

Attitudes of nurses and nurse managers towards violence risk assessment and management: A cross-sectional study in psychiatric inpatient settings

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Accessible Summary

What is known on the subject:

- Workplace violence is a significant challenge in psychiatric hospital care.
- Some existing practices of violence risk assessment and management are based on nurses' intuition and clinical experience instead of structured tools.

What the paper adds to existing knowledge:

- Nurses and nurse managers consider violence risk assessment and management their responsibility. Still, nurses and nurse managers have mixed attitudes towards the use of validated risk assessment tools.
- The attitudes towards service users' positive risk-taking in nurses and nurse managers vary, with some nurses and nurse managers supporting its importance.

What are the implications for practice:

- Change in nurses' and nurse managers' attitudes towards risk assessment tools is required before their implementation into practice.
- More profound change in practices towards recovery-oriented care is required also in risk assessment.

Abstract

Introduction: Workplace violence is a prevalent issue in psychiatric inpatient care. Prevention efforts require the identification of at-risk service users using validated violence risk assessment tools. The shift in violence prevention emphasises preventive measures and collaborative risk assessment together with service users. Nurses have a central role in this process. Therefore, their attitudes are crucial when implementing evidence-based methods.

Aim: To assess the attitudes of nurses and nurse managers towards violence risk assessment and management.

Method: A cross-sectional online survey in Finnish psychiatric inpatient care. Data analysis was conducted with statistical methods. The STROBE guideline was used in reporting.

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Results: Nurses ($n = 142$) valued risk assessment and felt that it was their responsibility. Attitudes towards service users' risk-taking as part of their recovery varied. Nurses had mixed attitudes regarding the effectiveness of risk assessment tools. Older participants and nurse managers had more positive attitudes towards risk assessment tools.

Discussion: The study findings highlight a feeling of responsibility of nurses towards violence risk assessment and at the same time their preference towards their own clinical judgement.

Implications for Practice: Understanding nurses' attitudes is crucial in training and implementation processes to address concerns, provide support and enhance positive attitudes.

KEYWORDS

attitude, psychiatric hospital, risk assessments, survey, violence

1 | INTRODUCTION

Workplace violence is a significant issue with a high prevalence in the health care sector; a systematic review estimated that physical workplace violence towards nurses in psychiatric inpatient care in the past year ranged from 2.3% to 58.4% (Jang et al., 2022). There are harmful consequences of workplace violence, including physical injuries (Renwick et al., 2016) and psychological distress (Itzhaki et al., 2018). Furthermore, exposure to workplace violence can increase turnover and burnout among nurses and reduce job satisfaction (Yeh et al., 2020). Violence and aggression stirs up fear among service users (Lantta et al., 2021), which has a negative impact on the ward climate (Lantta, Anttila, et al., 2016; Lantta, Kontio, et al., 2016). Prevention of workplace violence requires improving the ward's social climate (Dickens, Tabvuma, et al., 2020), physical environment, staff training, ensuring a sufficient number of experienced staff (Hallett et al., 2014) and identifying service users who are at risk of violence (Soliman et al., 2023) by utilising violence risk assessment screening tools (Anderson & Jenson, 2019) and by following appropriate management methods (O'Rourke et al., 2018).

The management of workplace violence in psychiatric inpatient care has shifted from coercive measures to more preventive approaches (Gaynes et al., 2017; Spencer et al., 2018). Successful violence management requires identifying service users who are at risk of violence (Hermanstynne & Mangurian, 2015). The National Institute of Care Excellence (NICE) calls for using an objective violence risk assessment in collaboration with the service users (NICE, 2015). Meta-analyses has demonstrated that objective violence risk assessment are significantly better at predicting violence and aggression than chance ($AUC > 0.50$) in psychiatric settings (Dickens, O'Shea, & Christensen, 2020; Ramesh et al., 2018). Nurses have a central role in identifying service users at risk of aggression using structured, validated violence risk assessment tools (Anderson & Jenson, 2019), such as the Brøset Violence Checklist (BVC, Almvik & Woods, 1999) and the Dynamic Appraisal of

Situational Aggression (DASA, Ogloff & Daffern, 2006). In modern psychiatric care, violence risk assessment and management should also support the recovery of service users by allowing positive risk-taking. (Felton et al., 2017; Higgins et al., 2015). Positive risk-taking embraces the idea that risk is not inherently negative, rather it has potential for opportunities and growth for the individual (Felton et al., 2017). This requires a change in the culture of psychiatric care to recognise that all risk need not, nor could be managed (Felton et al., 2017; Reddington, 2017). Instead, recovery-oriented violence risk assessment that service users' positive risk taking is important for their recovery (Higgins et al., 2016).

