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Encountering a violent patient

NRF Clinical Practice Guidelines™

COMPOSITION AND AFFILIATIONS OF THE WORKING GROUP

CHAIR

JAANA ASIKAINEN, RN, PhD, Nurse Manager, Niuvanniemi Hospital

VICE-CHAIR

SATU KAMMONEN, RN, PHN, MHSc, Nurse Manager, HUS, Perioperative and Intensive Care Centre

MEMBERS

TERHI HAGMAN, RN, MHSc, Senior Lecturer, Karelia University of Applied Sciences

HEIDI HYTTINEN, RN, MHSc, Nurse Manager, HUS, Emergency Medicine and Services

KATJA HÄNNINEN, RN, MHSc, Nurse Manager, HUS, Children and Adolescents

ANJA HOTTINEN, PhD, Director of Nursing, HUS, Psychiatry (member of the working group until 19 October 2025)

EXPERTS

MIKKO JOENSUU, MD, Specialist in Psychiatry and Forensic Psychiatry, Clinical Supervisor, MBT Therapist, Niuvanniemi Hospital; Clinical Lecturer, University of Eastern Finland

OLAVI LOUHENRANTA, PhD, Master of Theology, Docent in Psychiatric Anthropology, Clinical Supervisor and Advanced-Level Psychotherapist, Niuvanniemi Hospital

SARIANNE MAKKONEN, RN, BHSc, Anaesthetic Nurse, Terveystalo Kamppi

IDA PENNANEN, Master of Health Care, Paramedic, Wellbeing Services County of Satakunta

JARI PESOLA, RN, Bachelor of Business Administration (Security Management), Fire Inspector, City of Helsinki Rescue Department

SUVI VETELÄSUO, RN, Wellbeing Services County of Pirkanmaa, Mental Health and Substance Use Services for Young People

ELINA ÖSTRING, Specialist Degree in Occupational Physiotherapy, MHSc, Vocational Teacher, MBA, Senior Specialist, Finnish Institute of Occupational Health

Expert by experience

The expert group includes one expert by experience representing a patient who has exhibited violent behaviour.

CONFLICTS OF INTEREST:

The members of the guideline working group and the expert group have no affiliations related to the subject of the guideline that would benefit them financially or affect the reliability of the guideline.

ISSN 2489-5024

Table of contents

COMPOSITION AND AFFILIATIONS OF THE WORKING GROUP 2
Introduction 5
Purpose, aim, and target groups of the guideline 6
Purpose and aim of the guideline 6
Target groups 6
Key concepts 7
Recommendations 10
1. Factors predicting violence: patient 10
2. Factors predicting violence: healthcare professionals 14
3. Ensuring competence 15
4. Interaction with the patient 16
5. Factors related to the care environment 18
6. Factors related to the organisation 20
7. Experiences of the effects of violence on wellbeing 21
8. Reporting violent incidents 22
9. Post-incident management of violent incidents 24
Implementation of the guideline 26
References 30

Introduction

In Finland, health and social care is a sector in which the risk of physical violence is higher than average[1], with more than half of employees in the sector having experienced violence or the threat of violence at work during the preceding three years[2]. The increase in violence may be attributed to societal uncertainty and social exclusion, as well as the increasingly widespread misuse of alcohol, pharmaceuticals, and illicit drugs[3].

Violence refers to the actual or threatened use of physical, psychological, or emotional force with the intent to cause harm[4]. Violent behaviour by patients is associated with reduced job satisfaction among healthcare professionals and may lead them to consider leaving the profession[5]. Workplace violence causes substantial financial losses in Finland, comprising direct costs, such as sickness-related absences, and indirect costs, such as reduced productivity and higher staff turnover[6].

Anticipating and identifying situations in which staff may be threatened or subjected to violence are central to violence prevention[6,7]. Therefore, healthcare staff require a range of methods and interventions to anticipate, prevent, and manage violent incidents and to support their post-incident management. Increasing awareness, identifying potentially violent situations, and interacting with patients appropriately help to prevent violence against healthcare staff. No previous national clinical practice guideline has addressed the anticipation and prevention of violence against health and social care staff, despite the need for a guideline and consistent procedures for encountering a violent patient in Finnish health and social care settings.

The Nursing Research Foundation is currently preparing a guideline addressing behaviour perceived as challenging among people with a memory disorder; therefore, encounters with this patient group are not addressed in the present clinical practice guideline.

Purpose, aim, and target groups of the guideline

Purpose and aim of the guideline

The purpose of this NRF Clinical Practice Guideline® is to synthesise evidence based on critically appraised research and expert opinion and to provide evidence-based recommendations for encountering a violent patient, including the anticipation, prevention, and post-incident management of violent incidents. The guideline aims to harmonise practices for encountering a violent patient and thereby improve the quality of care and patient safety, as well as the occupational safety of health and social care professionals. Achieving these aims requires professionals to be able to anticipate, prevent, and identify situations in which staff are at risk of being threatened with or subjected to violence.

Target groups

The clinical practice guideline has been developed for all health and social care professionals who may encounter patients exhibiting violent behaviour in their work. It is suitable for use in primary healthcare and specialised healthcare and, where applicable, in social care. In addition, the guideline may be used to support nursing management in workforce planning and in ensuring staff competence. It may also be used as learning material and to support the development of educational content in nursing education and in initial vocational education, further training, and continuing professional development.

