MEETING AN AGGRESSIVE PATIENT

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ABSTRACT

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COJOC, MARIAN & NGUI, JANE: Meeting an Aggressive Patient

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The purpose of this Bachelor's thesis was to produce a booklet for the first year nursing students on how to manage during an encounter with an aggressive patient. The project started from the premises that student nurses are at a high risk of suffering aggressive attacks during their clinical trainings because of their lack of knowledge.

The thesis researched the concepts of aggression, aggressive patient and de-escalation in evidence based literature, in order to establish a theoretical framework. This was the basis of an in depth research that outlined the content of the booklet. The final product of the thesis contains simplified information about aggression, its causes, risk factors, warning signs, and de-escalation and preventive tactics.

The authors recommend further research of the prevalence of aggressive acts aimed at nursing students during their clinical training periods. Also recommended is the development of an educational programme or inclusion of the topic in the curricula.

Keywords: Aggressive patient, de-escalation, nursing student.

TIIVISTELMÄ

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Tämän opinnäytetyön tarkoituksena oli tuottaa ensimmäisen vuoden sairaanhoitajaopiskelijoita varten opaskirjanen siitä, miten kohdata aggressiivinen potilas. Projektin lähtökohtana oli se oletus, että ensimmäisen vuoden sairaanhoitajaopiskelijoilla on suuri vaara joutua aggressiivisen käytöksen kohteeksi työharjoittelujen aikana tiedon puutteen vuoksi.

Opinnäytetyön teoreettinen viitekehys muodostettiin tutkimalla aggression, aggressiivisen potilaan ja de-eskalaation käsitteitä näyttöön perustuvassa kirjallisuudessa. Tämä oli perusteellisen tutkimuksen pohjana, minkä avulla muodostettiin opaskirjasen sisältö. Opinnäytetyön lopullinen tuotos sisältää pelkistettyä tietoa aggressiosta, sen syistä, riskitekijöistä ja varoitusmerkeistä sekä tietoa de-eskalaatiosta ja ennalta ehkäisevistä toimista.

Tekijät suosittelevat lisätutkimusta työharjoittelujaksojen aikana sairaanhoitajaopiskelijoihin kohdistuvien aggressiivisten tekojen yleisyydestä. Olisi suositeltavaa kehittää myös aiheeseen liittyvää koulutusta tai sisällyttää se opetussuunnitelmaan.

Asiasanat: Aggressiivinen potilas, de-eskalaatio, sairaanhoitajaopiskelija

TABLE OF CONTENTS

1 INTRODUCTION

Incidents of aggression and violence in the health care sector are increasing phenomena around the world. Nurses are three times more likely than any other service occupational group to experience violence in the work place. (ICN, 2007, 1-11.) Studies show that aggressive and violent events are likely to happen, regardless of which field of health care is being looked at. (O'Connell, Young, Brooks, Hutchings & Lofthouse 2000, 603; Bernstein & Saladino 2007, 301.) The impact of this kind of incidents is seen in psychological (stress, fear, depression, self-blame) and physical (injuries, migraines, loss of sleep) disturbances of the nurses and in interference in the workplace (absenteeism, lack of motivation, increased rate of nurse turnover, anxiety of staff and patients) (ICN, 2007, 1-11).

A survey about aggressive events done by the Health Service Advisory Committee (UK) had 5000 questionnaires given out to different health workers and health care students. The results showed that student nurses are at a greater risk of being victims of aggressive patients than graduated nurses. (Turnbull & Paterson 1999, 11.) Post graduate trainings are given to graduated nurses but nursing students lack knowledge and experience. Student nurses, practicing in any type of clinical environment, are at high risk of becoming victims of aggressive patients due to this lack of adequate knowledge. (Nau, Dassen, Halfens & Needham 2007, 933.) According to Beech & Leather, a training programme for student nurses on aggression can produce a lasting and measurable change in knowledge and confidence. It is therefore important that education about aggression and ways of dealing with aggressive patients is incorporated in the curricula of nursing programmes. (Beech & Leather 2003, 605, 611.)

The nursing students' lack of adequate knowledge on the subject and the fact that the Degree Programme in Nursing at Tampere University Applied Sciences does not provide a course about meeting aggressive patients has motivated the authors to choose the topic of this Bachelor's thesis. The topic is "Student guide to meeting aggressive patients". The thesis aims to produce a booklet containing information for the nursing students on dealing with aggressive incidents. The booklet is meant to be used as an educational tool and an easy to use reminder about dealing with an aggressive patient.

2 PURPOSE AND OBJECTIVES

The purpose of this Bachelor's thesis is to produce a booklet for the first year nursing students on how to manage during an encounter with an aggressive patient.

The objective of this thesis is to provide the first year nursing students with a guide that will help them be better prepared for meeting an aggressive patient during their practice placements or working life. The booklet will discuss the following:

- What is aggressive behaviour?
- What are the causes of aggression and the factors that increase the risk of a patient becoming aggressive or violent?
- What are the warning signs that a patient may become violent?
- What should nursing students know about preventing aggressive behaviour?
- What de-escalation techniques are useful in interacting with an aggressive patient?
- What should students do after an aggressive incident?

