

Correspondence

A model for managing violence in acute adult admission wards

A retrospective survey of contemporaneous electronic case records in a male psychiatric intensive care unit (PICU) in central London was carried out for 2012. The notes were scrutinised for records of serious violence where there was threat to life or limb that resulted in patients being given rapid tranquillisation and seclusion. The survey revealed that of 72 admitted individuals, 58% were responsible for this degree of behaviour. Most incidents (67%) were perpetrated in multiples by slightly fewer than 25% of all those who were admitted. This suggests an average of 3 serious incidents per patient.

In a meta-analysis on in-patient aggression,¹ a literature review shows that the estimated percentage of aggression on acute admission wards is extremely variable, with figures quoted from 8 to 44%. A third of in-patients have experienced violent or threatening behaviour, with higher figures for staff – 41% of clinical staff and almost 80% of nursing staff working in in-patient units have experienced aggressive behaviour. It is important therefore to understand the strength of association between risk factors for in-patient aggression and the extent to which these disruptive and distressing events can be predicted and prevented.

In the present retrospective survey, it was clear from the data that the incidence of violence decreased consistently week on week; 45% of all behaviours ($n=80$) requiring emergency nursing intervention occurred in the first week of all admissions. This reduced to 15% by the second week and 7.5% by the third week, however, by week 8 there was a rise to 13%. This is an interesting observation which may indicate the point at which PICU becomes counter-productive. Department of Health guidelines for PICU admission recommend that admission should not ordinarily exceed 8 weeks.²

The observation that the first week represents the highest risk period of an admission fits in well with previous data. This high-risk period could be an opportunity to monitor imminent behaviours through routine enhanced nursing observations, allowing a proactive rather than reactive response style bearing the brunt of staff/patient interactions.^{3,4} The observations of week-on-week reduction in serious violence could be explored further with a case-control study. Although resource intensive, ultimately any procedure that is likely to reduce violence to staff and patients is worth pursuing.

- 1 Dack C, Ross J, Papadopolous C, Stewart D, Bowers L. A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. *Acta Psychiatr Scand* 2013; **127**: 255–68.
- 2 Department of Health. *Mental Health Policy Implementation Guide: National Minimal Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. Department of Health, 2002.
- 3 Papadopolous C, Ross J, Stewart D, Dack C, James K, Bowers L. The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatr Scand* 2012; **125**: 425–39.

- 4 Bowers L, Gournay K, Duffy D. Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies. *J Adv Nurs* 2000; **32**: 437–44.

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Neuroimaging in dementia: how best to use the guidelines?

Kuruville *et al*¹ completed an audit cycle on neuroimaging practice after national and European guidance was adapted to local resource availability. The audit showed an improvement in the number of patients who have had at least one form of neuroimaging performed from 68 to 76%, and although this was not statistically significant, it seems to suggest a general improvement in the service provided, as reflected also in the improved documentation of the reason for not requesting neuroimaging and in having no significant impact on waiting times. Improvement in the service may also be reflected in a patient and relative satisfaction survey that could be carried out.

In a similar study (details available from the author on request), I audited the practice of a memory clinic in Southport, Merseyside, against 2006 National Institute for Health and Care Excellence (NICE) guidance on dementia,² which stated that 'structural imaging should be used in the assessment of people with suspected dementia' and that magnetic resonance imaging (MRI) 'is the preferred modality [...] although computed tomography (CT) scanning could be used'. The audit included 75 patients and showed that 56 (75%) had at least one neuroimaging procedure performed: 53 (95%) of these had CT scans and only 1 patient had an MRI scan. My audit revealed a similar problem with documentation of reasons for not scanning patients, with 31% of patients who were not scanned lacking such documentation compared with 50% in Kuruville *et al*'s initial audit. In my study a re-audit was not carried out.

An additional aim of my study was to look at whether the diagnosis of dementia subtype, provisionally made based on clinical interview and using scales such as MMSE and ACE-R, was changed following neuroimaging. This revealed that the diagnosis was changed following a scan in 45% of cases, mostly from Alzheimer's or vascular dementia into a mixed-type dementia. It also showed that no provisional diagnosis was documented in 38% of case notes reviewed, suggesting that clinicians were perhaps uncomfortable about making a diagnosis before a scan was performed.

Bearing in mind that NICE guidelines are driven partly by cost-effectiveness, studies such as Kuruville *et al*'s provide good support for the usefulness of adapting these guidelines to the local availability of resources, which results in better care for patients with dementia.

- 1 Kuruville T, Zheng R, Soden B, Greef S, Lyburn I. Neuroimaging in a memory assessment service: a completed audit cycle. *Psychiatr Bull* 2014; **38**: 24–8.