Key concepts

Violence

This clinical practice guideline applies the Finnish Institute for Health and Welfare's[4] definition of violence. Violence refers to the actual or threatened use of physical, psychological, or emotional force or power against another person, group, or community with the intent to cause harm. It may also involve a violation of sexual autonomy, in which case it constitutes sexual violence.[8] Violence is highly likely to result in physical or psychological injury, death, impaired development, or the deprivation or loss of basic needs[9]. According to the World Health Organization (WHO), violence may also be self-directed[10]; however, self-harm, suicide, and suicide attempts are outside the scope of this clinical practice guideline.

Workplace violence

Workplace violence is defined as any action, incident, or behaviour in which an employee is verbally abused, threatened, or assaulted in circumstances related to their work and which directly or indirectly endangers employees' safety, health, or wellbeing. In this clinical practice guideline, violence refers to being subjected, or threatened with being subjected, to physical, psychological, emotional or sexual violence perpetrated by a patient while carrying out work duties.[6,11] In this context, violence does not refer to psychological violence perpetrated by other employees, such as bullying or inappropriate treatment[12]. Hereafter, the term ‘violence’ is used to refer to workplace violence.

Assessing the risk of violence and recognising a violent situation

The organisation must establish the conditions required to identify violent incidents through systematic risk assessment. The workplace must ensure that an action plan and instructions are accessible to employees, describing how they should act in situations involving violence or threats of violence. The action plan should be discussed proactively with employees and incorporated into induction and competence assurance to prevent or address adverse events as promptly and effectively as possible. In preventing violent behaviour, healthcare staff are supported by the organisation's safety culture, which is shaped by the organisational culture and by the values, attitudes, experiences and perceptions of management and staff.[13]

Assessing the risk of violence when encountering a patient involves identifying factors associated with violence and its possible consequences and estimating their likelihood. In an acute situation, the risk of violence is assessed on the basis of existing information and the patient's behaviour.[13] Background information may be obtained, for example, from patient records, colleagues, previous experiences, or public authorities. Recognising a potentially violent situation requires observation by a healthcare professional. Observing the patient's appearance, gestures, and mannerisms may provide information about their intentions.[13,14]

Staff members' work experience may be associated with violent behaviour by patients[15]. Recognising and responding to the risk of violence may be challenging for employees who lack

sufficient competence. Risk assessment in health and social care may also be influenced by staff attitudes, including prejudices and stereotypes. Prejudice may particularly be directed towards patients who are socially excluded or at risk of social exclusion, who misuse substances, or who suffer from mental health issues. For example, healthcare professionals' own fear or attitudes may lead them to overestimate the risk of violence. This may result in excessive use of force and security measures, which may themselves provoke aggressive behaviour in the patient. Conversely, risk factors may also be overlooked or denied.[16]



Examples of instruments developed to assess the risk of violence

Various instruments are available for assessing the risk of violent behaviour, particularly in psychiatric care. Of the instruments used in Finland, DASA and BVC assess short-term risk of violence, whereas START and HCR-20 place greater emphasis on longer-term considerations when assessing violence. Staff must be trained to use these instruments.

DASA (Dynamic Appraisal of Situational Aggression) is a validated, structured instrument developed to assess and monitor the imminent risk of aggression among psychiatric patients[17]. It may be used to assess risk levels and inform nursing interventions aimed at preventing potentially violent behaviour[17-20].

BVC (Brøset Violence Checklist) is a validated, structured instrument developed to assess a patient's risk of violence on a psychiatric ward, particularly over the short term. It guides nursing professionals in assessing patient behaviour and predicts violent behaviour.[21,22]

START (The Short-Term Assessment of Risk and Treatability) is a structured professional judgement scheme for assessing the risk of violence on the basis of the patient's behaviour. The assessment draws on both the strengths and the risk factors of the patient being assessed when planning care interventions to reduce risk behaviour.[23,24]

HCR-20 (Historical, Clinical and Risk Management – 20) is a structured clinical tool for assessing the risk of violence that guides nursing judgement according to low, moderate, and high levels of risk[25].

Patient and client

The Act on the Status and Rights of Patients[26] defines a patient as a person who uses health or medical care services or is otherwise the recipient of such services. The Act on the Status and Rights of Social Welfare Clients[27], in turn, defines a client as a person who applies for or uses social welfare services. In this clinical practice guideline, the term ‘patient’ is used hereafter to refer to both clients and patients.

Encounter

An encounter refers to interaction between healthcare staff and a patient, characterised by genuine presence and respect. These foster the patient's sense of safety and trust. A genuine encounter with a patient requires sufficient time, active listening, and consideration of the patient's individual needs and emotions.[28] The aim is patient-centred care in which the patient participates in their own care and feels heard. Such encounters are a central component of healthcare staff's professional competence and support successful care, recovery, and adherence to treatment.[28,29]

Healthcare staff and nursing professionals

In this clinical practice guideline, the term ‘healthcare staff’ is used when participants in the studies underpinning the recommendation statements represent a multidisciplinary group. The term ‘nursing professionals’ is used when the recommendation statements are based on research findings concerning nursing professionals, such as registered nurses or practical nurses.

Recommendations

1. Factors predicting violence: patient

Be aware of the influence of the patient's background factors on the risk of violence, as

- **there is strong evidence of nursing professionals perceiving patients' substance use to be associated with an increased risk of violent behaviour[30–34]. (A)**

- **there is strong evidence of changes in a patient's cognitive state being associated with an increased risk of violent behaviour[30,31,35–37]. (A)**
  - Changes in cognitive state may include, for example, memory disorders[31,37] or delirium[30,35,37].