3 AGGRESSION

Aggression has been studied for many decades. Freud has proposed that humans are born with the aggressive drive, and it is part of the personal development (Freud, 1958). Later, in 1966, Bandura published the results of a study which revealed that aggression is a learned behaviour (Bandura, 1966). More recently, Kingsbury, Lambert and Hendrickse (1997), took a socio-psychological perspective in the classifying of aggressive behaviour. They divide aggression into instrumental and hostile.

Instrumental aggression means that the individual will seek a response with aggressive behaviour. He uses the aggression and expects a desired outcome. This behaviour is learned by observation and interaction with the environment. It has a purpose and is goal oriented. On the other hand, hostile aggression is characterized by the intention to hurt another person (Kingsbury et al., 1997). The goal here is that harm be brought onto another individual. This kind of aggression is born because of different environmental and interpersonal factors that lead to a heightened state of arousal.

One theory of aggression states that in an increasingly frustrating situation people might react with violence. In his article "De-Escalating Angry and Violent Clients", Kevin Fauteux Ph.D. describes the stages of aggression. Faced with a situation that is not expected and not wanted, people will first become frustrated. They will then become defensive as a response to feeling disrespected. The next step is to be difficult about whatever resolution might be offered. Further escalation leads to hostility and then feelings of enragement will surface. As the situation develops further, feelings move the person to an offensive state where they will threaten and then finally express violence in a physical form. (Fauteux 2010, 197.)

3.1 Defining aggression, aggressive patient and violence

According to the Oxford dictionary, aggression is defined as, "feelings of anger or antipathy resulting in hostile or violent behaviour; readiness to attack or confront". Violence is defined as," behaviour involving physical force intended to hurt, damage, or kill someone or something:" (Oxford dictionaries, 2011). In both definitions, there is a co-existing factor which is intention to harm another person. For the purpose of this thesis the authors have decided to use the terms aggression and violence interchangeably. This has been done by other researchers as well like Hislop & Mebel 2003, Kynoch et al. 2009 and Greenwood et al 2005. Therefore, aggression will be defined as any behaviour that is intended to harm another person physically or psychologically (Irwin 2006). An aggressive patient is one who exhibits any behaviour that intimidate, induce fear, humiliates and physically harms another individual (Health personnel, other patients or visitors.) (Lehestö, Koivunen, & Jaakkola, 2004).

3.2 Forms of aggression

The World Health Organization (WHO, 2002) has categorized the forms of violence that may be encountered by health care workers into physical and psychological violence. These two major forms of aggression are the same ones nursing students may face during their clinical training (Cooper & Swanson 2011).

The WHO (2002) described physical aggression as “Using force against another person that results to physical, sexual or psychological harm.” Acts of physical aggression include kicking, biting, slapping, spitting, throwing objects at somebody, pinching, pushing, shooting, and stabbing (WHO, 2002; Pich, Hazelton, Sundin & Kable, 2011).

Verbal aggression, as an act of psychological violence, is the most common form of aggression experienced by nurses (Turnbull & Paterson 1999). More often than not, verbal aggression is concurrent with other forms of aggression (Lau, Magarey & McCutcheon 2004). Verbal aggression can be described as harsh or abusive language towards another individual (Whelan 2008). Other acts included into verbal aggression are threats of physical harm, threats of harming ones family (WHO 2002). Attacks on personal attributes like gender, race sexual orientation and general outlook are considered as acts of verbal aggression (Whelan 2008). Also included are verbal sexual remarks which may range from sexual remarks of intimate unwanted questions (Hesketh et al 2003).

3.3 Risk factors

Nurses, students practicing in clinical environments and medical staff in general work closely with all kinds of patients, their relatives, friends and other visitors. This places them easily within range of a physical assault. However, knowing what the risk factors for a person to be aggressive or violent – the most important fact in risk assessment – can reduce attacks and injuries towards staff. (Ferns 2007, 35.) Nurses should also bear in mind that a patient that falls into one of the risk factor categories, does not prove conclusive that the patient will be aggressive. (Lehestö, Koivunen & Jaakkola, 2004)

3.3.1 Gender

There have been conflicting reports from different researchers about gender being a risk factor of violence or not. Researchers like Sands (2007), Wand and Coulson (2006), McFarland & McFarland (1993) and Lu and Jihui (2010), suggest that male patients pose a greater threat of aggression than female patients. Other researchers however, have claimed this to be a general

stereotype that society gives that males are more likely to commit violent crimes and be the victims of violence. In the clinical setting this is not necessarily true. Because women are seen as less of a threat, nurses are more likely to put themselves in riskier situations when caring for them. Ferns (2007) states that "once threatened or stimulated the gap between men and women in terms of aggression is considerably reduced". This, in turn, means that the number of incidents caused by women patients is comparable to that of men. (Ferns 2007, 37.)

3.3.2 Age

In his article "Characteristics of people who assault nurses in clinical practice", Ferns finds that there are two age group peaks for aggressive tendencies: 15-35 years and 70-85 years. (Lehestö, Koivunen & Jaakkola, 2004), (Ferns 2007, 36.) The younger age seems to be related to aggressive acts reported in the accident and emergency departments while the elders make up the majority of incidents reported in the in-patient settings. While younger people can be considered to more fit and be more capable of inflicting serious physical damage, elderly people diagnosed with dementia or in a state of confusion can be unpredictable and still possess plenty of power and agility. (Ferns 2007, 36.)