A survey of nurses working in psychiatric inpatient care in the United Kingdom found that nurses highly support violence risk assessment, they consider it their responsibility, and they believe that validated tools for risk assessment are effective. Even so, 36% of the nurses were undecided, and 19% agreed that unstructured clinical assessment is superior to validated tools (Downes et al., 2016). Further, Downes et al. (2016) reported that some nurses think that risk assessment tools and risk management methods can conflict with therapeutic relationships. However, studies have also shown that the formation of therapeutic relationships facilitates staff and service user collaboration in risk assessment (Ahmed et al., 2021).

Nurses' attitudes have a significant role in the implementation of new working methods, such as violence risk assessment and management tools. Attitudes can serve as either facilitators or barriers for successful implementation. Attitudes themselves influence and are influenced by the perceived usefulness of the new working method (Fishman et al., 2021). Attitudes have a mediating role between knowledge and implementation, meaning that nurses with limited knowledge may hold less positive attitudes towards implementation, and vice versa (Alqahtani et al., 2020; Brathovde, 2021). For example, a study focusing on implementation of technology in psychiatric inpatient care identified that health care professionals' negative attitudes towards technology hindered implementation (Golz et al., 2022). Implementation can

be facilitated if those who use the new method are convinced of the benefits (Cowie et al., 2020). Here, training and education are important in influencing nurses' attitudes towards the new method (Alqahtani et al., 2020, Brathovde, 2021). Successful implementation requires that nurses' attitudes are addressed (Morténus et al., 2012) by considering their concerns and by providing support and training (De Beuf, 2023). However, not only should the nurses' attitudes be considered, conflicting or negative attitudes from management can act as a barrier for implementation (De Beuf et al., 2020; Lantta et al., 2015).

This study is a part of a larger research and quality improvement project where the eDASA+APP (Electronic Application of the Dynamic Appraisal of Situational Aggression with an embedded Aggression Prevention Protocol) (Griffith et al., 2021; Maguire et al., 2019) has been modified to suit the Finnish context, integrated into an electronic health care record and implemented in an psychiatric inpatient care setting. The eDASA+APP is an electronic support system for clinical decision-making (Maguire et al., 2022) and comprises DASA, a structured risk assessment tool used to estimate the risk of aggression (low, moderate and high) for 24h, and APP, which recommends evidence-based, non-coercive nursing interventions based on the DASA risk levels (Maguire et al., 2019). Existing evidence shows that the use of the eDASA+APP can reduce both workplace violence and the use of restrictive interventions (Griffith et al., 2021; Maguire et al., 2019). We aimed to facilitate successful implementation of the eDASA+APP model by recognising the attitudes that nurses hold and influencing these in training and during the implementation process.

1.1 | Aim

This study aimed to assess the attitudes that nurses and nurse managers working in psychiatric inpatient care had towards violence risk assessment and management prior to the training and implementation of the eDASA+APP model.

2 | METHODS

2.1 | Design

The study used a cross-sectional survey design where the attitudes of nurses and nurse managers were studied. The study reporting followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guideline (von Elm et al., 2007).

2.2 | Study setting and participants

The study setting was one hospital system with multiple psychiatric hospitals in Southern Finland with a catchment area of 1.7 million inhabitants. A total of 26 adult psychiatric inpatient wards from eight

hospitals, with a nursing workforce of approximately 600, were included in the study. All nurses that met the inclusion criteria working on the wards were recruited for the study using convenience sampling based on availability (Stratton, 2021). The inclusion criteria for the participants were that they were nurses or nurse managers. Nurses in Finland are either registered nurses with a bachelor's degree (210 European Credit Transfer and Accumulation System [ECTS]) from a university of applied sciences (Finnish Nurses Association 2023) or practical nurses who have a vocational education of 180 competence points (Finnish National Agency of Education 2017). Nurse managers in Finland typically have completed a master's degree (90 ECTS) programme at a university of applied sciences or a master's degree (180 ECTS) in a scientific field at a university. Further, participants were eligible if they were employed permanently or had at least a 3-month contract. Students and short-term substitutes were excluded.