- **there is strong evidence of nursing professionals perceiving patients' mental health disorders to be associated with an increased risk of violent behaviour[30,31,34]. (A)**

- **there is moderate evidence of healthcare staff perceiving patients' negative attitudes towards and experiences of healthcare to be associated with an increased risk of violent behaviour[31,33,34,38,39]. (B)**
  - Attitudes and experiences that may increase the risk of violence include, for example, a patient's lack of experience[38] or previous adverse experiences of healthcare[34], as well as the patient's or a close person's prejudice towards healthcare professionals[39], misunderstandings concerning professionals' behaviour[31], or a lack of respect for women or authority figures[40].
  - Nursing professionals have expressed that patients from different ethnic backgrounds who do not speak the official language or understand how the emergency department operates may pose an increased risk of violent behaviour[33].
  - Cultural and religious factors may influence individuals' perceptions of health and the causes of illness, as well as how immigrants view treatment or their prospects of recovery[41–43]. Potential traumatic events experienced in their former home country may be associated with health issues[44].

- Discrimination experienced by immigrants in Finland may, in turn, lead to mental health symptoms, reduced social wellbeing, and mistrust of healthcare[45].

➢ **there is moderate evidence of nursing professionals perceiving patients' unmet expectations of healthcare to be associated with an increased risk of violent behaviour[32,33,37]. (B)**

- Emergency department nurses have reported an increased risk of violence, for example, when a patient has been prohibited from leaving, their personal belongings have been removed, or the patient or a close person feels that their needs are not being met[40].
- Trauma ward nurses have reported that conflicts between patients and nurses increase the risk of violence. Such conflicts may arise from the patient's intoxication, dissatisfaction with the dosage of prescribed medication, restrictions required for care, such as restrictions on movement or leaving the unit, a mental health or a memory disorder.[46]
- Hospital healthcare staff have reported that violent incidents are often associated with patients' financial difficulties, dissatisfaction with treatment outcomes, or misunderstandings in communication[47].
- Nursing professionals working in triage have reported that the risk of violence is increased by patients' limited understanding of how the emergency department operates, particularly the triage system, and by unrealistic expectations regarding waiting times and admission to hospital through the emergency department.[32]

➢ **there is moderate evidence of healthcare staff perceiving patients' previous aggressive behaviour to be associated with an increased risk of violent behaviour[34,39,48]. (B)**

➢ **there is moderate evidence of a patient's physical illness being associated with an increased risk of violent behaviour[33,36]. (B)**

- Physical health issues that may be associated with an increased risk of violent behaviour include, for example, sepsis, hypoxia, or delirium. Nursing professionals have reported that it may be challenging to recognise when violent behaviour has a physical rather than a psychological or cognitive cause, and to identify the principal issue and the appropriate course of action.[33]

➢ **the evidence is inconclusive, but it indicates that nursing professionals perceive patients' multiple concurrent health issues to be associated with an increased risk of violent behaviour[33]. (C)**

➢ **there is moderate evidence of male patients carrying an increased risk of violent behaviour[35,36]. (B)**

- **there is moderate evidence of younger patients carrying an increased risk of violent behaviour[30,32,35,36]. (B)**
    - Younger patient age (mean age 49 years) was associated with an increased number of alerts due to violent or threatening behaviour.[36]
    - Nursing professionals working in triage have expressed that patients aged under 35 years have the highest risk of violent behaviour.[30]

Recognise the early signs of a patient's violent behaviour, as

- **there is moderate evidence of patient's increasing vocal volume and sharp tone of voice, as well as motor restlessness, predicting violent behaviour[14,30]. (B)**
    - **Tone and volume of voice**: during violent incidents, patients often speak loudly, make sarcastic comments, and use a demeaning tone. Warning signs in a patient's speech include curt responses, a sense of urgency, and belittling or disparaging a nursing professional through vocal emphasis. Increasing vocal volume was identified as a possible indicator of the risk of violence. Nurses reported that tone and volume of voice are important cues, both independently and in conjunction with other verbal or physical cues.[14]
    - **Restlessness**: pacing and restless movement, for example in a waiting area, on a ward, or near nursing professionals' workstations, indicate increasing restlessness, which nurses recognise as a warning sign of violence. Other observed physical signs of restlessness include swaying, waving of the arms, or other uncontrolled movements.[14]
- **the evidence is inconclusive, but it indicates that a patient's staring, signs of physical distress, and muttering predict violent behaviour[14]. (C)**
    - **Eye contact**: a patient's staring or deliberate avoidance of eye contact is an early warning sign, particularly when combined with restlessness and other warning signs. If nurses respond to these warning signs, for example by discussing the patient's concerns with them, escalation to violence may be avoided.[14]
    - **Distress**: physical signs of distress, such as skin flushing, rapid breathing, rapid speech, dilated pupils, as well as expressions of pain and confusion, are associated with an increased risk of violence. Patients' distress may arise, for example, from psychosocial, situational or contextual stressors, concurrent health issues, or from limited understanding of how the unit operates.[14]
    - **Muttering**: quiet speech in which the patient mutters just loudly enough to be heard, repeated questions, and unclear or incoherent speech are signs of increasing frustration and risk of violence. Muttering combined with a fixed stare or

physical signs of restlessness constitutes a significant warning sign of violence. In addition, patients who repeat the same questions and express increasing restlessness, impatience or frustration may exhibit violent behaviour.[14]

The guideline working group recommends using a safety plan developed jointly by the patient and healthcare staff during a longer care relationship to prevent violence. The safety plan includes the patient's early warning signs and strategies for preventing the situation from developing into a violent incident.