3.3.3 History

The National Institute for Clinical Excellence UK (NICE), in their 2005 "Guidelines on Violence", identify a history of alcoholism, previous use of weapons, impulsive dangerous acts, and the verbal threat of violence as risk factors for physically violent behaviour (NICE 2005, 19-20). A history of violent behaviour in the hospital setting or having a police criminal record of aggressive behaviour is a strong indicator for future similar acts (McFarland & McFarland 1993, 599). People that are comfortable with violence and use violence to solve

problems are likely to do the same when in a clinical environment (Ferns 2007, 36). This brings up the importance of reading the patient's medical history and also of reporting clearly any tendencies towards aggressive behaviour (McFarland & McFarland 1993, 599).

3.3.4 Situational factors

The hospital environment may increase stress factors for some individuals, and various situations like limited access to family and friends due to strict hospital policies, rigid hospital routines and limited facilities like internet, may cause the person to be irritated and anxious hence being in the risk criteria of aggressive behaviour. The patient may also feel that he/she has no autonomy of their care or they do not know or understand the diagnostic testing that may be taking place. This, in turn, may cause the patient to want to "fight back". (McClelland, Humphreys, Conlon & Hillis 2001, 42-49.)

Some departments of the hospital like, the Accident and Emergency (A&E), and clinics may have some features like: long waiting time, noise, limited privacy and increased activity which can be irritating to the patient making them be more at risk of snapping out and acting out in aggression. (Wand and Coulson 2006.) In surgical wards, nurses may experience aggressive behaviour as procedures are sometimes delayed and later cancelled. Patients are kept fasting and waiting for many hours, only to be informed later of the cancelation. (Whelan 2008.)

Nurses may encounter aggressive patients during any time of the day. It is however also true that nurses are frequently faced with aggressive patients during evening and night shifts. This is because the number of nurses is reduced during these shifts. Patients may have to wait to be attended to by the nurses and may feel as though they are being ignored. This may lead to a

conflict between the patient and the nurse. (Lehestö, Koivunen, & Jaakkola, 2004, 87).

The situational factors are not necessarily all related to the hospital setting. The frame of mind of the client at the time of interaction with medical staff is important. The events of the day, stress, sensory overload, emotional baggage, language barriers, intercultural miscommunications, are factors that can increase frustration, irritation and anxiousness. (Ozolins & Hjelm 2003.)

3.4 Causes

3.4.1 Mental health

Different types of mental health problems have been linked to aggression and violence often in literature. Ferns (2007) identifies clinical variables that link patients with violent behaviour as including: hallucinations, delusions, agitation, anxiety, confusion, anti-social behaviour, and impulsivity. The nature of the hallucinations or delusions is of great importance in understanding the reasoning behind the aggression. Delusions of persecution, for example, can make patients act in self-defence for self-preservation. Similarly hallucinations that command the patient to do harm to others are significant risk factors for violence. (Ferns 2007, 38.)

3.4.2 Physical health

Aggression in the hospital setting can be triggered by a number of illnesses. Nurses should be aware that patients that are diagnosed with the physical conditions showed in Table 1 may have a predisposition for behaving aggressively.

Physical factors that predispose patients to behave aggressively	
▪ **Brain trauma, Cerebra vascular accidents**	Turnbull & Paterson (1999) have said that, “aggression is a well known consequence of brain injury. However; reasons for this are complex and not well understood.”
▪ **Hypoxia**	Hypoxia hinders the development and function of the hippocampus. The hippocampus is part of the limbic system, which has a role in aggression regulation. (Liu & Wuerker, 2005.)
▪ **Metabolic disorders**	Diabetic patients who are having hypoglycaemia, often are confused and are ”combative”. They may have misjudgements hence behaving violently. (Smeltzer & Bare 2004, 1179.)
▪ **Endocrine disorders**	According to Smeltzer & Bare (2004) untreated hyperthyroidism may cause a patient to be disoriented and aggressive.
▪ **Epilepsy, Seizures**	A condition known as postictal aggression is seen in patients 5-30 min after an epileptic attack (seizure). During this period, the patient is in a state of confusion and maybe physically and verbally aggressive. (Ito et al 2007.)
▪ **Dementia**	Dementia affects the cognitive behaviour of an individual but more so, the non-cognitive behavioural symptoms caused by dementia cause the individual to be in distress and aggressive (Dettmore, Kolanowski & Boustani 2009).

▪ **Infections**	Infections like urinary tract infections, pneumonia and tuberculosis are known to cause confusion to old persons. This may in turn cause them to behave aggressively. (Smeltzer & Bare 2004, 1313, 535, 528.)
▪ **Pain**	Patients having chronic pain have reported having feelings of anger. This feeling of anger in turn increases pain. This is why patients who have chronic pain may have aggressive tendencies. (Greenwood et al. 2005.)
▪ **Insomnia**	Although people that suffer from primary insomnia are more likely to internalize than externalize problems (Baglioni, Spiegelhalder, Lombardo & Riemann 2010); there is a clear correlation between the lack of sleep and aggression (Ireland & Culpin 2006).