2.3 | Data collection

For this study, the data were collected with an online survey between 13 February and 3 March 2023 using REDCap electronic data capture tools hosted at the University of Turku. REDCap is secure web-based software for data collection in research studies (Harris et al., 2019). Nurse managers were recruited as contact persons to the study, because they had access to the contact information of the potential participants. They participated in an online information session prior to the data collection. The survey link was sent to the eligible participants via email by contact persons. Nurses were contacted through their work email, and they were supported to participate during their working hours. Two reminder emails were sent during the data collection. In addition, the questionnaire was piloted using a paper format on four wards (May to June 2022). The results of the pilot survey were included in the sample as no changes were made to the survey after the pilot.

We collected background information from the participants (age, gender, nursing role, hospital of employment, number of years in current work position and number of years working in mental health care) to understand their demographics and to explore if the attitudes had an association with these variables. The attitudes of the nurses were evaluated using a pre-existing tool called 'Mental health nurses' attitudes towards risk assessment, risk assessment tools and positive risk' (Downes et al., 2016). This instrument includes 13 attitudinal statements related to risk assessment, responsibilities and risk management, and is measured on a 5-point Likert scale (strongly agree, agree, undecided, disagree and strongly disagree). The appropriateness and relevance of the items have been assessed by mental health clinical specialists in the United Kingdom (Downes et al., 2016). The internal consistency of the instrument in our data was between .44 and .63. The instrument was back-translated into Finnish with permission from the developers. No modifications were made to the instrument in the translation process. The study participants were asked to focus specifically on violence risk assessment tools.

2.4 | Data analysis

The data were analysed using IBM SPSS Statistics (version 27). Data completeness was checked. From respondents who completed the survey ($n=112$), 4.5% ($n=5$) had missing data. One respondent had missing data in 8 out of 13 items (62%) in the mental health nurses' attitudes towards risk assessment, risk assessment tools and positive risk instrument and was excluded. The rest ($n=4$, 3.6%) had only one missing item each. These values ($n=4$) were substituted with a mean value. Sample characteristics are presented with descriptive statistics (percentage, frequency, median and interquartile range). The attitudinal statements are presented in three groups ('role responsibility and support for risk assessment and safety practices', 'recovery and risk taking' and 'risk assessment tools') according to the subdimensions of the Downes et al. (2016) tool. Statements that were positively worded were reverse coded to allow for sum variables.

Normality of the variables were checked using Shapiro–Wilk test, suggesting there were no violation of the assumption of normality ($p \leq .05$). The association between participants' age, experience in their current position and experience in mental health care and the grouped attitudinal statements were analysed using Pearson correlation. The age of the participants was categorised into 'younger participants' aged between 18 and 35 years based on the commonly used definition of young adults (Unick et al., 2017), and 'older participants' aged between 36 and 65+ years of age. Experience in mental health care, and experience in the current work position were categorised into two groups, one being experience of 0–10 years and the other being experience over 10 years. The cut-off of 10 years work experience was defined based on a previous study which defines early career nurses as those who have work experience of less than 10 years (Nagai et al., 2022). *T*-test was used to analyse the binary groups age, work experience in the current position and work experience in mental health care. We analysed gender as a binary variable with the attitudes tool using *T*-test, excluding three respondents who had selected other than male or female as gender. ANOVA was used to analyse the participants' current role with the grouped attitudinal statements. In the participants' current role, assistant nurse managers and nurse managers were combined, as they both represented nurses in managerial positions. We conducted a standard multiple linear regression modelling to examine whether, and how much each explanatory variables were associated with attitudes towards risk assessment. The explanatory variables used were age, experience in current position, experience in mental health care and current role. Dummy variables were used to represent the subgroups of the current role (practical nurse, registered nurse and nurse manager) using nurse manager as reference category. The level of significance was set at $p \leq .05$.

2.5 | Ethical considerations

The study received ethical approval from the HUS Regional Committee on Medical Research Ethics (S 203/2021). The research permit was acquired from the study organisation. The voluntariness

of participation was emphasised. All study participants were provided with detailed information regarding the study, their role, their rights and how the data was processed and stored so that they could make an informed decision on whether to participate in the study. Participants provided informed consent before the survey by clicking a tab 'I consent'. Participation in the study was anonymous as no direct personal information was gathered. The study results are reported so that individual participants cannot be identified.