2. Factors predicting violence: healthcare professionals

Be aware of how your background factors may influence your increased risk of being subjected to violence, as

- **there is strong evidence of limited work experience among nursing professionals being associated with an increased risk of being subjected to violence[30,49,50]. (A)**

- **there is moderate evidence of younger nursing professionals carrying an increased risk of being subjected to violence[50]. (B)**
  - Among nurse-related factors, being under 30 years of age may increase susceptibility to violent incidents[50].

- **there is moderate evidence of sleep disorders and chronic illnesses among nursing professionals, and the resulting impairment in functional capacity, being associated with an increased risk of being subjected to violence[51]. (B)**
  - Studies have identified an association between poor sleep quality and increased burnout among nurses[52,53], particularly burnout related to patient care[52]. Nurses' concerns about their own health may also impair their concentration at work[54]. Reduced functional capacity in challenging patient situations may increase nurses' susceptibility to being subjected to violence[51,53].

- **the evidence is inconclusive, but it indicates that nursing professionals perceive dissatisfaction and a lack of motivation towards their work to increase the risk of being subjected to violence[34]. (C)**

Pay attention to safe workplace practices, as

- **there is moderate evidence of nursing professionals perceiving awareness of a patient's warning signs to reduce the risk of being subjected to violence[32,46]. (B)**

- **there is moderate evidence that indicates remaining calm and requesting assistance, when necessary, support nursing professionals in maintaining control of the situation[50]. (B)**

3. Ensuring competence

It is important for the workplace to enable healthcare staff to participate in training aimed at preventing violence, as

- **there is strong evidence of healthcare staff perceiving violence-related training to be insufficient[34,39,50,55–59]. (A)**
  - Nursing professionals have perceived training in, for example, violence prevention[55] and the management of aggressive behaviour to be insufficient[55,56]. Training should be multidisciplinary[56], continuous, and include practical exercises[55,58].
- **there is strong evidence of training increasing healthcare staff's confidence in their ability to manage violent incidents[60–65]. (A)**
- **there is strong evidence of healthcare staff perceiving training to help clarify staff roles during violent incidents[38,56,66]. (A)**
- **there is moderate evidence of training for nursing professionals potentially reducing their risk of being subjected to violence[67,68]. (B)**
- **there is moderate evidence of nursing professionals perceiving training to improve their understanding of violence being unacceptable in nursing practice[61,65]. (B)**
- **there is moderate evidence of nursing professionals perceiving training to increase their competence in anticipating violent incidents and using de-escalation techniques[64,65]. (B)**
- **there is moderate evidence of healthcare staff perceiving training to enhance their communication skills[60,69,70]. (B)**

4. Interaction with the patient

Pay particular attention to interaction with a patient who carries an increased risk of violent behaviour, as

- **there is strong evidence of healthcare staff perceiving effective interaction between healthcare staff and the patient to prevent violent incidents[46,56,59,69]. (A)**

- **there is moderate evidence of healthcare staff perceiving a calming[34,71] (B) and respectful[31,32,34] (B) encounter with the patient as an important element in violence prevention.**
  - Patients treated in emergency departments have expressed a wish to be treated respectfully and courteously and for healthcare staff to establish a trusting relationship with them[56].
  - Healthcare staff's competences in cultural sensitivity and ensuring that immigrants receive sufficient information about their health status, factors affecting their health, and the service system in their new country of residence are central to integration[44].

- **there is moderate evidence of nursing professionals perceiving shortcomings in communication and information exchange between nurses and patients to be associated with escalation of the situation into violence[37,48]. (B)**
  - Nursing professionals have experienced frustration particularly due to inadequate communication, for example, when patients' procedures are repeatedly cancelled without providing clear and proper information. Inadequate communication within the multidisciplinary team may result in nursing professionals encountering angry and aggressive patients. In addition, nursing professionals have expressed that poor communication between healthcare staff and patients may increase the risk of violence, for example in relation to treatment decisions, planned care, procedures and their changes.[37]

- **there is strong evidence of nursing professionals perceiving deficiencies in their interaction and communication skills to be associated with escalation of the situation into violence[39,50]. (A)**

- **the evidence is inconclusive, but it indicates that healthcare staff perceives an empathetic encounter to prevent violent behaviour by the patient[71]. (C)**

- **the evidence is inconclusive, but it indicates that healthcare staff perceives that escalation into violence may be avoided by allowing the patient to have the time and space to calm down[71]. (C)**

- **the evidence is inconclusive, but it indicates that healthcare staff perceives establishing a trusting relationship with the patient to reduce the risk of escalation into a violent incident[71]. (C)**

Inform the patient about the access to care, waiting times, and the progress of their care, as

- **there is strong evidence of long waiting times increasing the risk of violence[14,30–32,38,48,72]. (A)**

- **there is moderate evidence that indicates keeping patients informed about access to care and the progress of their care reduces the risk of violence[56]. (B)**



5. Factors related to the care environment

The organisation must assess the risk of violence at regular intervals, as

- **there is moderate evidence of hospital environments containing factors that increase exposure to violence[34,48]. (B)**

  - Nursing professionals have identified, for example, the absence of security systems and organisational guidelines as factors that increase exposure to violence.[34]

Ensure that your organisation has premises, equipment, and arrangements appropriate to the care environment for violence prevention, as

- **there is strong evidence that a calming and clear layout design may prevent violence[30,34,39,56,69]. (A)**

  - Emergency department healthcare staff and managers have reported that separating violent patients from others is an important means of managing violent incidents. Emergency department healthcare staff has expressed a need for more secure and protected areas in which violent patients can be accommodated.[56]

  - Common measures used in emergency departments to prevent equipment from being used as weapons include securing seats to walls, replacing glass bottles with plastic ones, and moving clinical supplies outside the room[69].

