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REVIEW ARTICLE

WILEY

A systematic review and thematic synthesis of inpatient nursing staff experiences of working with high-risk patient behaviours

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Abstract

Introduction: Nursing staff are frequently exposed to high-risk patient behaviours within inpatient health services, yet staff commonly report a lack of training and support in managing these behaviours.

Aim: The aim of the study was to examine nursing staff experiences of high-risk behaviours in inpatient mental health settings.

Methods: Four electronic databases (CINAHL, Medline, PsycINFO, EMBASE) were searched. The protocol for this review was prospectively registered in PROSPERO (Ref: CRD42022334739). A meta-synthesis of nursing staff's experiences of high-risk behaviours in inpatient mental health settings was conducted.

Results: We identified 30 eligible studies. Six themes were constructed from the meta-synthesis: the social contract of care; the function of risk behaviours; the expectation of risk; risk as a relational concept; navigating contradictions in care; the aftermath.

Discussion: Nursing staff conceptualize risk as a meaningful behaviour shaped by patient, staff and environmental factors. Managing risk is an ethical dilemma for nursing staff and they require more training and support in ethical risk decision-making.

Implications for Practice: Inpatient mental healthcare services should formulate and manage risk as a relational concept comprising staff, patient and environmental factors. Future research and clinical practice should place further consideration on the varied experiences of different types of risk behaviours.

Relevance Statement: Nursing staff are frequently exposed to high-risk patient behaviours within inpatient health services, yet staff commonly report a lack of training and support in managing these behaviours. This systematic review offers insights into how high-risk behaviours are experienced by nursing staff and makes recommendations about how to improve the understanding and management of them. Inpatient mental healthcare services should formulate and manage risk as a relational concept comprising staff, patient and environmental factors. Future research and clinical practice should place further consideration on the varied experiences of different types of risk behaviours.

KEYWORDS
aggression, psychiatric inpatient staff, self-harm, suicide, Systematic Literature Reviews

1 | INTRODUCTION

Inpatient psychiatric services provide assessment, treatment and care for individuals presenting with significant mental health needs and risk behaviours that require more intensive support than that which can be offered in community services (Royal College of Psychiatrists (RCP), 2017). Suicide, self-harm and aggression constitute high-risk behaviours associated with poor mental health (Haw et al., 2001; Singhal et al., 2014; Too et al., 2019), which serve as indicators for inpatient psychiatric admission (Ziegenbein et al., 2006). Despite one of the central purposes of inpatient mental health care being to mitigate these high-risk behaviours, they are still prevalent within these settings (Bowers et al., 2005; National Health Service (NHS), 2019).

A pooled estimate of suicide rates has been calculated as 147 per 100,000 inpatient years, which is far greater than suicide rates in the community (Walsh et al., 2015). A review by James et al. (2012) found the average percentage of patients who self-harm in inpatient services to be 17.4%. Those who self-harm are at an increased risk of suicide (Cooper et al., 2005). In the case of aggression, mental illness does not independently predict violent behaviour. However, a recent meta-analysis indicated the weighted mean prevalence of aggressive behaviours in inpatient settings is 54% and ranges between 7.5% and 75.9% (Weltens et al., 2021). Another review found 17% of patients perpetrated at least one aggressive behaviour during their psychiatric admission (Iozzino et al., 2015). However, it has been suggested that these rates are relatively low, given the diversity of patients' presentations and environmental stressors emerging from inpatient settings (Fletcher et al., 2021).