Table 1. Physical factors that may cause aggressive behaviour
(Adapted from Ferns & He 2007, 196)

3.4.3 Alcohol and drugs

The relationship between alcohol and aggression or violence has been proven to be a fact by scientists and researchers. This is because alcohol diminishes brain mechanisms that control impulsive behaviour. (Saatcioglu & Erim 2009.) Alcohol also reduces the thought patterns of an individual, which in turn may lead to misperceived social clues, and overreaction to perceived threats. (Ferns & He, 2005.) The aggressive behaviour of an alcohol user is usually revealed when the person is under the influence of alcohol or if the individual is suffering

from alcohol withdrawal or alcohol delirium. (Saatcioglu & Erim 2009.) Alcohol delirium and withdrawal may happen 7-48 hours after heavy drinking (Kipping 2007, 486).

Researchers have not found a correlation between tobacco use and aggression. This is because nicotine increases enjoyment and relaxation. On the other hand, nicotine withdrawal may lead to mood disturbances and irritability, hence increasing the chances of a patient being aggressive. (Bole & Miotto 2003.)

Like tobacco, there is no link between the use of opioids and aggression or violence. However, when an individual is going through withdrawal, the user tends to have amplified aggressive and defensive responses. (Boles & Miotto 2003.) In hospitals and clinics, opiod users going through withdrawal may become aggressive towards the nurses in order to have a dose of an opiate (Kipping 2007, 488). Withdrawal begins in 8-12 hours after the last dose. Withdrawal from opioids can be painful enough to make the user use violent means to alleviate the pain. (Boles & Miotto 2003.)

Sedatives are drugs that are used to alleviate symptoms of insomnia and anxiety. However, Boles and Miotto (2003) say that the drugs may cause an individual to lose inhibitions. When sedatives are used in high doses they cause a user to have “paradoxical effects”. These effects are characterized by aggression and violent behaviours (Kipping 2007, 490). Sedative intoxication has similar effects to those of alcohol intoxication. It may lead to mood fluctuations causing the patient to become irritable and anxious. Like alcohol intoxication the patient may have poor judgment, therefore increasing the risk of aggressive behaviour (Boles & Miotto 2003.)

Marijuana is the most used illicit drug in the world. When it is used in small amount, it depresses activity and inhibits aggressive behaviour. On the other hand, when marijuana is used in high doses it is extremely dangerous as the

user may exhibit symptoms of euphoria, panic attack, paranoia, anxiety and psychosis. These symptoms make an individual be in the risk factor group of aggression and violence. (Boles & Miotto 2003.)

Unlike marijuana, which tends to depress activity in small doses, cocaine causes irritability, heightened state of arousal, excitement and physical aggression (Kipping 2007, 491). Cocaine has a great association with violence due to its rapid onset and offset of effects, which are said to bring out higher levels of irritability and aggression (Bole & Miotto 2003).

Individuals using amphetamines and methamphetamines may experience psychosis due to the blockage of serotonin reabsorption (Brotto & Lee 2007). Long term use of these drugs may lead to severe aggression, psychosis, insomnia, paranoia, frightening disillusions, impaired reality testing, hallucinations, disorientation, confusion, fear, and anxiety. With all this symptoms combined, an amphetamine user may pose a great risk to the nurses by becoming aggressive. (Bole & Miotto 2003; Brotto & Lee 2007.)

3.5 Warning signs

Warning signs of a person becoming aggressive or violent are not concrete and cannot be always interpreted as a sure sign of aggression. This is because human beings are individuals and react differently in different situations (NICE 2005, 18-19). This being said, it is of great importance for nurses to know the most common features that individuals may present prior to a violent act. Table 2 shows some of those features.

Verbal warning signs	Physical warning signs	Behavioural Warning signs	Emotional Warning signs	Other warning signs
Impolite language	Angry and tensed facial expression	Refusal to communicate	Irritation and discontentment	Refusal to follow instructions and orders
Swearing	Restlessness pacing and body tension	Poor concentration	Over exaggerated reactions to problem	Blocking escape routes
Threats and intimidating words	Threatening gestures	Slamming doors		Hallucinations of violence
Reports of angry feelings	Increased breathing	Prolonged eye contact		Behaviours similar to previous episodes of violence
Increased volume of speech	Muscle twitching			
Complaining	Dilated pupils			
Dissatisfaction	Clenched fists & jaws			

Table 2. Warning signs
(Adapted from Lehestö, Koivunen, Jaakkola 2004; Norman & Ryrie 2004; NICE 2005, 18-19; Sien & Brentin, 1997; Stuart & Laraia 2001, 642)

3.6 Consequences

The first consequence that comes to mind following a violent act is the physical damage inflicted to the victim. Depending on the particulars and severity of the assault it can mean physical trauma or psychological trauma or both. This, in turn, can lead to hospitalization of the victim followed by sick leave, therapy and even inability to work. The costs to society and the economy are difficult to calculate accurately. Staff replacement costs, treatment costs, and compensation claims are just a few examples. (Beech & Leather 2006.)