  - In addition, the guideline working group recommends ensuring unobstructed exit routes in consultation rooms and positioning the patient so that staff can leave the room without obstruction if necessary.

- **the evidence is inconclusive, but it indicates that healthcare staff utilises security devices as part of violence prevention[69]. (C)**

  - Under the Occupational Safety and Health Act, the employer must provide employees with a suitable alarm system. Correspondingly, employees are obliged to use the occupational safety equipment provided by the employer.[7]

  - **Alarm systems**: emergency department healthcare staff has regarded alarm systems as the most effective technological preventive measure. These include fixed **emergency-button** and **bell systems, wireless telephone** or **paging solutions** equipped with an emergency button, and pocket alarms. Alarms may be audible, summoning

assistance from the immediate vicinity (such as a colleague), or silent, alerting a designated person (such as a security officer or police officer) without the potential aggressor becoming aware of the alarm. Healthcare staff have perceived these devices to enhance their sense of safety and their ability to act in situations involving a threat of violence.[69]

- **Access-control systems**: emergency department healthcare staff has perceived access-control systems to be an effective means of preventing violent incidents. Entry to a unit protected by an access-control system requires the use of a doorbell. Access can also be based on codes or access cards available only to authorised staff. The sense of safety associated with access-control systems is particularly important to healthcare staff at night.[69]

- **Video surveillance**: emergency department healthcare staff has described video surveillance as a means of monitoring critical areas, entrances, and ambulance entrances. Critical areas include waiting areas and treatment rooms, particularly when monitoring patients affected by substances. In addition, video surveillance has been regarded as a preventive measure.[69]

To ensure the safety of healthcare staff when encountering patients who pose a risk of violence, it is important to consider the specific characteristics of the care environment, as

- **there is strong evidence that indicates working in long-term care, intensive care, emergency departments, or psychiatric units is associated with an increased risk of violence[50,51,73–76]. (A)**

  - The risk of violence has been found to be low when working in student health services, neonatal units, somatic care units for children or adolescents, or private practices[73].

- **there is moderate evidence that indicates working in triage in an emergency department is associated with an increased risk of violence[30,77]. (B)**



Working in a patient's home involves specific considerations for recognising the threat of violence that are not addressed in this guideline. For more information, see, for example, the Finnish Institute for Health and Welfare publications *Turvallisia kotiin annettavia sotepalveluja: opas kotihoitoon*[78] and *Näkökulmia sosiaalihuollon palvelujen turvallisuuteen*[79] (available in Finnish).

6. Factors related to the organisation

The organisation must establish consistent procedures for violence prevention, as

- **there is strong evidence that indicates clear procedures for preventing and managing violence to reduce violent incidents[51,74,80,81]. (A)**
  - The Occupational Safety and Health Act[7] requires the employer to prepare procedural guidelines that proactively address the management of threatening situations and the measures by which the effects of violent incidents on employee safety may be prevented or limited.
  - Under the Criminal Code[82], the constituent elements of an offence against health or liberty are met, for example, in cases of assault, including petty assault, negligent bodily injury, unlawful threat, or stalking. In situations involving violence or threats, the employer is obliged to report or to assist the employee in reporting the offence to the police.
- **there is moderate evidence of nursing professionals perceiving clear organisational procedures to be important in preventing violent incidents[34,66]. (B)**
- **there is moderate evidence of unclear visiting arrangements within a unit increasing the risk of violent incidents[31]. (B)**

The organisation must safeguard the wellbeing of healthcare staff, as

- **there is moderate evidence of healthcare staff perceiving support from their immediate manager to be important[69]. (B)**
  - Healthcare staff has regarded support from their immediate manager when encountering aggressive patients, together with attention to staff wellbeing and resilience, as important elements for their ability to tolerate stress[69].

Where possible, the organisation should seek to minimise the risk of violence through shift planning and resource allocation, as

- **there is strong evidence that indicates working evening or night shifts or at weekends is associated with an increased risk of violence[32,50,51,75,77,80,83]. (A)**
- **there is strong evidence that indicates excessive workload and insufficient resources are associated with an increased risk of violence[34,48,50]. (A)**

7. Experiences of the effects of violence on wellbeing

Be aware of the effects of violence on your wellbeing and, when necessary, seek support, as

- **there is strong evidence of violence adversely affecting the wellbeing of healthcare staff[32,37–40,46,50,51,55,58,59]. (A)**
  - Nursing professionals have experienced psychological harm following violent incidents, including hostile emotions such as anger, and mental health problems such as anxiety, depression or post-traumatic stress[39].
  - Nurses working in emergency departments have expressed violence to affect their sense of safety in the workplace. This includes concerns over monitoring access to the emergency department and the effectiveness of security measures.[50]
  - Home care staff has reported violence to have adverse effects on their wellbeing. This manifests as negative emotions and thoughts, including helplessness, anger, and fear. Experiencing violence has also been described to be associated with lower self-esteem.[58]
  - Violence increases stress, anxiety, fear, and burnout among nurses. They may also experience more serious mental health issues, including post-traumatic stress disorder (PTSD), depression, or deliberate self-harm. Nurses may experience an overall deterioration in both their physical and psychological health as a consequence of violence.[50]

