate when: the risk factors change significantly; a patient with a PRF requests a review; or for other appropriate reasons as determined by the facility that established the flag. A reminder for an upcoming review must be generated 60 days prior to the 2-year anniversary date of each PRF.

g. PRFs serve only to preserve and enhance the safety and appropriateness of patient care.

h. PRFs alert staff to a potential risk only; they are advisories. At each patient encounter, the examining physician or other clinician remains responsible for making appropriate clinical decisions.

i. Each facility must have clearly written definitions and entry criteria (that are consistent with this VHA Directive) for all Category I and Category II PRFs.

j. PRF should be entered, only by employees who have been trained in the technical aspects of entry, with the appropriate criteria, and in the conventions for security, format, and terminology.

k. PRF must be free of redundant language, slanderous or inflammatory labels, and must provide sufficient information or guidance for action. PRF narratives must be written in language sufficiently specific as to inform readers of the nature of the risk and recommended actions to reduce that risk. The PRF narrative should also avoid alluding to site-specific persons, acronyms, abbreviations, processes, buildings, or other descriptors unique to the originating site that would have no meaning for other sites where the Veteran may appear.

l. In order for PRFs to be effective, they must be used only when necessary. PRFs should be deactivated when their usefulness has passed. Overuse dilutes the importance of a PRF. Each facility must exercise great care in establishing optional Category II PRFs. Only when there is a compelling immediate clinical safety issue should additional PRF types be utilized. PRF is not to be used for staff convenience, or to address administrative or law enforcement concerns. Category II PRF types must adhere to the standards as spelled out in this attachment.

m. Patients may request an amendment to the presence or content of a PRF advisory through the facility privacy officer.

n. The Deputy Under Secretary for Health for Operations and Management (10N) provides oversight to the Veterans Integrated Service Networks (VISN) to ensure that PRFs are appropriately implemented by the facilities.

o. All VHA staff must respond appropriately to the appearance of PRF.

p. All VISNs must establish processes for the origination and appropriate use of Category I PRFs.

(1) All facilities are required to implement and respond to Category I PRFs, regardless of which facility originated the flag.

(2) All facilities must participate in utilization of PRF, regardless of the originating facility for any individual advisory or type of PRF advisory. Only the nationally developed PRF is to be utilized.

q. The responsibility for ensuring the quality, timeliness, routine review, and documentation in support of a PRF advisory belongs to the originating facility.

(1) The advisory itself will reference the authorizing facility and the COS or designee who can provide additional information about a specific PRF advisory. A facility that, in the course of providing care to a patient who was "flagged" by another facility, discovers new information that could influence the status of that advisory should not amend the original advisory, but instead should contact the originating facility with the new information.

(2) The responsibility for ownership and maintenance of PRF needs to be transferred when it appears that a flagged patient has relocated to a new facility. The originating facility should make available to the new facility, copies of all documents and records in support of the advisory.

r. PRF Training.

(1) Training must provide instruction on how to utilize PRF software on the assignment, continuation, inactivation, and review of flags.

(2) Training content must address:

(a) Various types of PRF;

(b) Appropriate responses;

(c) PRF confidentiality; and

(d) Compliance with Public Law 105-220 Section 508 (see subpars. 5h and 5i).

ATTACHMENT B

CATEGORY I PATIENT RECORD FLAGS (PRF): SPECIAL REQUIREMENTS

a. Category I **Violent and Disruptive Behavior** are currently the only implemented ***types*** of Category I PRFs that are designed to appear in all Department of Veterans Affairs (VA) facilities where a Veteran is registered to receive care. All Category I PRFs require a Text Integrated Utility (TIU) Progress Note in the Computerized Patient Record System (CPRS).

b. Category I **Violent and Disruptive Behavior** PRF describe patient risk factors that may pose an immediate threat to the safety of other patients, visitors, or employees. Category I **Violent and Disruptive Behavior** PRF also recommend specific behavioral limit settings or treatment-planning actions designed to reduce violence risk.