There is a vicious circle that is created as nurses become victims of violence, they tend to ignore their patients or spend less time with them. This makes the patients become dissatisfied with their care hence being at risk of becoming aggressive (Arnetz & Arnetz 2001). Aggression towards nurses has negative consequences to the victim, assailant and society (Irwin 2006). Table 3 gives examples of these consequences:

Victim	Aggressors	Institution
▪ Death ▪ Physical injury ▪ Increased levels of stress ▪ Anxiety and fear ▪ Depression ▪ Psychosomatic symptoms e.g. migraine, vomiting, nightmares ▪ Sexual disturbance ▪ Guilt, self blame, shame ▪ Anger and resentment ▪ Burn out ▪ Post traumatic stress disorder	▪ Impaired nurse - patient relationship ▪ Labelling ▪ Criminal record ▪ Use of physical and chemical restraints ▪ Remorse ▪ Psychiatric follow up ▪ Physical injury ▪ Prolonged stays in the hospital	▪ Staff replacement costs ▪ Treatment costs ▪ Compensation claims ▪ Low work morale ▪ Resignations

Table 3. Consequences of aggression
(Beech & Leather 2006; ICN 2007; Needham et al. 2005; Stubbs 2009; Arnetz & Arnetz 2001; Ferns & He 2005)

4 PREVENTION

There is an old English saying that states that "prevention is better than cure." This is also true in the case of aggression in the hospital settings. Preventing aggressive attacks is a combined effort from both the administration and personal effort from the individual i.e. nurse or student (Irwin 2006). One of the key preventative measures against aggression is the knowledge of known risk factors of violence and aggression (Sands 2007) as discussed in the chapters above.

4.1 Environment

The first step that can be taken towards the prevention of escalation of aggressive behaviour is familiarisation with the physical environment where the interaction takes place. This type of knowledge helps when in need of an escape route, or when you need to guide the restless client to a more secluded quiet area, or just because elements in the environment can be triggers for aggression. (Ferns 2007.)

The hospital environment is composed of many features that, when not properly controlled, may lead to patient irritability and the risk of aggression (Sookoo 2007, 733; NICE 2005.). Some of the features that should be taken into consideration are:

- Temperature - Healthcare facilities should have a central air-conditioning system which will control temperature and humidity. The nurse should also explain to the patients why windows cannot be opened in the health facility. (Dewit 2005.)
- Cleanliness - Nurses should ensure that the patient’s rooms are as clean as possible. Straightening and changing the bed linen on the patients bed when

necessary is of importance. The nurses should also empty the commode toilets to avoid foul smell in the rooms. (Dewit 2005.)

- Noise - The hospital should be a place of rest and rejuvenation. It is, however, a place where many activities happen and a lot of unwelcome noises are produced. Noise comes from pushed trolleys, neighbouring patients or from the healthcare staff. Dewit (2005) says that healthcare staff should avoid speaking with a loud voice in the corridors. Dewit continues to say that nurses should have the upper hand in controlling the noise in the patients' rooms by talking to the patient who may be having visitors till late, watching TV with the sound turned up after bed time.
- Space – The hospital environment should provide adequate space for both the patient and the care giver. This is because limited space may cause anxiety to the patient. In addition any unpredicted movement from the caregiver may result to an aggressive act in order to protect the personal space (Gates 2005).

The environment should allow patients to have some privacy (NICE 2005). This means that the nurse should knock before entering the room and there should be curtains between beds in rooms with multiple patients (Dewit 2005). Same sex patients should be put in the same rooms. In the NICE Guidelines (2005), the authors have suggested that there should be separate toilets and shower rooms for males and females.

Reducing boredom in the hospital environment can be achieved by providing access to TVs or magazines in the waiting rooms (NICE 2005). It has however been suggested by Sookoo (2007) that there should be a separate TV room. The noise from the television set may cause patients to become agitated or irritated. In long term facilities e.g. psychiatric hospitals, rehabilitation wards and geriatric facilities, well structured group activities should be set in place (Sookoo 2007).

In an event where the patient becomes aggressive or violent the nurse should immediately find help from other nurses and security personnel (Lehestö, Koivunen & Jakkola 2004). Every hospital setting should have 24 hours security personnel available. This means, whenever verbal de-escalation efforts by the nurse are not successful and the patient continues to be more aggressive, then the security officers should be available in due time. (Lau, Magarey & McCutcheon 2004). The hospital administration should also provide alarms for the nurses. These alarms should be portable and easy to use. Once the alarm button is pressed, it then alerts other nurses in the ward and also the security personnel. When needed, the police should also be contacted. (Lehestö, Koivunen & Jakkola 2004.)

4.2 Self awareness

Self awareness is a key part of nursing as one of the goals of nursing is to reach an authentic, open and personal communication with the patients (Stuart 2009, 14). Nurses should therefore be able to examine their personal feelings, actions and reactions and how they affect others in order to acquire emotional competence which will give rise to acceptance of patient's uniqueness and differences (Stuart & Laraia 2001, 16-17; Boyd 2005, 174).

Countertransference is a situation where the nurse's reactions towards a patient are unconsciously based on the nurse's needs, problems and world views. These reactions interfere with the nurse-patient relationship. (Boyd 2005, 914.) Negative countertransference may increase the chances of an aggressive event escalating further. This is because the nurse will not be separating his/her own needs from that of the patient. (Stuart & Laraia 2001, 644.)

5 DE-ESCALATION

A definition given by the Oxford dictionary describes de-escalation as “reducing the intensity of a situation” (Oxford dictionaries 2011). De-escalation is a concept best described as “talking somebody down” before they lose their temper. It can also be seen as a negotiation initiated by the person doing the de-escalating. The de-escalation process is composed of different techniques and skills that together aim for the same goal of defusing the crisis situation. They include elements of verbal behaviour like language content and tone of voice, and non-verbal behaviour like the use of gestures, posture and physical positioning in the environment. These elements are intertwined and should be used together as the nurse’s job means interaction with patients that are in the same physical space. (Cowin, Davies, Estall, Berlin, Fitzgerald & Hoot 2003, 65-66; Hodge & Marshall 2007, 64-65.)