- **there is moderate evidence of exposure to violence being associated with sleep difficulties among nursing professionals[51,80]. (B)**

- **there is moderate evidence of exposure to violence adversely affecting the family life of nursing professionals[37,80]. (B)**

Be aware of the effects of violence on your work, as

- **there is strong evidence of violence leading nursing professionals to consider leaving their current job or the healthcare sector[37,39,50,51,80]. (A)**

- **there is strong evidence of violence causing burnout among nursing professionals[39,51,59,80]. (A)**
  - Violent incidents have adverse consequences for nurses' work, manifested as reduced work motivation and work performance, sickness-related absences, poorer quality of care, and work-related injuries[50].

- **there is moderate evidence of violence impacting nursing professionals' attitudes towards patients[32,59]. (B)**
  - Nursing professionals' previous adverse experiences of violence may increase job dissatisfaction and lead to disrespectful attitudes towards patients[34].

8. Reporting violent incidents

It is important to establish practices within the work community that encourage and guide the reporting of violent incidents, as

- **there is strong evidence of healthcare staff's uncertainty over what and how to report violent incidents[31,56,84,85]. (A)**
- **there is moderate evidence of nursing professionals perceiving guidance on reporting violent incidents to reduce the risk of violence[31,81]. (B)**
- **there is moderate evidence of nursing professionals perceiving lack of time to interfere with reporting violent incidents[50,85]. (B)**

The organisation must ensure that violent incidents are neither accepted nor normalised, as

- **there is moderate evidence of nursing professionals not reporting violent incidents because violent behaviour is interpreted to be a part of the patient's illness[85]. (B)**
- **there is moderate evidence of nursing professionals prioritising patient care over occupational safety[59]. (B)**

The organisation must ensure that healthcare staff receives sufficient support following incidents involving violence or the threat of violence, as

- **there is strong evidence of fear of adverse consequences among nursing professionals interfering with the reporting of violent incidents[31,59,85]. (A)**
  - Underreported violence is associated with several fears, including fear of losing one's job or facing serious or legal consequences[85], fear of retaliation by managers[59,85], negative reactions from managers or colleagues[31], or an adverse effect on the reporting person's career progression[59].
- **there is strong evidence of healthcare staff not reporting violent incidents because they feel that they receive insufficient support from their immediate manager[31,37,56,84]. (A)**
- **there is moderate evidence of nursing professionals not reporting violent incidents because they feel that they receive insufficient support from their peers[84]. (B)**

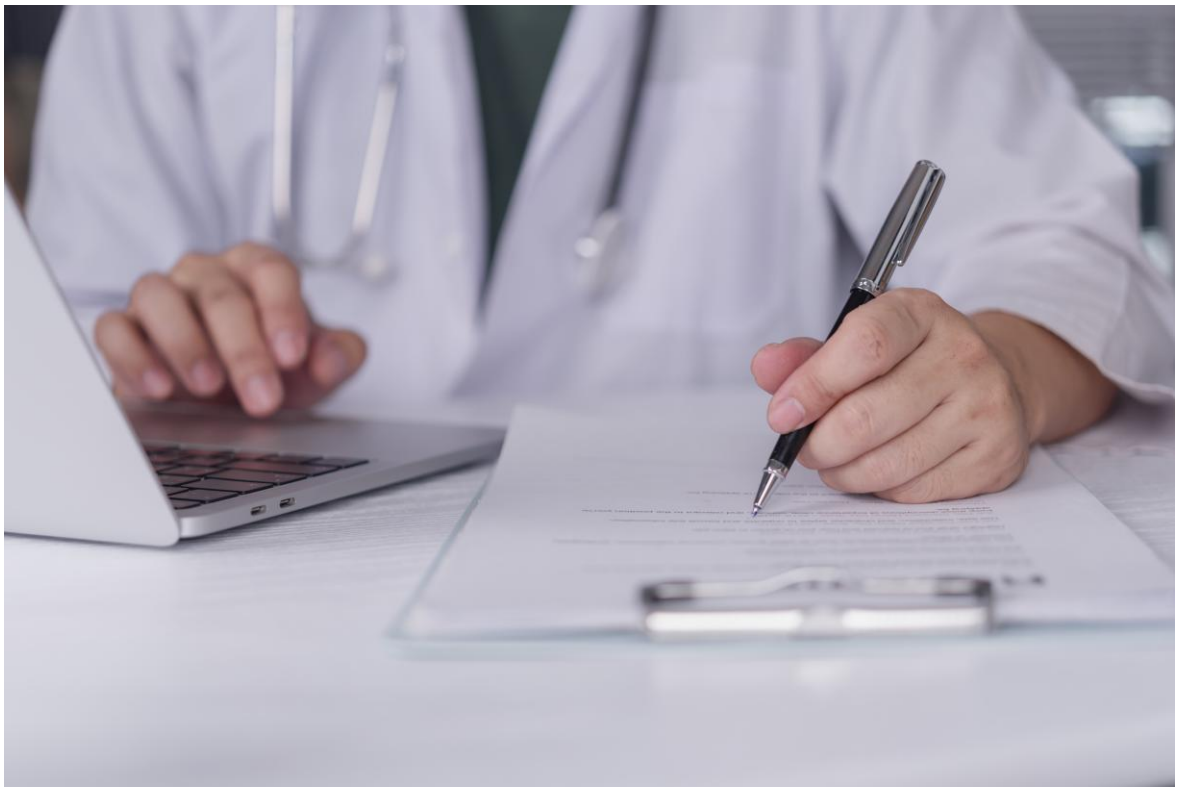
The organisation must demonstrate the concrete actions taken in response to reports of violent incidents to the work community, as

