VISA
Assessment Tool
Aim and Objectives

Aim:
To ensure clinical staff can safely use the VISA Assessment Tool to assess the level of care required for patients presenting with mental ill health

Outcomes:
1. Why the VISA Assessment tool was initiated
2. Introduction to the documentation
3. How the document works
4. Managing an initiated VISA
5. Case examples
Why the VISA Assessment tool was initiated

- Caring for patients with mental health problems who are at risk of self harm can be a challenge
- Patients have come to harm as a result of their Mental Health
- Whatever the method, or procedure of applying a level of observation, the practice is necessarily intrusive. Dodds and Bowles (2001) suggested that changing the philosophy of observation, from control to care, can have dramatic effects
- The VISA form is a locally designed tool to enable us to make a measured and uniform decisions about the likelihood that a patient in our care is at continuing risk of self harm
# Introduction to the Document

**VISA Assessment Tool**

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Circle</th>
<th>VISA Assessment – notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital No:</td>
<td></td>
<td>V - Violent behaviour/Fear or Pre-planned</td>
</tr>
<tr>
<td>D.O.B:</td>
<td></td>
<td>I - Irrational, psychotic or hallucinating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S - Suicidal intent remains</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A - Alone (in department or at home)</td>
</tr>
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</table>

### Appearance (e.g. descriptors and clothing):

<table>
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<tr>
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<tbody>
<tr>
<td>A - Anxious/Distressed</td>
<td>Y/N</td>
</tr>
<tr>
<td>V - Inappropriate behaviour</td>
<td>Y/N</td>
</tr>
<tr>
<td>P - Attentive/Cooperative</td>
<td>Y/N</td>
</tr>
<tr>
<td>O - Presentation as per patient norm</td>
<td>Y/N</td>
</tr>
<tr>
<td>U - Plans to hurt self/others</td>
<td>Y/N</td>
</tr>
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</table>

*Is there anything we could do to make you feel safer?*

E.g. does the patient have medications or potential weapons with them that they’d like removed?

Comment: ___________________________________________________________

| Intoxicated? (Alcohol or drugs) | Y/N |
| Fit to undertake a mental state examination? | Y/N |
| MH Liaison team needed? | Y/N |
| Police present? | Y/N |

**Risk Level (circle):**

- Calm, Passive Thoughts, Active Plans, Immediate Concerns

**Plan**

- Engagement Frequency: 30mins or bespoke................... (Ensure patient knows checks will be made)

If the patient is moved to another area or their behaviours change from those documented above, a reassessment must be completed.

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**Derby Teaching Hospitals**

NHS Foundation Trust

**Taking pride in caring**
V = Violent Method (preplanned/organised attempt)
If a patient attends following a violent method of self-harm, then this signifies an increased risk. Violent methods include jumping from a building or bridge, attempted hanging, running in front of a car. If their self-harm attempt was organized and preplanned, then this also indicates increased risk.

I = Irrational Thinking (e.g. psychotic features)
If a patient has irrational thinking, then this is linked to increased risk. A patient may be delusional (fixed erroneous beliefs) e.g.. Patient believes they are Jesus or believes they have extra-sensory powers. This would also be true of those hearing voices or having hallucinations.
**VISA Assessment**

**S = Suicidal Intent Remains**
Not every patient who self-harms wants to commit suicide, and many are impulsive acts which are regretted. However, if a patient continues to want to commit suicide, especially with ongoing plans they are at increased risk. It is safe to ask a patient directly “Are you feeling that you want to hurt yourself?”, “Do you have any plans to hurt yourself?” This has been shown not to influence a person's actions.

**A = Alone (either now or at home)**
Clearly if a patient is on their own on the ward we need to be considering where the patient’s bed is located. Consider putting the patient in a more visible area. Is there anyone we can call to sit with them? What is their social support at home? Someone might live alone but have good social networks – they would be at less risk than someone who lives alone and has no friends or family locally.
On admission any patient who has a potential MH presentation, including suicide or overdose, should have a VISA assessment initiated.

This can be done by any registered practitioner; nurse, doctor, ACP etc

It allows us to plan for any risks or concerns, to themselves or others, the need for supervision to monitor changes and if the patient absconds a clear plan of action.
Case Study 1

- Emily is an 18 year old, regular attender to ED for paracetamol ODs. She has attended today after taking x9 paracetamol tablets.
- This is within her normal pattern of presentation and she has a full MH support and care package in place in the community.

How would you assess Emily?
Case Study 1 Continued

- Emily is an 18 year old, regular attender to ED for paracetamol ODs. She has attended today after taking x9 paracetamol tablets.
- This is within her normal pattern of presentation and she has a full MH support and care package in place in the community.

Emily has been assessed as low risk therefore ‘Calm’ – she is presenting within her normal pattern of attendance and no suicidal presentation.

What would your plan of care be?
**Plan**

**Engagement Frequency:** 30mins or bespoke.............. (Ensure patient knows checks will be made)
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Signature:  
Time and Date:  

VISA completed by Name:  
Signature:  
Time and Date:  

Taking pride in caring
Case Study 2

Paul is a 25 year old who has no known history of mental health illness. He has attended ED after a suicide attempt via hanging. He appear to have no alcohol or drugs on-board. He is breathalysed as zero. Paul has a friend with him, who is helping to calm Paul, he has no current plan to hurt himself or others.