c. Health care workers experience one of the highest rates of nonfatal injuries from workplace assault of any occupation in the United States (U.S.). Health care is one of only two industries that have merited special attention from the U.S. Occupational Safety and Health Administration (OSHA) (see subpars. 5a and 5b). When compared to employees of other health care systems, Veterans Heath Administration (VHA) employees are two and a half times more likely to suffer injuries in violent incidents involving patients (United States Postal Commission, 2000; Hodgson et al, 2004). In recognition, VHA has initiated a broad-based program of violence prevention, including performance monitors through the Office of the Deputy Under Secretary for Operations and Management. Efforts have included the redesign of the basic course for all employees, "Prevention and Management of Disruptive Behaviors," and the development of new courses for geriatrics and other disciplines.

d. The Joint Commission recently made patient violence and its prevention, a focus of the Environment of Care Standards (see subpar. 5c).

e. VA's Office of Inspector General (OIG) in its report "Evaluation of VHA's Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients" (6HI-A28-038, dated March 28, 1996) recommended that facilities communicate among themselves so that staff are aware of high risk patients regardless of where in VHA's system they may seek health care (see subpar. 5f).

f. For PRF to assist in the prevention of adverse events when high risk patients travel between facilities, all facilities must follow uniform processes as described in current VHA policy on inter-facility transfer. This would include noting any existing Patient Record Flag. The effectiveness of PRFs depends upon limiting their use to those unusual clinical risks that immediately threaten health care safety, and quality in the initial moments of a patient encounter.

g. The safety of patients and employees, the effectiveness of care, and the patient's right to privacy need not be compromised by threats of violence. Risk of violence can be mitigated by reporting, assessing, documenting, communicating, and developing treatment plans that specifically make violence reduction a treatment objective.

h. The decision to enter a Category I **Violent and Disruptive Behavior** PRF must be made by the Disruptive Behavior Committee (DBC) or the Disruptive Behavior Board only after completion of an evidence-based, multidisciplinary, and multi-dimensional threat assessment, which considers static and dynamic violence risk factors present in the patient, violence risk mitigators, and violence risk factors associated with the setting where the incident occurred (see subpar. 5o). Attachment C describes a threat assessment protocol that meets these requirements. There may be other protocols or instruments that are suitable, but the burden is on any DBC to use a threat assessment protocol that is evidence-based.

i. Competent prediction of violence is always multi-dimensional, and a thorough assessment of violence risk should consider factors relating not only to the patient but also to the training and behavior of the Department of Veterans Affairs (VA) employees, and to aspects of the situation in which the patient is treated.

j. The facility must develop a systematic approach for collecting reports involving incidents of disruptive, threatening, or violent behavior.

k. Interdisciplinary review and threat assessment of patient behavior is documented, and the documentation of this review and of all associated incident reports are kept in a secure location. In many cases, a summary of the threat assessment should be shared with the patient's care providers in an effort to address the problem of violence risk in the patient's treatment plan.

l. Appropriate training of staff, who in the course of their duties, must assess and document violence risk, as well as implement or recommend behavioral limits and treatment plans, will be documented. All DBC members should avail themselves of ongoing training opportunities available through the Employee Education System and VA's Office of Occupational Safety and Health (see http://vaww1.va.gov/VASAFETY/OSH_Education.asp). ***NOTE:*** *This is an internal VA Web site not available to the public.*

ATTACHMENT C

THREAT ASSESSMENT

The purpose of Disruptive Behavior Committees (DBC) or Disruptive Behavior Boards (DBB) is to evaluate the risk of violence in a given setting or situation, with a given patient and to recommend measures that may be taken to mitigate that violence risk. This is often called "threat assessment." In their 2007 guide entitled, WAVR-21, A Structure Professional guide for the Workplace Assessment of Violence Risk, White and Meloy describe the purpose of groups like DBCs:

"They will gather information concerning the context and critical aspects of the behavior in question, and about the employee or third party whose behavior has generated concern. The risk assessment professional will then synthesize and evaluate the data and apply careful professional judgment to answer the ultimate questions: Does the person whose conduct has generated concern pose a threat? And if so, what is the general level of threat? What steps can be taken to mitigate any risk, and what actions might exacerbate it?"

Examples of common sentinel events that should lead to a violence risk assessment by the DBC or DBB include, but are not limited to: a report of physical violence against patients or staff at a medical center or clinic; documented acts of repeated violence against others; credible reports verbal threats of harm against specific individuals, patients, staff, or the Department of Veterans Affairs' (VA) property; reports of possession of weapons or objects used as weapons in a health care facility; a documented history of repeated nuisance, disruptive or larcenous behavior that disrupts the environment of care; or a documented history of repeated sexual harassment toward patients or staff.