- **there is strong evidence of nursing professionals not reporting violent incidents because they do not believe that reporting will lead to practical changes[57,84]. (A)**

- **there is strong evidence of nursing professionals' personal attitudes and beliefs influencing their willingness to report violent incidents[31,59,84-86]. (A)**

- **there is moderate evidence of nursing professionals' personal characteristics and previous experiences influencing the non-reporting of violent incidents[85]. (B)**

  - Personal characteristics of healthcare staff associated with underreporting workplace violence include female sex, younger age, limited work experience, working alone, and personal characteristics, such as caring and empathy. Working in specialised healthcare, repeated previous exposure to violence, desensitisation to violent patients and preconceptions regarding the reporting of violence have also been associated with underreporting.[85]



9. Post-incident management of violent incidents

The organisation must provide healthcare staff with an opportunity for post-incident management following a violent incident and encourage those involved to participate, as

- **there is moderate evidence of healthcare staff who have been subjected to violence perceiving the opportunities for post-incident management to be insufficient[56,59,86]. (B)**

- **the evidence is inconclusive, but it indicates that nursing professionals involved in violent incidents perceive post-incident management to help them cope with the incident[32]. (C)**

The organisation must ensure that healthcare staff have access to support following a violent incident, as

- **there is strong evidence of nursing professionals perceiving peer support following violent incidents to be important[34,50,51,58,86]. (A)**

- **the evidence is inconclusive, but it indicates that nursing professionals consider it important to receive support in processing violent incidents[86]. (C)**

- **the evidence is inconclusive, but it indicates that nursing professionals perceive the support received for processing violent incidents to be insufficient[86]. (C)**

Encourage an employee or colleague who has experienced violence to discuss their feelings related to the incident with close persons, as

- **the evidence is inconclusive, but it indicates that nursing professionals perceive support from family and friends to encourage them to seek professional help after the violent incident[86]. (C)**

The guideline working group emphasises the duty of confidentiality of health and social care professionals outside the workplace. Several Acts[26,27,87,88] require professionals to maintain the confidentiality of all information concerning a client or patient that they have obtained by virtue of their position or duties.

Management of violent incidents

A range of debriefing methods is used in health and social care. Together, these form a tiered approach aimed at supporting employees' psychological functioning and preventing prolonged strain. The methods may be organised according to timing into early measures implemented immediately after a distressing event and longer-term, more rehabilitative forms of support. Key early-stage methods include group defusing and individual peer defusing, which draw on trained peer support and resources within the work community to address psychological strain. These are complemented by various work-community-based post-incident measures, such as follow-up or information sessions, which can support recovery and the development of a shared understanding of the incident over a longer period. More intensive post-trauma workshops have been developed for those who have experienced more severe strain or exposure to traumatic events; these combine psychoeducation, peer support, and rehabilitation facilitated by professionals. In addition, clinical supervision serves as a key preventive and long-term method, enabling both acute and cumulative stress to be addressed as part of professional reflection and work-community development.[89–91]

Implementation of the guideline

Implementation of the guideline

This national NRF Clinical Practice Guideline® is intended for all health and social care professionals who may encounter patients or clients exhibiting violent behaviour in their work. The clinical practice guideline is intended to inform national programmes and quality recommendations and to support managers working in health and social care in decision-making and workforce management. Developing organisational or unit-level practices on the basis of the guideline contributes to client and patient safety and to the occupational safety of health and social care professionals.

Establishing consistent practices

The clinical practice guideline provides a basis for consistent national practices. It enables the development of local, detailed procedural guidance for different settings in which violence occurs, including emergency departments, home care, and mental health and substance use care units. The guideline is intended to support organisations in developing operating models and processes, such as safer practices for identifying and reducing the risk of violence. Procedural guidance translates the recommendations into practice and helps to ensure that local procedures are aligned with consistent national practice.

Evidence-based strategies and interventions for preventing violence are available internationally. In Finland, the most commonly known examples of these include Six Core Strategies[92] and Safewards[93]. Six Core Strategies is an evidence-based model comprising leadership, the use of data, workforce development, the use of prevention tools, strengthening the patient's role, and debriefing[92]. Safewards is a model based on research and collaboration with clinical practice that can reduce conflict and aggressive incidents, as well as the coercive measures used to manage them. The Safewards model includes ten practical interventions for preventing violent behaviour and de-escalating aggressive incidents: clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, and discharge messages.[93] Safewards provides a framework for encountering a violent patient, for example by strengthening interaction between the patient and the nursing professional. These strategies are broad in scope, and their implementation across all organisational units and staff groups requires dedicated development and planning.