How would you assess Paul?
Case Study 2 continued

- Paul is a 25 year old who has no known history of mental health illness. He has attended ED after a suicide attempt via hanging. He has no alcohol or drugs on-board. He is breathalysed as zero. Paul has a friend with him, who is helping to calm Paul, he has no current plan to hurt himself or others.

Paul has been assessed as ‘Passive Thoughts’, as he has scored as ‘Violent’ due to his method of attempted suicide. He has no previous MH or attempted suicide attendances. He does not score for ‘Immediate Concerns’ as is calm with his friend and has no ‘Active Plans’ to hurt himself.

What would your plan of care be?
**Introduction to the Document**

**Plan**

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Taking pride in caring
Laura is a 32 year old who has a documented diagnosis of schizophrenia. Laura’s partner is with her but this is causing her increased distress and she has turned violent and aggressive towards him. When you attempt to make an assessment of Laura, she is unwilling to co-operate, her partner attempts to calm her down but she lashes out and hits him.

How would you assess Laura?
Laura is a 32 year old who has a documented diagnosis of schizophrenia. Laura’s partner is with her but this is causing her increased distress and she has turned violent and aggressive towards him. When you attempt to make an assessment of Laura, she is unwilling to co-operate, her partner attempts to calm her down but she lashes out and hits him.

Laura has been assessed as ‘Immediate Concerns’, she is scoring as ‘Violent’ and ‘Irrational’ and she is also actively attempting to hurt her partner.

What would your plan of care be?
### Introduction to the Document

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<tr>
<td></td>
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Case Study 4

- Simon is a 42 year old who is a known patient with alcohol dependency. He is admitted with low mood, he has no-one with him and lives alone. He is expressing that he wants to kill himself and has a clear plan to end his life, he appears more withdrawn than when he was last seen.

How would you assess Simon?
Simon is a 42 year old who is a known patient with alcohol dependency. He is admitted with low mood, he has no-one with him and lives alone. He is expressing that he wants to kill himself and has a clear plan to end his life, he appears more withdrawn than when he was last seen.

Simon is assessed as ‘Active Plans’ as he has a current desire to end his life and is alone both in department and at home. Were his behaviours to deteriorate or he wish to leave he might then be raised to ‘Immediate Concerns’.

What would your plan of care be?
Has the patient got capacity?

- Is the patient willing to stay?
  - If yes, there are no immediate concerns
  - If no, has the patient got capacity to leave?

The MCA says a person is unable to make a decision to leave if they can't:

- understand the information relevant to leaving
- retain that information
- use or weigh up that information as part of the process of making the decision to leave

‘Can we talk about what would happen if you were to leave?’
‘What do you think might happen?’
Has the patient got capacity?

If the patient cannot give you the information to show they have capacity to leave, appropriately supporting with any communication support needed, you can treat in their best interests.

If you feel that a person has capacity to leave but you are concerned for their wellbeing this needs to be raised to the medical doctor in charge of your area.

This is due to a possible need for a mental health assessment as they may be able to demonstrate capacity but may not have the ability to leave due to their mental health impacting their decisions. That when well, they may not make.
Has the patient got capacity?

Please remember that capacity assessments, even around a single question ‘can the patient leave?’, can be difficult.

If in any doubt around capacity, ask a colleague to carry out a conversation as well or go through things with you.

If in any doubt, capacity is assumed. Please remember that capacity is both a time and a question specific measure.

A person’s capacity to leave may change as they sober or things change, so a re-evaluation may be needed. As both the state of the patient and time of the assessment has changed.

If in doubt, re-evaluate and/or ask for support!
Managing a patient on a VISA assessment

Engagement Frequency: In line with the plan

- Do you feel Calm?
- Do you feel Distressed?
- Do you feel Agitated?
- Do you feel Aggressive?
- Have they Absconded?
- In comments section: you can make your observation of the patient

Mental Health Presentation

Engagement Record

Date: __________________________

Patient name: ________________
Hospital No: ________________
D.O.B.: ________________

Engagement Frequency: 30mins or bespoke...........

“How are you feeling?”

<table>
<thead>
<tr>
<th>Mental State</th>
<th>Changes to previous behaviours?</th>
<th>Y / N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time:</th>
<th>Calm</th>
<th>Distressed</th>
<th>Agitated</th>
<th>Aggressive</th>
<th>Withdrawn</th>
<th>A</th>
<th>V</th>
<th>P</th>
<th>U</th>
</tr>
</thead>
</table>

Comments/actions

Deteriorations must be highlighted to the Nurse in Charge. Needed Y / N
Managing an initiated VISA

- HCAs & Assistant Practitioners can complete the observations (not the assessment) but **it is essential to escalate variances to NIC or bleep holders as soon as they are recognized.**
- Changes in the frequency of observations, based on those changed observations, can and should be put in place.
- Re-evaluation of the plan should take place as the physical environment changes, i.e. transfers to new wards/areas.
- Escalate staffing needs and include VISA in handovers.
Summarise

- You have been trained in VISA Assessment tool completion.
- The need for close interprofessional working.
- The need for this supportive document
- Also: Flo – quick links – ‘Liaison Team’ information
Any questions?