5.1 Being assertive

Assertiveness is defined in the Oxford dictionaries as “confident and direct in claiming one's rights or putting forward one's views” (Oxford dictionaries 2011). Arnold & Boggs (1999) have described assertiveness as a behavior where one sets goals, acts on them in a clear and consistent manner taking responsibility for the consequences of his or her actions. Assertiveness can be misinterpreted for aggressive behavior. However, assertive people speak clearly and distinctively, they use “I” statements instead of “You” statements. ”I” statements show that the person is taking full responsibility of their feelings at the current situation. When “You” statements are used they may be interpreted as aggressive statements. (Sheldon 2009, 169; Arnold & Boggs 1999, 341.) When dealing with an aggressive patient the assertive nurse should use the DESC format as described by Sheldon (2009, 169):

Describe the situation "Correct me if I am wrong but you are saying you did not get..."
Express your feelings about the situation:"I feel that….."
Specify the change or action that you want: "I would like for you to…"
Consequences, identify the desire results: "In that way…."

It takes practice for a person to be able for a person to learn assertive skills. It is particularly difficult for students and newly graduated nurses as they may be unsure of themselves and their clinical knowledge. It is therefore of importance that a nurse has self awareness skills. (Sheldon 2009, 169.)

5.2 Respect

“Respect” derives from the Latin “respicere” (Purtilo & Haddad 2002, 4), that means, “to approach a person, group, idea, or object with regard or esteem”. Respect towards a person should be directed towards that person's dignity. Considering that the Latin word for “worth” is “dignitas”, the respect shown to another person becomes directed towards that person's inherent dignity, their basic worth. To put it simply, respecting another means “to look past positive or negative attributes to the very core of what makes the person human.” (Purtilo & Haddad 2002, 4.)

Although encountering a patient who is angry, help rejecting or verbally aggressive is bound to raise negative feelings in a nurse, showing disrespect is never justified. A good way of continuing to show respect is to initially attribute the aggressive or angry behaviour to some modifiable or treatable factor. In this way, the nurse can avoid immediately categorising this particular patient into a group of flawed character individuals that would make them prone to prejudice in the future. This approach also invites the nurse to try to find a resolve the problems or factors that may be involved in creating the anxiousness or aggressiveness. (Purtilo & Haddad 2002, 349.)

If the aggressive behaviour persists even after all outside factors have been explored, nurses should adopt “a deliberate, consistent approach … referred to as 'setting limits'” (Purtilo & Haddad 2002, 349). The setting of limits or boundaries should be part of a plan agreed upon by the whole health care team in order to maintain consistency and help the patient strengthen inner control. (Purtilo & Haddad 2002, 349.)

General guidelines for showing respect toward difficult patients:

1. Avoid the use of derogatory labels as means of reducing your frustration or anger.
2. Remember that the caring function is as important as other intervention.
3. Do not have unrealistic expectations of your own power as a health professional to force compliance.
4. Do not expect to change aspects of the patient's situation beyond your control.
5. Take care of your emotional well-being.
6. When interacting with an aggressive patient, “Assure that exit is possible for both you and the patient; Monitor your body language and tone of voice; avoid pointing your index finger or putting your hands on your hips in a threatening stance; Avoid sarcasm or loudness.”
7. Recognize your limitations.

(Adapted from Purtilo & Haddad’s 2002 Health Professional and Patient Interaction p. 350.)

5.3 Communication

Communicating with hostile aggressive persons requires some special skills and self restraint. Without self restraint it easy to fall in the trap that is direct verbal assault, and react by agreeing to the aggressors’ demands (Procter 2011). It is important to be able to stand up to these people without fighting so

as to avoid further escalating the conflict. In order to get the other person's attention, one must interrupt them in a friendly but firm manner, and try to start a problem solving discussion. This could be achieved "by a comment such as: 'I can see this is important to you. I want to discuss this with you but not like this'" (Marriner Tomey 2009, 19). In this way the nurse can give the patient a chance to regain self-control without putting him down or showing disrespect. (Marriner Tomey 2009, 19.) It is also important for the nurse to communicate with the patient like an adult. Cork and Ferns (2008) suggest using words like: how, when, what, decide, alternative; as effective ways of trying to understand the patients' frustrations and allowing them to feel as though one is genuinely interested in what they are going through.

5.3.1 Non-verbal communication

Matti Kaarne (2010) of MAPA (Management of Actual or Potential Aggression) says that, non-verbal communication plays a major role during the de-escalation process. He also affirms that what the patient assimilates from the interaction is only 7% words while gestures, facial expression and posture up to 55%, tone of voice and clarity of speech 38%. Delbel (2003) adds that as the patient becomes agitated they pay less attention to what you say and more attention to your body language.

When a patient is agitated and is becoming aggressive, they normally shout and use profanities. At this stage the nurse should speak using a clear voice, use short and simple sentences and speak in a soft low tone (Sien & Brentin 1997). If the nurse is to react back and shout as the patient is, this may be perceived as though the nurse is aggressive and may escalate the patient further (Stuart & Laraia 2001, 644-645). The nurse should be aware of his/her own reactions and use self restraint. This means that even if the nurse may feel fear or anger, he/she should appear calm, self controlled and confident. (Procter 2011; Sookoo 2009, 714-715.) Smiling and laughing should be avoided as these may

be interpreted as though the nurse does not take the situation seriously (Stuart & Laraia 2001, 644-645).