3 | RESULTS

The total sample size was 142 participants. The response rate was 24%. Out of the respondents, 112 completed the whole survey. The most of the study participants were female (57.0%, $n=81$). The mean age of the participants was 42.7 years (SD 12.4). The majority of the participants were either registered nurses (46.5%, $n=66$) or practical nurses (32.4%, $n=46$). Nurses mean work experience in mental health care was 13.4 years (SD 10.8) and 7.2 years (SD 8.6) in their current work position. The participants' characteristics are described in Table 1.

3.1 | Role responsibility and support for risk assessment and safety practices

Almost all (92.9%, $n=104$) of the participants strongly disagreed/disagreed with the statement 'risk assessment is not my responsibility'. Around a quarter (24.1%, $n=27$) strongly agreed/agreed that risk assessment is the doctor's responsibility. Nearly all participants (99.1%, $n=111$) strongly disagreed/disagreed with the statement saying that developing a risk management plan is a waste of resources. Most respondents thought that it is possible to predict who is at risk as they strongly disagreed/disagreed with the statement 'There is no way of predicting who is at risk' ($n=106$, 95.5%). They also did not agree with the statement that risk assessment

TABLE 1 Participants' characteristics.

Characteristic	<i>n</i> / <i>m</i> (% , SD)
Gender ($n=130$)	
Female	81 (57.0%)
Male	42 (29.6%)
Other	5 (3.5%)
Prefer not to say	2 (1.4%)
Age ($n=130$)	42.7 (12.4)
Current role ($n=131$)	
Practical nurse	46 (32.4%)
Registered nurse	66 (46.5%)
Assistant nurse manager	10 (7.0%)
Nurse manager	9 (6.3%)
Experience in current position, years ($n=129$)	7.2 (8.6)
Experience in mental health care, years ($n=129$)	13.4 (10.8)

and management is done to protect the services from legal action (strongly disagreed/disagreed, $n=101$, 90.9%). None of the participants' characteristics were associated with their attitudes towards role responsibility and support for risk assessment and safety practices (Table 2). In the multiple linear regression model (Table 3), age, experience in current position, experience in mental health care and current role were associated with 4.3% ($R^2=.043$, $F_{(5)}=.94$, $p=.46$) attitudes towards role responsibility and support for risk assessment and safety practices.

3.2 | Recovery and risk taking

There was variance in nurses' attitudes towards risk taking as part of the recovery process. Around one-fifth (18%, $n=20$) strongly agreed/agreed, one-third were undecided (31.5%, $n=35$) and around half (50.4%, $n=56$) strongly disagreed/disagreed that service users are entitled to take informed risks. Around half of the participants ($n=63$, 56.8%) disagreed, around one-fifth ($n=25$, 22.5%) strongly disagreed and 18.9% ($n=21$) were undecided regarding the statement 'The emphasis on risk reinforces risk aversion'. Over one-third of the participants ($n=41$, 36.9%) were undecided on whether 'Creative risk taking is vital for people's recovery'. Only two participants (1.8%) strongly agreed and 18.9% ($n=21$) agreed with the statement. Almost half ($n=47$, 42.3%) strongly disagreed/disagreed with the statement. Participants who were over 35 years old had more positive attitudes ($M=11.23$, $n=75$) regarding recovery and risk taking than younger participants ($M=10.14$, $n=35$), $t(108)=2.55$, $p=.012$. The effect size Cohen's d was .522. In the multiple linear regression model (Table 3), age, experience in current position, experience in mental health care and current role were associated with 7.5% ($R^2=.075$, $F_{(5)}=1.7$, $p=.141$) attitudes towards recovery and risk taking.

3.3 | Risk assessment tools

Regarding validated risk assessment tools, almost half (41.4%, $n=46$) were undecided, 14.4% ($n=16$) strongly agreed/agreed and less than half (44.1%, $n=49$) strongly disagreed/disagreed that 'Validated risk assessment tools are not effective at identifying people at risk'. Most participants ($n=81$, 72.9%) did not consider risk assessment tools to be too mechanical or dehumanising, but around one-fourth ($n=26$, 23.4%) of the participants were undecided. While around half ($n=53$, 47.7%) of the participants disagreed that their own clinical assessment is a better predictor of risk than validated tools, 36% ($n=40$) were undecided, and 16.2% ($n=18$) did consider their clinical assessment to be a better predictor than validated risk assessment tools. Participants mostly ($n=94$, 84.7%) did not perceive the use of validated risk to block practitioners' engagement with the service users. Instead, they mostly ($n=93$, 83.8%) considered risk assessment tools to support their decisions. Participants over 35 years of age ($M=17.32$, $n=76$) had more positive attitudes