Among healthcare staff, inpatient nursing staff are most frequently exposed to aggression (Arnetz et al., 2015). Nijman et al. (2005) suggest that in 1 year, 84% of inpatient psychiatric nurses will witness mild self-harm, 57% severe self-harm and 68% a suicide attempt. As such, nurses play a fundamental role in managing these risks. This includes identifying warning signs, assessment and management and promoting the safety and recovery of patients (Bolster et al., 2015; Delaney et al., 2001; James et al., 2012). Restrictive practices such as compulsory medication and physical restraint may be used to safely manage risks (Doedens et al., 2020), but these practices can also harm patients, staff and negatively impact the ward environment (Marangos-Frost & Wells, 2000). The cumulative effect of experiencing and managing risk behaviours can worsen the psychological and physical health of nursing staff, which can ultimately lead to decreased job satisfaction, burnout, stress and symptoms meeting the criteria for post-traumatic stress disorder (Busch et al., 2020; Hilton et al., 2022; Langsrud et al., 2007) These effects can negatively impact the delivery of care and, consequently, patient safety (Jun et al., 2021). This is compounded by the issue that nursing staff consistently report a lack of training and resources in managing risk behaviours (Bolster et al., 2015; Hallett et al., 2014; Smith, 2002). Furthermore, Baby et al. (2014) have suggested that insufficient resources and increased workloads are resulting in nursing staff working in increasingly challenging environments. These circumstances highlight the importance of supporting staff with their well-being needs and continued professional development in this setting as set out in the NHS (2019) Long Term Plan.

Efforts in both research and practice have sought to reduce restrictive interventions and promote safety using holistic multidisciplinary approaches (Clark et al., 2017). 'Safewards' has become an increasingly utilized system-wide and psychosocially informed set of interventions designed to reduce restrictive practice and risk behaviours (Bowers, 2014). Yet high prevalence of restrictive practices continues and mitigating high-risk behaviours has presented as a serious challenge to healthcare professionals and researchers (Finch et al., 2022; Large et al., 2017; Timberlake

Accessible Summary

What is known on the subject?

- Nursing staff working in inpatient settings report being negatively impacted by high-risk behaviours, such as self-harm, suicide, violence and aggression, which can cause them to feel deskilled, stressed and burnt out.
- Nursing staff require more support to manage these behaviours, especially as they are becoming increasingly more common now that patients' needs in this setting are becoming more complex.

What the paper adds to existing knowledge?

- The paper has demonstrated that patient needs have become more complex and more detailed relational risk formulations are required to understand and manage risk.
- This paper demonstrates that staff find managing risk an ethical dilemma and that they require support in ethical decision-making through training and reflective practice.
- This study has also shown that risk is a relational experience combining staff, patient and environmental factors and should be formulated and managed as such.

What are the implications for practice?

- Inpatient care teams should formulate risk as a relational experience that is influenced by the patient, staff and environment and find management strategies that consider these different components.
- Staff also need support and training regarding ethical decision-making relating to risk, for example the dilemma of restricting someone's personal freedoms to keep them safe.

et al., 2020; Royal College of Psychiatrists (RCP), 2022; Weltens et al., 2021). Therefore, further research capturing the experiences of those involved in the occurrence of high-risk behaviours is urgently required to better understand why they happen and how to reduce the harm that they cause.

Much of the qualitative research exploring high-risk behaviours to date focuses on specific interventions of risk behaviours or their impact, and there is limited research capturing the variety of experiences nurses have during these incidents. A recent collection of qualitative systematic reviews on nurses' experiences of either patient suicide (Shao et al., 2021), self-harm (Clua-García et al., 2021; O'Connor & Glover, 2017) or aggression (Fletcher et al., 2021) in inpatient settings, all highlighted the negative psychological impact, insufficient training and support that staff experience. Given that nursing staff are likely to experience all of these high-risk behaviours within their practice, research is needed to develop a novel conceptual framework for how these experiences are collectively understood, which specifically explores how the various high-risk behaviours converge and diverge in their management as well as their impact on staff. To our knowledge, there does not exist a review synthesizing qualitative studies of nursing staff's experiences of working with high-risk patient behaviours to both self and others.

The aim of this review was to identify and synthesize evidence relating to nursing staff experiences of suicide, self-harm and aggression in inpatient mental health settings, explore the similarities and differences that exist between experiences and consider what recommendations can be made for nursing staffs' inpatient practice.

This review aimed to address the following research question:

What are nursing staff's experiences of working with high-risk patient behaviours in psychiatric inpatient settings?

2 | METHODS

The protocol for this review was registered in PROSPERO (Ref: CRD42022334739). We adhered to the guidelines outlined by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) throughout the review (Moher et al., 2015). The PRISMA checklist can be found in the Tables S1–S3.