However, the mere occurrence of a sentinel event should not be cause to initiate a Category I **Violent and Disruptive Behavior** PRF. DBCs or DBBs are not "Flagging Committees." Patients are not "flagged" because they have demonstrated disruptive behavior or because their Primary Care Provider or other provider, having been verbally abused or threatened, is upset and demands that the patient be flagged. DBCs apply a Category I **Violent and Disruptive Behavior** PRF to a patient's record only when the DBC concludes in a review of violence risks and mitigators that to do so will likely reduce violence risk.

All members of DBCs or DBBs should take advantage of training offered by VA Employee Education System (EES), and when possible, by outside vendors. The references in this Directive provide suggested resources for training and information on violence prediction and threat management.

The following is one evidence-based threat assessment protocol suggested for use by DBCs or DBBs (adapted from Meloy, 2000 see subpar. 5o):

Patient Risk Factors: (list of factors is not exhaustive and factors not equally weighted)

Static Risk Factors: (Include additional detail for each item checked)

_____ Male Gender (10X risk for females).

_____ Veteran's history of violence in and outside of health care facilities.
Consider frequency and recency of violence, and severity of injury to victims, if any.
Additional Comments:

_____ Veteran's self-report of arrests and convictions for violent crimes.
(Criminal background investigation data may be available in selected cases, if VA Police conclude that there is probable cause for obtaining and sharing this information on a need-to-know basis.)
Additional Comments:

_____ Documented credible threats toward VA employees or patients.
Additional Comments:

_____ Prior supervision/treatment plan failures, (e.g., probation, mandated Drug and Alcohol treatment.
Additional Comments:

_____ Presence of serious psychiatric disorder, especially psychopathy or paranoia.
Additional Comments:

_____ Head injury with Loss of Consciousness by history.
Additional Comments:

Dynamic Risk Factors: (Include additional detail for each item checked)

_____ Recent incidents of disruptions, threats, or violence in or out of health care settings.
Additional Comments:

_____ Recent (past 6 mos) abuse of Central Nervous System (CNS) stimulants, including Cocaine and Methamphetamines.
Additional Comments:

_____ Recent abuse of ETOH or other CNS disinhibitors.
Additional Comments:

_____ Presence of situational stressors and destabilizing events, such as recent incarceration, death of loved ones, financial problems, estrangement from his or her family, homelessness, onset of acute medical problems, and other destabilizing events.
Additional Comments:

_____ Chronic pain or narcotics seeking behavior.
Additional Comments:

_____ Documented impulsivity (e.g., financial, sexual, or other decision making).
Additional Comments:

_____ Veteran's claims of weapons in his possession, especially new acquisition or relocation of firearms.
Additional Comments:

Risk Mitigation Factors: (Include additional detail for each item checked)

_____ Numerous visits to Medical Center without incidents.
Additional Comments:

_____ Positive recommendation of Veteran's health care providers.
Additional Comments:

_____ Documentation of successful participation in substance abuse recovery program with a significant (60 days or more) period of sobriety.
Additional Comments:

_____ Documented resolution of destabilizing events or factors.
Additional Comments:

_____ Patient's acknowledgement of his previous disruptive behavior with plans for preventing recurrence.
Additional Comments:

_____ Changes in patient's health status or mobility that would mitigate any threat the patient previously posed.
Additional Comments:

SETTING RISK FACTORS

_____ Staffing issues (please describe):

_____ Training deficits (please describe):

_____ Supervisory issues (please describe):

ATTACHMENT D

NEW SERVICE REQUESTS
CATEGORY I PATIENT RECORD FLAG (PRF)

1. BACKGROUND

Patient Record Flags were initially mandated by the Veterans Health Administration (VHA) Under Secretary for Health at the urging of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) solely as a tool for reducing the risk of imminent violence associated with 'high risk' patients. On August 28, 2003, Directive 2003-048, National Patient Record Flags, was issued in conjunction with a release of revised Veterans Information System and Technology Architecture (VistA) Computerized Patient Record System (CPRS) software. By alerting VHA employees to a significant *immediate* risk of violence, this software enables health care providers and other VA employees who may encounter a high-risk patient to take measures to offer the patient safe and appropriate health care regardless of where, in the VHA system, the patient appears and regardless of where the PRF originated. While initially intended to address the problem of high-risk-for-violence patients only, the PRF software was recognized as offering potential additional uses. It is expected that New Service Requests (NSR) for additional types of Category I PRF may be proposed. This packet is intended to assist those who are considering the proposal of NSR for Category I PRF types.

