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CLINICAL PRACTICE UPDATE — MENTAL HEALTH

An ABC approach to assessing the risk of violence at triage

Natisha Sands, RPN, RN, PhD*

Course Coordinator, Mental Health Nursing, The School of Nursing, The University of Melbourne, Australia

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Summary There is evidence to suggest that the incidence of violent behaviour in the emergency department by patients toward staff is on the rise. As part of the process of determining urgency, triage nurses must assess the risk of violence at point of entry. The risk of violence, that is, behaviour that either involves a threat of physical or psychological harm to one's self or to others, is considered a critical predictor of urgency in mental health triage. A rapid violence risk assessment strategy will be described which can be utilised in emergency department triage.

Introduction

There is a growing body of evidence that shows an increase in the incidence of violence, directed from patients toward staff, in Australian Emergency Departments (EDs).[1,2] As frontline providers of emergency health care, ED triage nurses are often faced with the complex task of determining whether a person presenting for treatment has the potential to become violent, and if so, what the likelihood of an actual incident of aggression might be.

The ED is the first point of contact for many people who are seeking health care, and this includes a sizeable number of people with mental health problems.[3,4] While there has been some recent evidence to suggest that mental illnesses are a risk factor for violence,[5—7] the relationship between mental illness and violence is complex. Pain, loss, grief, confusion, and fear are common experiences for people who access emergency care, and it is likely that those who experience such heightened emotional states are more susceptible to extremes of behaviour.[8,9]

The ED is a dynamic, highly technical environment characterised by an atmosphere of time pressure and unpredictability, which may impact on a person's ability to manage their emotions and behaviour.[8,9] Moreover, many patients presenting to the ED experience some level of psycho-social crisis. This state of crisis may, or may not, co-exist with other physical symptoms, illnesses, or injuries.[8,9] It is, therefore, not surprising that the ED can often become the scene of extremely challenging human behaviours. People with a mental illness are likely to be even more vulnerable to the pressures and challenges of the ED environment, given these conditions typically involve high levels of anxiety and impairments in thinking, behaviour, and communication.[10]

In addition, rising rates of ED presentations that involve substance abuse are also likely to be impacting on the increasing numbers of violent incidents in Australian EDs.[2]

* Correspondence address: 1/723 Swanston Street, Carlton, Victoria 3053, Australia. Tel.: +61 3 83440776; fax: +61 3 93474172.
E-mail address: nsands@unimelb.edu.au.

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Table 1 The 'Top Ten' known risk factors for violence

Risk factors for violence
1. History of aggression
2. Male
3. Youth
4. Anti-social traits
5. Substance misuse
6. Intoxication
7. Impulsivity
8. Irritability
9. Suspiciousness
10. Mental illness

Adapted from Mullen P. Dangerousness, risk and the prediction of probability. In: Gelder MG, Lopez-Ibor JJ, Andreason N, editors. *Oxford textbook of psychiatry*. London: Oxford University Press; 2000.[16]

Recently, Kennedy[2] reported that up to 50% of violent events that occurred in one large metropolitan ED in Victoria involved substance misuse. Kennedy[2] noted that these incidents are more likely to occur at weekends and in the evenings, when there are less staff available to manage events. In this context, it is important that emergency nurses are well prepared to assess, prevent, and manage episodes of patient violence.[2] While there is no foolproof method for assessing and predicting the likelihood of a violent incident, risk assessment practices can help identify potential for violence, and thus provide opportunities for safety measures to be put in place to minimise risk of harm.[2,11–14]

Known risk factors for violence

According to mental health experts, one of the strongest predictors for future episodes of violence is a past history of aggression.[15,16] This evidence underscores the need to highlight previous episodes of aggressive behaviour in the clinical record. Ideally, alerts should be electronic and quickly notify the triage nurse at point of entry.

Youth, male gender, and substance misuse further increase the potential for violence, and patients exhibiting irritability and suspiciousness in their manner must also be approached with caution.[16] Mental illness, in particular, patients experiencing 'command' auditory hallucinations in the context of an acute psychosis, is also a risk factor for violence.[15,16] Table 1 shows a list of the 'top ten' known risk factors for patient violence.