towards risk assessment tools than younger participants ($M=15.89$, $n=35$, $t(108)=3.062$, $p=.003$), with an effect size Cohen's $d=.627$. There was a statistically significant difference in attitudes towards risk assessment tools in relation to the different roles of the participants, practical nurses ($M=16.37$, $n=35$), registered nurses ($M=16.76$, $n=61$) and nurse managers ($M=16.85$, $n=15$) were significant, $F_{(2,108)}=3.931$, $p=.022$. Post hoc Tukey HSD found that the attitudes towards risk assessment tools were significantly different between practical nurses and nurse managers ($p=.018$), and between registered nurses and nurse managers ($p=.05$) with an effect size $\eta^2=.068$. The overall findings are presented in Figure 1. In the multiple linear regression model (Table 3), age, experience in current position, experience in mental health care and current role were associated with 9.3% ($R^2=.093$, $F_{(5)}=3.26$, $p=.009$) attitudes towards risk assessment tools.

4 | DISCUSSION

This study aimed to assess the attitudes of nurses working in psychiatric inpatient care towards violence risk assessment and risk assessment tools. The findings of this study show that nurses have a strong sense that risk assessment is their responsibility. However, based on the results, we can argue that no significant change has happened over the years in nurses' attitudes towards structured violence risk assessment. A study conducted in the same hospital district around 10 years ago revealed negative attitudes towards structured methods and a preference for nurses' own unstructured violence risk assessment (Lantta et al., 2015). Nurses' preference of their own clinical judgement regarding risk assessment rely on their experience and intuition (Dickens et al., 2023). The role of intuition is often emphasised by nurses in clinical decision-making. Intuition can support the decision-making process when it is integrated into the use of objective assessments (Melin-Johansson et al., 2017).

There was discrepancy in the participants attitudes towards risk assessment tools. Almost half of the participants did not think their own clinical assessment is a better predictor of risk than validated tools. Yet, over half of the participants were undecided or agreed with that tools are not effective at identifying people at risk. One of the underlining issues might be a current practice gap, where risk assessment is not always integrated into practice, and where there has been limited guidance about what to do in situations where risk is identified (Maguire et al., 2022). This might have led to situations where the use of violence risk assessment tool has been just another form to fill out (Lantta et al., 2015) or where the assessment tool has not been used systematically (Lantta, Anttila, et al., 2016; Lantta, Kontio, et al., 2016). One solution to address these identified issues is the eDASA+APP (Maguire et al., 2019), which incorporates nursing interventions into the DASA risk assessment levels. This can provide more possibilities for genuinely integrating short-term violence risk assessment and management into clinical practice, and thus bringing more visible benefits to nursing work.

TABLE 2 Comparison between participants' characteristics and attitudes towards risk assessment.

Participant characteristics	Role responsibility and support for risk assessment and safety practices				Risk assessment tools				Recovery and risk taking				
	Mean	SD	t	p	Mean	SD	t	p	Mean	SD	t	p	Cohen's d
Gender													
Male	21.08	2.79	.662	.509	17.10	2.75	.872	.385	10.92	2.41	.161	.872	.032
Female	21.39	2.10			16.68	2.17			10.86	1.91			
Age													
18–35	21.23	2.49	.079	.937	15.89	2.06	3.062	.003*	10.14	2.20	2.55	.012*	.522
35+	21.27	2.28			17.32	2.37			11.23	2.02			
Experience in current position													
0–10years	21.32	2.26	.285	.776	16.62	2.35	1.792	.076	10.83	2.11	.447	.656	.097
10+ years	21.17	2.59			17.52	2.31			11.04	2.18			
Experience in mental health care													
–0–10years	21.06	2.35	.794	.429	16.60	2.32	1.102	.273	10.49	2.20	1.843	.068	.356
10+ years	21.42	2.37			17.10	2.41			11.24	2.01			
Current role													
Practical nurse	21.14	2.75	2.30	.041	16.37	2.24	3.93	.068	10.43	1.85	2.27	.040	.108
Registered nurse	21.06	2.13			16.76	2.36			10.92	2.25			
Nurse manager	21.28	1.89			16.85	2.19			11.80	1.94			

*P < .005.