2. PROCESS

a. Applicants should thoroughly familiarize themselves with the VHA Patient Record Flag policy prior to completing the attached application. The policy addresses the specific use of Category I PRF for preventing violence, but also includes many standards that will be used to measure the appropriateness of any future Category I PRF uses. These standards have been reviewed in depth and approved by the VA OIG, the VA Center on Ethics, and others that continue to monitor the use of Category I PRF. Applicants can also find more information about the intent and proper use of PRFs on the PRF Web site: http://vaww.vistau.med.va.gov/vistau/PRF/default.htm . ***NOTE:*** *This is an internal VA Web site not available to the public.*

b. Category I PRF are, by definition, disseminated throughout all VHA facilities where the patient is registered. Category II PRF, in contrast, are entered locally and appear only locally at the originating facility. The present packet relates to Category I (national) PRF only. However, Directive 2003-048 is clear that even 'local' (Category II) PRF should be used judiciously and, as with Category I PRF, *only* for alerting users to immediate threats to the clinical care and safety of patients or staff. The more PRFs of any type to which receptionists, clerks, and other VA employees must attend in the initial moments of an encounter with a patient, the less potent any PRF alert will be. More is not better when it comes to PRF.

c. The responsibility for PRFs is assigned to the Office of Mental Health (116) under Patient Care Services (11). The Deputy Chief Patient Care Services, Officer for Mental Health Services (116) has authorized the formation of a PRF Advisory Review Board to review NSRs for new

Category I PRFs. The PRF Advisory Review Board considers the NSR and other input required (textual or verbal presentation) and makes recommendation(s) back to the PRF Program Office (116A) to approve or disapprove with comments. The PRF Program Office (116A) then responds to the NSR with recommendation(s).

d. The PRF Program Office (116A) forwards the decision to the Chief Officer of Patient Care Services (11) for any other action that may be required.

e. Current membership of the PRF Advisory Group includes:

(1) The Deputy Under Secretary for Health for Operations and Management (10N).

(2) Patient Care Service, VA Central Office (11).

(3) Health Information Management (HIM) Program Office, VHA Office of Health Information (19).

(4) VA Office of Information and Technology (OI&T) (005), PRF Project Manager.

(5) Field Subject Matter Experts, at least two at any given time.

(6) Office of the General Counsel, VA Central Office (02).

(7) National Center for Ethics, VA Central Office (10E).

(8) VHA Occupation Health Program (136A).

f. At the discretion of the chair, Deputy Chief Patient Care Services Officer for Mental Health (116), other subject matter experts may be called upon to evaluate specific NSRs.

3. APPLICATION

a. An online NSR application is available at: http://vista.med.va.gov/nsrd/ and is accessed by pressing the New Request button.

b. When filling out the form it is important to identify the unique issues of a PRF:

(1) Describe the clinical safety issue to be addressed. Note that the use of PRFs is restricted to the communication of information of a clinical safety nature that must be available in the initial moments of a patient encounter. As PRFs are effective only to the extent that they are unusual stimuli in the user's visual field, Category I PRF are to be used only for immediate clinical safety purposes, and only when there are no viable alternatives. Describe all possible alternatives to a PRF that you explored to meet your safety goals and objectives.

(2) Other factors might include any additional factors that make this request a high clinical safety priority that must be available in the initial moments of a patient encounter. Provide all

relevant VHA references, (e.g., Congressional Mandate, Directive, Secretary's Performance Measure, studies). Note factors both inclusive and exclusive that would justify entry of a PRF of this proposed type into the health record of a given patient, and also the factors that would be used to determine that the PRF would be no longer necessary. Describe the frequency with which a PRF of this type would be reviewed and by whom. Note on what basis this frequency of review is proposed. Also note that the PRF must be accompanied by a CPRS progress note.