Triage violence risk assessment chart

The ABC of violence risk assessment at triage is not an exhaustive violence risk assessment tool, but rather, a three-step guide that aims to provide a practical framework for a systematic approach to violence risk assessment. Table 2 shows the three components of violence risk assessment, which includes; performing the primary survey, observing behaviour, and obtaining a self report of symptoms from the patient.

Step A of the violence risk assessment is to complete the usual primary survey. Here the triage nurse should pay special attention to the presence of physiological indicators for impending aggression; for example, flushing of the skin, dilated pupils, or excessive diaphoresis, and note any signs of intoxication.

Step B of violence risk assessment is to make discrete observations of the patient's behaviour and, in particular, identify any threatening or intimidating gestures. Here the triage nurse should also look for signs of agitation such as pacing or irritability.

Step C of violence risk assessment at triage involves an analysis of the patient's conversation. Here information about threats and/or thoughts of harm to self, or to others, and any admissions of previous episodes of aggression are particularly noteworthy. If the patient exhibits two or more indicators from the Triage violence risk assessment chart,

Table 2 Triage violence risk assessment chart

A = Assessment	*B* = Behavioural indicators	*C* = Conversation
Primary survey	Observations of behaviour	Patient self-report
1. Appearance	1. General behaviour (*intoxicated*, *anxious*, *hyperactive*)	1. Admits to weapon
2. Current medical status	2. Irritability	2. Admits to history of violence
3. Psychiatric history (*history of violence*)	3. Hostility, anger	3. Thoughts about harm to others
4. Current medication	4. Impulsivity	4. Plans to harm others
5. Oriented (*time*, *place*, *person*)	5. Restlessness, pacing	5. Threats to harm
Physiological indicators for impending aggression		
6. Flushing of skin	6. Agitation	6. Admits substance use/abuse
7. Dilated pupils	7. Suspiciousness	7. Command hallucinations (*voices*) to harm others
8. Shallow, rapid respiration	8. Property damage	8. Admits extreme anger
9. Excessive perspiration	9. Rage (*especially children*)	
	10. Intimidating physical behaviour (e.g. clenched fists, 'shaping up')	

strategies for aggression prevention and management must be considered.

Managing aggression

The best strategy for managing aggression is prevention. By being aware of known risk factors for violence, and making structured behavioural observations as part of the triage assessment, nurses can minimise risk of harm.[2] If the triage nurse has concerns about a patient's risk of becoming violent, support should be sought from the psychiatric consultation liaison service or the code grey team, who will have skills in de-escalation techniques and aggression management.[2] In some situations, for example in rural or remote areas, nurses may not have immediate access to specialised psychiatric services. In such situations the nurse must mobilise available security and clinical resources as soon as possible in order to ensure a safe environment. Local protocols must be developed and implemented to ensure rapid detection and intervention for aggressive behaviour in all EDs. At times it may be appropriate to re-triage potentially aggressive patients to expedite care, especially in the context of acute mental illness and distress.[17]

Any actual incidents of aggression require immediate emergency intervention (Australasian Triage Scale ATS category 1),[17] this will usually involve instigating a hospital wide security response, sometimes known as a 'Code Grey'.[2] If a patient admits to, or is observed carrying a weapon, a 'Code Black' must be called (ATS category 1),[17] this event involves an emergency response from security staff and/or police.

As a final point, it is important for nurses who have been involved in an aggressive incident to have the opportunity to debrief after the event, or seek counselling if further support is required. Exposure to violence is often extremely traumatic,[18,19] and can impact negatively on confidence and clinical performance, as well as have ramifications for emotional health and well-being. Nurses should also be encouraged to participate in aggression management training programs, which can provide further support and guidance for assessing and managing occupational violence.[2]

To summarise, violence risk assessment is an essential component of triage decision making. Being aware of the critical predictors for violent behaviour, and using a systematic approach to urgency assessment that includes the primary survey and observations of behaviour and conversation, enables the triage nurse to perform a quick violence risk assessment. This approach is not intended to provide a comprehensive risk assessment for violence, but rather, alert triage nurses to the need for additional behavioural management strategies and early intervention.

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