2.1 | Search strategy

We searched the databases CINAHL, Medline (Ovid), PsycINFO (Ovid) and EMBASE (Ovid) on the 23rd May 2022 and had no restrictions on date. A combination of free text words and Medical Subject Headings (MeSH) terms specific to each database were developed relating to the following four key concepts: nursing staff, experiences, high-risk behaviours, qualitative research. An example of the search strategy can be found in the Tables S1–S3. Reference lists of eligible studies were manually searched to identify any further eligible studies.

2.2 | Study eligibility criteria

The inclusion criteria were developed using the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) framework for qualitative studies (Methley et al., 2014). Studies were included if they (a) examined nursing staffs' experiences of high-risk behaviours (self-harm, suicide, violence and aggression), the management of high-risk behaviours or the professional and personal impact of experiencing these behaviours within inpatient mental health settings; (b) were peer-reviewed studies using qualitative methodology (either focus groups or interviews); (c) included nursing staff (both qualified nurses and nursing/healthcare assistants) participants. Studies including different participants—such as other healthcare professionals, patients and carers—were eligible if nursing staff constituted >50% of the sample. Studies were excluded if they (a) explored interventions related to risk behaviours, rather than the experience of behaviours themselves; (b) used quantitative or mixed-methods; (c) were grey literature. Searches were restricted to English language and no date restrictions were applied.

2.3 | Data screening

We imported relevant studies identified from electronic database searches into Covidence and removed duplicates. We independently assessed the titles and abstracts against the inclusion criteria. Full texts of papers potentially meeting the inclusion criteria were retrieved and we established eligibility of the studies by reading the papers in full. At each stage of the data screening process, a second independent reviewer screened 25% of the studies and any disagreements regarding included and excluded studies were resolved through discussion. Reference lists of included papers were hand searched for any relevant papers that may have been missed. Data from included papers were extracted on to a pre-designed data extraction template with key characteristics.

2.4 | Quality appraisal

Included studies were assessed using the Critical Appraisal Skills Programme (2017) checklist for qualitative studies (see Table 1), which is the most frequently used tool for appraising qualitative research (Hannes & Macaitis, 2012). The CASP tool comprises of 10 questions with 'Yes', 'No' or 'Cannot Tell' responses. Following Lachal et al. (2017), answers were correspondingly written as 'Met', 'Partially Met' or 'Not met'. A second reviewer independently completed quality appraisal ratings for 25% of the included studies. Any discrepancies found were resolved through discussions between the reviewers. Given the threshold for exclusion is necessarily subjective (Dixon-Woods et al., 2007), no studies were excluded based on their quality. However, it was important to identify poor-quality research that may distort the review's findings and/or produce

TABLE 1 CASP checklist.

Criteria	Totally Met[a]	Partially Met[a]	Not Met[a]
1. Was there a clear statement of the aims of the research?	28	2	0
2. Is a qualitative methodology appropriate?	30	0	0
3. Was the research design appropriate to address the aims of the research?	29	1	0
4. Was the recruitment strategy appropriate to the aims of the research?	19	10	1
5. Was the data collected in a way that addressed the research issue?	27	2	1
6. Has the relationship between researcher and participants been adequately considered?	13	4	13
7. Have ethical issues been taken into consideration?	24	3	3
8. Was the data analysis sufficiently rigorous?	20	8	2
9. Is there a clear statement of findings?	27	13	0
10. How valuable is the research?	23	7	0

[a]Number of studies.

erroneous conclusions (Dixon-Woods et al., 2006). The quality of studies influenced the construction of themes, with the aim that lower-quality studies would have a smaller impact on the thematic synthesis. Following recommendations for quality appraisal by Carroll and Booth (2015), we evaluated the relative weighting that studies of varying quality contributed to the thematic synthesis by individually removing studies from the data, to evaluate their impact on the final construction of themes.