TABLE 3 Regression coefficients associated with attitudes towards risk assessment.

Variable	B	SE	95% CI		p
			LL	UL	
Role responsibility and support for risk assessment and safety practices					
Age	-.01	.03	-.06	.04	.65
Experience in current position	.003	.04	-.07	.08	.93
Experience in mental health care	.008	.04	-.07	.08	.84
Practical nurse	-1.32	.77	-2.86	.22	.09
Registered nurse	-1.38	.75	-2.87	.11	.07
Intercept	22.33	.85	20.64	24.01	<.001
Risk assessment tools					
Age	.03	.03	-.02	.08	.17
Experience in current position	.07	.04	-.003	.14	.06
Experience in mental health care	-.03	.04	-.11	.04	.37
Practical nurse	-2.19	.74	-3.66	-.71	<.01
Registered nurse	-2.10	.72	-3.50	-.64	<.01
Intercept	18.62	.82	17	23.23	<.01
Recovery and risk taking					
Age	.02	.02	-.03	.07	.38
Experience in current position	.03	.03	-.05	.09	.54
Experience in mental health care	.21	.03	-.07	.07	.93
Practical nurse	-1.31	.69	-2.68	.06	.06
Registered nurse	-.87	.68	-2.30	.04	.15
Intercept	11.63	.78	10.13	13.13	<.001

Note: Age was centred at mean, age, experience in current position and experience in mental health care are continuous. Nurse manager was used as the reference category for current role.

We found that our model shows that there is a low association with the demographics and the variance in attitudes towards risk assessment. Further inquiry is needed to understand which factors are associated with nurses' attitudes towards risk assessment. This can be built on the synthesis and framework presented by (Dickens et al., 2023) of cognitive, emotional, personal and interpersonal attitudes towards risk assessment. In our study, there were a few factors in the demographics of the nurses that explain the variance in attitudes. Participants over 35 years old had significantly more positive attitudes towards risk assessment tools than younger participants, differing from the survey findings of Downes et al. (2016), where no difference was found between age and attitudes. We may wonder, then, why younger nurses with

latest education in our study did not prefer evidence-based assessment methods. Findings in previous research regarding how age is related to attitudes in this research area are mixed. A study conducted in Finnish psychiatric inpatient care found that nurses' attitudes towards aggression varies between individuals and is not related to age (Laiho et al., 2014). Recent systematic reviews have identified that in some studies older health care professionals have more negative attitudes towards the use of coercion (Husum et al., 2023) and that younger workers have more positive ones (Dickens et al., 2022), while other studies have not found any difference (Husum et al., 2023; Lee et al., 2021). Due to the conflicting findings regarding age, we can conclude that attitudes need to be addressed in all age groups. The attitudes towards risk assessment tools and coercive methods are important, as the more favourable attitudes towards risk assessment tools and less favourable attitudes towards coercive methods and aggression can be seen as a suitable building ground for implementing risk assessment tools and non-coercive management approaches.

We found that nurse managers have a more positive attitude towards the use of risk assessment tools than registered and practical nurses. This is a similar finding to a study conducted among UK nurses by Downes et al. (2016). One explanation for this may be that nurse managers often have a master's level education, which can result in more favourable attitudes towards the use of validated tools as part of evidence-based practice. Furthermore, based on existing qualitative work, nurse managers feel that it is their responsibility to provide good quality, evidence-based care in their units (Sjøløe et al., 2020), which can reflect to their attitudes towards the use of risk assessment tools. The finding is important for creating a change in clinical practice, as managers have a pivotal role in facilitating implementation (Clavijo-Chamorro et al., 2022; Laukka et al., 2020; Miech et al., 2018) and maintaining new working methods, or supporting the use of traditional practices. For example, a Finnish study found that nurse managers' attitudes towards seclusion do influence how much this coercive measure is used in practice (Laukkanen et al., 2021). Implementation process benefits when nurse managers, especially those with positive attitudes towards the target of implementation, are utilised as implementation champions (Miech et al., 2018). Yet, in current practice, nurse managers do not always facilitate implementation. A recent study found that less than half (39.8%) of nurses considered nurse managers to facilitate changing practice based on evidence (Lunden et al., 2020). This finding warrants more attention in the area of mental health nursing so that managers understand the value of evidence-based practice and devote time in their daily practice to promote the use of it, which might not be always the case in hectic acute environments.