The nurse should try and maintain an adequate distance from the patient. Standing too close may be interpreted as a threatening gesture (Sookoo 2009, 714-715). Aggressive patients are noted to need four times more personal space than non-aggressive persons. If the normal personal space is about one mete,r then the personal space with an aggressive person should be around 3,5-4 meters. (Stuart & Laraia 2001, 646; Sheldon 2009, 90-91.)

The nurse should stand at an angle with the patient to avoid looking confrontational. He/she should not touch or point at the patient, should move slowly and with an obvious purpose, otherwise motives maybe misinterpreted. The aggressive patient takes the nurse as a threat and any misinterpretations may lead to a violent act (Sien & Brentin 1997).

The nurse should maintain natural eye contact with the patient. However, he/she should avoid staring at the patient as this may seem confrontational. At the same time avoiding eye contact may seem dismissive. (Austen 2005; Sookoo 2009, 714-715.) Different cultural values should be taken into consideration as in some cultures, direct eye contact is considered rude and inappropriate (Arnold & Boggs 1999, 201-202).

The nurse should be aware of his/her own body posture. The posture should be calm and relaxed. Hands should not be placed on the hips or folded on the chest as this suggests distance and unwillingness to help. The hands of the nurse should be free, with open palms and in a position where the patient can see them. (Stuart & Laraia 2001, 646; Kaarne 2010.)

5.3.2 Verbal communication

The aim of verbal communication is to move into the problem solving arena (Sookoo 2009, 715). The nurse should engage in a conversation with the patient acknowledging the concerns of the patient. By asking the patient to come to a more quiet area or to sit down, they will feel as though the nurse is concerned with what is disturbing them (Sookoo 2009, 715). The nurse should allow the patient time to speak their mind. By doing this, the nurse will get an idea of what is disturbing the patient and may find a solution to the problem. (Stuart & Laraia 2001, 646.) They should then continue on by using reflective listening. This could be achieved “by a comment such as: ‘I can see this is important to you.....” (Marriner Tomey 2009, 19.) The nurse should convey to the patient that they want to help them find a solution to their problem. However the nurse has to be realistic and not make promises that cannot be kept (Stuart & Laraia 2001, 646). Kaarne (2010) says that the nurse has to establish rapport and emphasize cooperation with the patient by using “we” statements meaning that the nurse is working with the patient (e.g: It is obvious we have a problem...). The nurse should strive to use open ended questions, listen to the answers carefully and show empathy towards the patient (Sookoo, S. 2009, 715).

6 POST INCIDENT ACTIONS

According to the NICE guidelines (2005) post incident actions are important as they serve as lessons for future reference. They offer support for the staff, reduce long term effects of aggression and encourage a continuity of the therapeutic relationship between the nurse and the patients. (NICE 2005.)

In the event where a patient has been aggressive, it is the nurses' duty to report what happened. The reporting is done in writing and verbally during the hand over report. (Lehestö, Koivunen & Jakkola 2004.) NICE guidelines (2005) recommend that reporting should be done within 72 hours of the incident. It is, however, unfortunate that most of the incidents of aggression go unreported because a majority of nurses think that it is part of their job and nothing much will be done about it anyway. (McClelland, Humphreys, Conlon & Hillis 2001.)

Kaarne (2010) suggests that speaking to a professional, like occupational health nurse or counsellor about what has happened is helpful and recommended. With the help of the professional the debriefing process can begin (Stuart & Laraia 2001, 654).

The WHO (2002) recommends that debriefing should be made available for all the workers affected by violence. The session should include:

- The nurse sharing the personal experience – what happened.
- The councilor helping the victim to come to terms and understand what happened.
- Offering support and reassurance to the nurse.
- Offer recommendation for future help.

7 LAW

Finnish law does not contain any special regulations that would protect health care professionals that encounter violent events. In dealing with patients and potentially violent patients, nurses must adhere to the Finnish law. The documents that apply to this situation are: Act on the Status and Rights of Patients (Laki potilaan asemasta ja oikeuksista 785/1992); Mental Health Act (Mielenterveyslaki 1116/1990); Penal Code (Rikoslaki 39/1889); and the Act Concerning Healthcare Professionals (Laki terveydenhuollon ammattihenkilöistä 559/1994).

The Act on the Status and Rights of Patients (Laki potilaan asemasta ja oikeuksista 1992/785) protects the patient in that their care must be done with the best interest of the patient in mind, while not violating their human dignity and privacy and protecting their right to self-determination (§3 and §6). The Mental Health Act (Mielenterveyslaki 1116/1990) does support the use of coercive measures when the patient's safety or the safety of others is at risk or when necessary for treatment (§28). The same act states that dangerous patients should be treated in the state psychiatric hospitals where there are specialised staff and specific regulations.

The only act that comes in the defence of a victim of violence is the Penal Code that gives the victim the right to defend themselves, other people and property against an ongoing and threatening attack (Rikoslaki 39/1889, 3: §6 and §7). The Act Concerning Healthcare Professionals (Laki terveydenhuollon ammattihenkilöistä 559/1994) aims to regulate the quality of care and to promote patient safety.