2.5 | Analysis

Data were analysed using the method outlined by Lachal et al. (2017) to synthesis qualitative research in psychiatry. Included studies were uploaded to NVivo 12 Pro (2018) for data analysis. Papers were read and re-read to facilitate familiarity and immersion with the data (Braun & Clarke, 2006). Studies were initially divided into papers referring to either self-harm, suicide or aggression. Data were extracted from the results/findings sections of included studies. Study characteristic data (the study aim, population sample and setting, method of data collection and analysis and a summary of the main findings) were extracted and summarized in a study characteristics table. All data referring to nurses' views or experiences were extracted, including direct quotes from the sample and authors' comments. All data were initially coded with descriptive themes according to their concept and risk behaviour. Coding of the different risk behaviours were then combined and organized into related areas, and inductive methodology was utilized to synthesize and develop a smaller set of descriptive themes representing the initial coding and findings of the original studies. Finally, suitable inferences were made by assessing how the constructed themes collectively related to the review's stated research questions. These were discussed with the research team to develop analytic themes, which aimed to construct generalizable overarching themes about nursing experiences that went beyond the qualitative data of individual studies, but which authentically captured individual nursing staff experiences (Thomas & Harden, 2008). This method of qualitative synthesis has two aims in psychiatric research: to enable a higher level of comprehension of a phenomenon and to answer clinical questions about pathology and care (Lachal et al., 2017).

2.6 | Reliability, validity and rigour

We used recommendations described by Morse. (2015) to achieve reliability, validity and rigour and followed best-practice guidance by Tong et al. (2012) in undertaking and reporting our review to minimize bias and increase rigour. Prolonged engagement was conducted by handwriting all coding into a large format spider diagram to identify the rich, quality data within the studies. Reflexivity was explored in the research team by systematically reflecting on our personal and professional experiences as healthcare professionals with significant experience working in inpatient mental health services, which influenced the construction of themes. This involved an explicit recognition that our preconceptions may impact our interpretation of the data (Brunero et al., 2015). To recognize and mitigate unwarranted personal influence in the analysis, we utilized Smith's (Smith et al., 2021) phenomenological perspective, which encouraged a focus on the meaning of experiences themselves within the text, rather than the theories or perspectives that we might ascribe to it. Discussion of analytical themes with the research team facilitated the triangulation of the analysis and transferability of the results (Morse., 2015). Important characteristics of included studies are presented in data extraction tables to enable the reader to draw their own conclusions about the quality of the studies and determine the validity of our analyses.

3 | RESULTS

3.1 | Study characteristics

A total of 1724 studies were retrieved from the searched databases, 1029 were imported into Covidence after de-duplication. One study was identified though hand searching of reference lists of retrieved papers. After titles and abstracts were screened, 769 studies were excluded. Two papers could not be retrieved. 260 studies were retrieved and read in full by the reviewers, and 230 were excluded, resulting in 30 studies for meta-synthesis (Figure 1).

Characteristics of included studies are shown in Tables S1–S3. Studies came from a range of countries in North America ($n=5$), Europe ($n=18$), Asia ($n=4$), Africa ($n=2$) and Oceania ($N=1$). Four studies explored self-harm, 11 explored suicide, 1 explored both self-harm and suicide and 14 explored aggression. Studies were published between 2003 and 2022. Various methodological approaches were used including thematic analysis, content analysis, framework analysis and phenomenological analysis. Eight studies did not state how their sample was obtained. One study did not include primary data.

The quality assessment is presented in Table 1. A full breakdown of the quality assessment can be found in the Tables S1–S3. Most studies met, or partially met, the majority of quality assessment criteria. Insufficient clarity on recruitment strategy, data analysis and lack of researcher reflexivity were the most frequently not met/partially met criteria. No studies were excluded bases on quality.

4 | META-SYNTHESIS

From our meta-synthesis of the data, we constructed six themes: the social contract of care; the function of risk behaviours; expectation of risk; risk as a relational concept; navigating contradictions in care; the aftermath (Table 2). These themes contained subthemes related to self-harm, suicide and aggression. Themes are illustrated by participants' quotes from the included studies.