Based on the findings, nurses' attitudes towards risk taking and recovery only partly coincide with the notions of positive risk taking as a fundamental part of service users' recovery (Felton et al., 2017; Higgins et al., 2015). The shift to more recovery-oriented violence risk assessment and management requires a change in nurses' views regarding recovery and risk. It means that services users are allowed

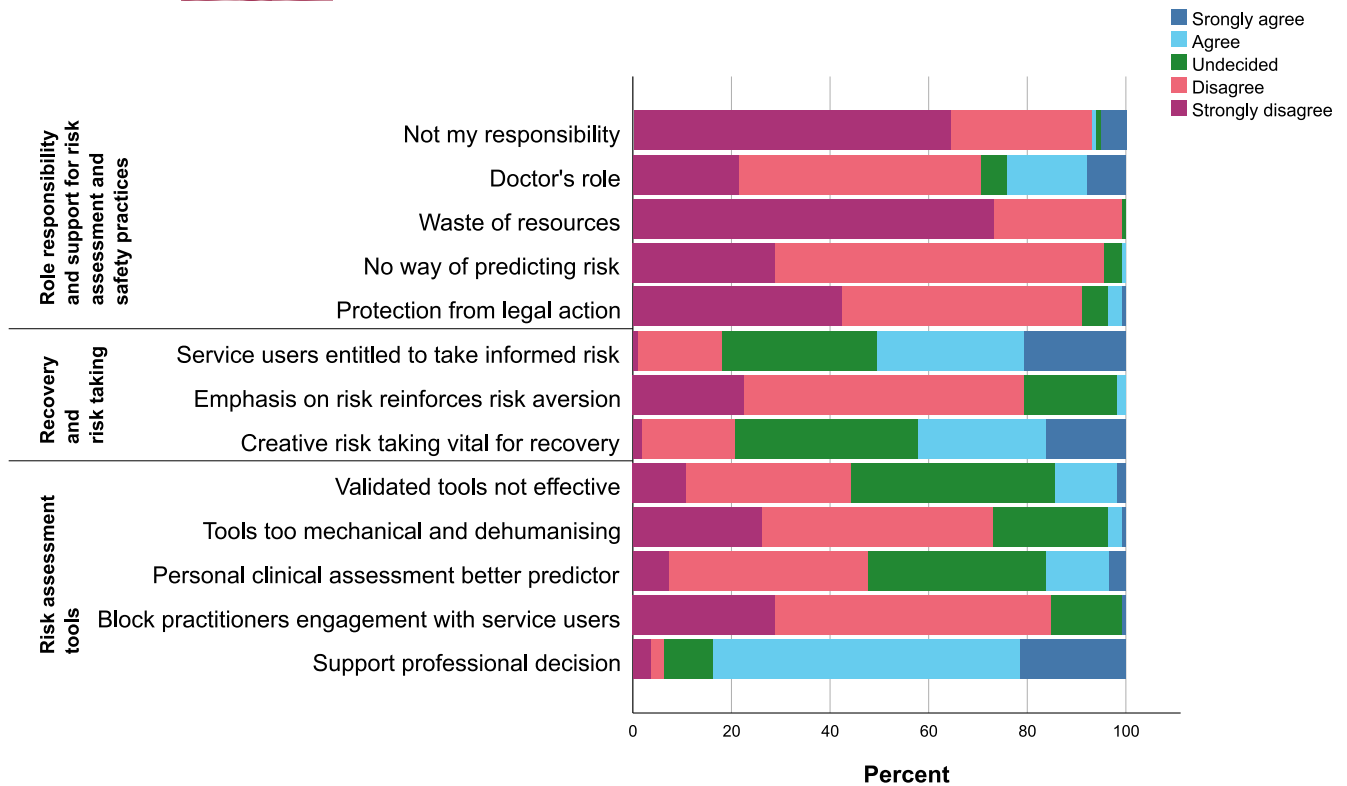


FIGURE 1 Attitudes towards risk assessment.

to take positive risks to facilitate their recovery journey (Higgins et al., 2016). Nurses are responsible for considering when there is a need to manage and prevent violence based on the risk assessment they have conducted (Muir-Cochrane et al., 2011). Furthermore, a shift is required in the organisational culture; nurses should be able to support positive risk taking without the fear of repercussions and blame (Just et al., 2021). A just culture, often emphasised in patient safety literature, where organisations do not focus on blame, but rather on restoration ('what went wrong and how to learn from it') (Dekker & Breakey, 2016) could be applicable in violence risk assessment and management.