Requirements for consistent practices

Implementing this clinical practice guideline requires the management of health and social care organisations and units to establish the conditions necessary for developing consistent practices and the associated procedural guidance. The management should enable stronger collaboration between professional groups so that multidisciplinary practice, in accordance with the guideline, becomes embedded as routine evidence-based practice. In addition, implementation

requires effective communication, development of a culture that supports the reporting of violent incidents, competence assurance through training and induction, collaboration among relevant parties, and sufficient time and financial resources. Financial resources include, for example, safe premises, a comfortable environment, and training. Human and financial resources are critical for the recommendations and new practices to become embedded in everyday nursing practice. Support structures and operating models are available to facilitate implementation of the clinical practice guideline, including the FinYHKÄ operating model™. Journal club activities may also facilitate implementation. Further information about these support structures is available on the website of the Nursing Research Foundation.

Following implementation, the establishment of practices should be monitored regularly using appropriate evaluation methods, including monitoring: 1) the occurrence of violent incidents in patient safety and occupational safety incident reports; 2) the provision of post-incident management; 3) participation in continuing professional development; and 4) staff wellbeing at work. Wellbeing at work may be monitored, for example, through staff surveys.

At the national level, the incidence of violent events may be monitored using the nursing-sensitive *Violent Events indicator*. The indicator includes sections intended to support the development of nursing quality within individual units by assessing the risk of violence and the methods used to manage it. At present, the indicator is used in psychiatric inpatient units.[94] In addition, violent behaviour occurring during care situations should be recorded in the risk information within the patient record in accordance with the recommendations of the Finnish Institute for Health and Welfare[95].

Benefits for patients

Violent incidents may compromise patient safety. This clinical practice guideline supports the safety and appropriate treatment of patients using health and social care services. A safe working environment enables healthcare staff to encounter patients with empathy and respect. A safe care environment is also important for patients, as violent behaviour may cause, among others, distress and feelings of insecurity. Managing violent incidents places a burden on healthcare staff and requires resources, which may delay care for both the patient exhibiting violent behaviour and other patients. Violence prevention must also safeguard patients' rights, autonomy and a confidential therapeutic relationship. Overemphasising a patient's risk of violence may, at worst, lead to stigmatisation, disproportionate security measures, and deterioration of the therapeutic relationship.

Benefits for health and social care professionals

The clinical practice guideline supports health and social care professionals who encounter violent patients in their work. The care of a violent patient requires knowledge of warning signs relating to the patient and the environment, effective communication when encountering the patient, and training that strengthens healthcare staff's de-escalation skills, including calming and anticipatory interaction. Furthermore, violent incidents must be addressed through post-

incident management, and adequate support must be provided after the event at individual, work-community, and organisational levels. Professionals' workload and wellbeing at work may be assessed using various instruments, such as the Finnish Institute of Occupational Health's Work Engagement Test[96], the Psychosocial Workload Factors Questionnaire[97], or organisations' tailored wellbeing and staff surveys. Violent experiences may affect the attractiveness and retention of the nursing workforce.

Implementing the clinical practice guideline requires commitment to consistent evidence-based practices, the preparation of guidance adapted to the needs of the local setting, and the allocation of sufficient operational resources. Although support from organisational management is an essential starting point for implementing and embedding the guideline, implementation also requires multidisciplinary competence in identifying and caring for a violent patient. The organisation is responsible for ensuring that health and social care professionals have sufficient competence and for regularly evaluating both competence levels and practices that promote patient and occupational safety. Continuing professional development must be provided as required.

Health and social care professionals play a key role in embedding this clinical practice guideline, evidence-based practices, and the use of different operating models.

Use of the guideline in education and induction

The clinical practice guideline should be incorporated into initial education in health and social care and used in further vocational education, continuing professional development, and staff induction. Members of the working group involved in developing this guideline may be invited to deliver expert presentations at communication and educational events.

The clinical practice guideline is available in full for download from the Nursing Research Foundation website.

Methods

Information retrieval and selection of information sources

The NRF Clinical Practice Guideline is based on a systematic literature search conducted by a library information specialist on relevant databases in accordance with a search plan developed by the guideline working group.

The selection of research articles is based on inclusion and exclusion criteria specified in advance by the guideline working group. The guideline working group systematically screens the records in Covidence, first by title and abstract and subsequently by full text. Each record is assessed independently by two members of the guideline working group. Any disagreement is resolved through consensus discussions.

From the selected research articles, the guideline working group identifies the findings that are central to the guideline. Thereafter, Researchers at the Nursing Research Foundation produce AI-assisted translations of the findings and prepare methodological descriptions of the studies in accordance with a predefined template.

Critical appraisal

The methodological quality of the included research articles is appraised using the JBI critical appraisal criteria adapted to each study design. First, two reviewers conduct an independent quality appraisal, after which the final assessment is reached through a consensus discussion between the reviewers. The clinical practice guideline includes scientific, peer-reviewed systematic reviews and primary studies whose methodological quality is assessed as sufficient: more than 50 percent of the criteria in the relevant JBI critical appraisal checklist must be met, together with the predefined critical criteria.

Preparation of evidence summaries and recommendation statements

For each recommendation statement, an evidence summary is prepared that describes the finding relevant to the recommendation statement, the methodological conduct of the study, the result of the critical appraisal, and the applicability of the research finding to the recommendation. The certainty of the evidence supporting each recommendation statement is determined by the strength and consistency of the evidence provided by the studies included in the evidence summary, acknowledging study quality and other considerations relevant to the certainty of evidence. The evidence summaries are published in Finnish on the website of the Nursing Research Foundation. In addition, the complete handbook for preparing NRF Clinical Practice Guidelines is available in Finnish on the Foundation's website.

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