Although some nurses might choose to deny or take some lighter aggressive acts as part of their job, there are some cases that result in legal action:
- assaults: simple assaults, assault, aggravated assault

- illegal threats (threatening with a gun or verbal threat; Rikoslaki 25, §7)
- vandalism (intentional damage to property; Rikoslaki 35)
- invasion of a public office (Rikoslaki 24, §3 and §4)
- criminal disturbance (noise offence, disturbance of peace in a public office, harassing telephone calls; Rikoslaki 17, §13).

8 METHODOLOGY

8.1 Functional thesis

A functional thesis is one type of thesis allowed by universities of applied sciences. It differs from other types of thesis in that it is not based on research questions or research problems. Its goal is to produce a final product that is useful in the professional context of the subject. The product can be a leaflet, booklet, web-page or even an event. (Vilkka & Airaksinen 2003, 9-10.) This thesis concentrates on producing an educational booklet.

The functional thesis report has support from a well researched theoretical basis and is also greatly influenced by the author's own educational background and professional skills (Vilkka & Airaksinen 2003, 16-17). The report contains a description of planning the project, the gathering of data, the writing process, and of the production of the booklet.

8.2. Producing quality printed educational material

Printed educational material should include well organized information i.e.: short descriptive titles and subheadings, ideas separated in paragraphs, and complex instructions divided into small steps. The language used should be easy to understand and appropriate for the reading audience. Appearance factors should also be considered by allowing enough white space, using a clear font with appropriate size, and by including well labelled graphics and diagrams that increase the visual appeal. (DeYoung 2009, 61-62; Vilkka & Airaksinen 2003, 65.)

8.3 Implementation

The topic of this functional thesis stems from the authors' perceived need for an educational module or course that would better prepare first year nursing students for their first contact with the clinical environment, and the possibility of meeting an aggressive patient. Both authors had personal experiences and heard other nursing students' stories that supported this lack of preparedness when meeting aggressive clients.

The process started with an initial research period in which the authors familiarised themselves with the topics of aggression, violence in the clinical environment, violence towards nurses and its prevalence, violence towards nursing students, educational programmes on aggression for nursing students, and de-escalation. Finding that aggression towards nurses has a very high prevalence, and that student nurses are at even a greater risk of being the victims of aggressive acts, the authors focused their research on a way that would reduce this risk. The solution found was to produce a booklet that would include information about the risks, the nature of aggression and ways of dealing with it.

Aggression and the ways of dealing with aggressive people are discussed at length in psychiatric journals. In an attempt to focus their research further, the authors decided to look at methods of responding to aggression that do not require lengthy studies in psychology or rely on physical force intervention or pharmacological restraints. The idea was that if the student is able to prevent or stall the aggressive patient from escalating the crisis, the consequences of a violent act would be avoided. Thus, the term de-escalation aroused the authors' interest and became the main concern of the research.

The research for theoretical support for the written report was done using relevant internet journal databases such as EBSCOhost and Sciencedirect, and by using books from the libraries of Tampere University of Applied Sciences

and the University of Tampere. The articles included were selected by their relevance to the topic, date of publication and language used. The initial inclusion criteria were limiting the journals to being relevant to the general clinical environment not just psychiatric clinical environment; year of publication no older than 10 years; and their being written in English language. During a year of research, the authors did find and include articles that were outside of these criteria. The reason for this is that the initial inclusion plan did not bring out enough information. Both authors have considered and agreed upon the inclusion of articles and books that were older than 10 years but still maintained relevance in the present time. Also, articles that were specialised in a specific limited area were used if they proved to have application to the general topic.

Writing the report was an ongoing process that happened concomitant with researching. The text is abundant with references to scientific works that support the validity of the report. The table of contents of the booklet was decided in the planning stage of the project, but the actual information included was chosen at the end of the research process.

9 DISCUSSION

9.1 Conclusion

This thesis has explored meeting an aggressive patient. It started from the thought that student nurses going to their first clinical practice are not well equipped to deal with meeting an aggressive patient. The idea was that by exploring aggression in the field of nursing care, and the way that it is being dealt with, the authors would find a set of skills or rules that could be compiled into an easy to read educational booklet. The proportions of the task became apparent as the project proceeded and the scarcity of materials related to de-escalation become evident. At the same time, this lack of well structured information on “what to do” strengthened the authors’ believe in the need and importance of this work.

The authors believe that this thesis achieved its goal of producing a booklet that contains the basic information that nursing students need to begin understanding aggression, and how they can have an impact on the de-escalation of a critical situation. This booklet can be used in all clinical learning environments and all fields of nursing.

9.2 Development ideas/Recommendations

The lack of education about aggression and de-escalation techniques in the first year of nursing studies is clear. It is the authors’ opinion that such a course should be developed and made available, if not in the main curricula of the nursing degree programme then at least as an optional course.

The authors recommend the research of the prevalence of aggressive acts aimed at nursing students during their clinical training periods. This research

may support the necessity of adding the subject of violence and its prevention in the schools curricula.

9.3 Ethical considerations

Dealing with an aggressive patient raises many ethical issues e.g.: nurses' use of power, labelling patients, taking revenge, wording of reporting, prejudice, etc (Thompson, I., Melia, K. & Boyd, K. 1996, 18). Most of these issues however appear after the aggressive event has happened. For this reason, the authors did not research them in depth. The whole spirit of this report and the booklet produced is that of upholding the nurses' professional behaviour and of the patients' rights.

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