As the survey presented in this paper is a starting point to create more positive attitudes towards short-term violence risk assessment, training nurses to use the eDASA+APP will need to involve a strong rationale for why validated tools are superior to unstructured judgement and why nurses are crucial in the process of identifying high-risk service users. We also acknowledge the great importance of nurse managers' attitudes towards implementing new working methods. As a novel approach, the eDASA+APP will be modified to the local context in workshops using co-creation. The workshops will involve relevant stakeholders (Skivington et al., 2021) such as end users of the eDASA+APP, service user experts by experience as well as persons responsible for health and safety at work. Furthermore, we have designed a short training module for nurse managers and champions to facilitate the implementation process. Time will tell if our attempts are changing attitudes, as the survey will be repeated at the end of the Finnish eDASA+APP project.

4.1 | Strengths and limitations

There are several strengths and limitations in this study. The psychometrics of the survey we used in this study by Downes et al. (2016) have not been previously published. According to our results, internal consistency was low on the three dimensions (Cronbach alpha .44, .61, .63). That indicates that the survey includes items that do not correlate well with each other. On the other hand, there are domains in the survey that nurses might have a differing opinion (e.g. risk-taking vs. validated tools), explaining weak internal consistency. Exploring the factor structure and internal validity could be the next step to developing the validity and reliability of the scale. The response rate is similar to those reported in other web surveys. Strategies used to improve the response rate included designing the survey to be quickly filled out and sending reminders (Sammut et al., 2021). There were missing data in 4.5% of the respondents who completed the survey, one was excluded having more than one item with missing value. We used mean imputation to the rest of the respondents ($n=4$, 3.6%) who had only one item with missing value according to recommendation by a statistician. This imputation may have resulted in bias. The sample included participants who represented only one area of Finland. Yet, they were from a large catchment area and from very different types of wards (e.g. psychogeriatric, psychosis, mood disorder and forensic mental). These wards provided treatment for diverse adult service user populations. The use of risk assessment tools was not standard practice in the study setting. However, risk assessment tools might have been used in some of the units, despite not being standard practice. This might have influenced the

respondents' attitudes regarding risk assessment tools. We can estimate that the results represent the situation in Finland well. The findings share similarities with those of Downes et al. (2016), meaning that despite organisational and cultural differences, nurses hold similar attitudes towards risk assessment, risk assessment tools and positive risk. Our sample also included nurse managers, which provide important information for the implementation of risk assessment and management tools. The findings might not be applicable to psychiatric inpatient care in different countries or organisations. Nevertheless, the findings provide important information on existing attitudes of nurses, which can be considered when implementing violence risk assessment and management protocols.

5 | CONCLUSIONS

The study revealed that most nurses acknowledged their role and responsibility in risk assessment, rejecting the notion that it is not their responsibility. They also recognised the importance of developing risk management plans and believed that it is possible to predict who is at risk. However, there was variability in attitudes towards risk taking in the recovery process, with some participants supporting the idea of service users taking informed risks and others disagreeing. Regarding risk assessment tools, there was uncertainty among participants about their effectiveness, but most did not view them as dehumanising or obstructive to practitioner–service user engagement. Notably, older participants and nurse managers exhibited more positive attitudes towards risk assessment tools compared to younger participants and practical nurses. These findings underscore the need for further exploration of attitudes and the development of comprehensive strategies to ensure implementation of effective risk assessment and safety practices in psychiatric inpatient care settings.

6 | IMPLICATIONS FOR PRACTICE

The study results provide insights into the attitudes of nurses regarding violence risk assessment and management in psychiatric inpatient care. Areas of agreement seem to be in nurses' role responsibility. Areas of improvement in attitudes to be considered when implementing violence risk assessment and management tools are nurses' views regarding the effectiveness of risk assessment tools, and recovery and risk taking. The findings can be used to inform discussions, training and policy development of implementing risk assessment tools in psychiatric inpatient settings.

7 | RELEVANCE STATEMENT

Nurses' attitudes towards violence risk assessment and management show that nurses regard it as their responsibility, but rely on intuition and clinical experience rather than structured tools. Attitudes

towards positive risk-taking show that recovery-oriented practices are not yet considered in violence risk assessment and management practices.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS APPROVAL STATEMENT

Ethics approval for this study was granted by the Ethics Committee of the HUS Hospital District (HUS/3421/2021).

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