4.1 | Theme 1: The social contract of care

The social contract within health care has been referred to as an agreement with society where both parties have obligations and expectations to each other (Cruess et al., 2008). Here, the social contract of care refers to the relationship between nursing staff and patients and

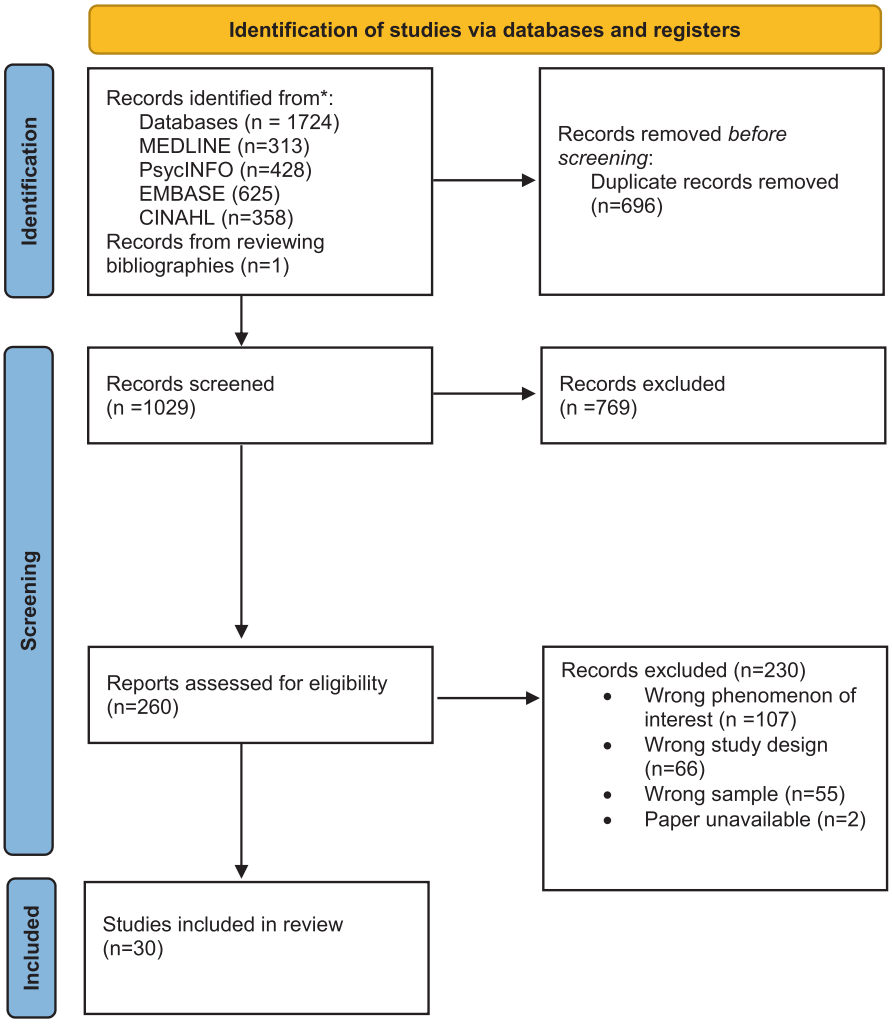

FIGURE 1 PRISMA diagram.

TABLE 2 Summary of themes.

Theme	Subtheme
1. The social contract of care	1.1 Collaboration of the contract 1.2 Freedom and responsibility
2. The function of risk behaviours	2.1 Function of aggression 2.2 Function of suicide and self-harm
3. Expectations of risk	
4. Risk as a relational concept	4.1 Environment 4.2 Tuning in 4.3 Staff characteristics
5. Navigating contradictions in care	5.1 Procedures 5.2 Education 5.3 Resources 5.4 Management
6. The aftermath	6.1 Emotional impact 6.2 Blame, guilt, and inadequacy 6.3 Debriefing 6.4 Burnout and stress

describes how their collaboration regarding patient autonomy and care planning can meet the needs of mental health care.

4.1.1 | Collaborations of the contract

Staff involved patients in their own care through collaboration and shared decision-making (O'Donovan, 2007; Vandewalle et al., 2019b, 2020), enabling patients to make realistic goals and develop ways of coping that they could use once discharged (Lindgren et al., 2021). This involved staff and patients co-constructing care plans or written contracts that included expectations for a patients' behaviour (O'Donovan, 2007; Vandewalle et al., 2019b; Zuzelo et al., 2012). The agreement of an agreed social contract was considered imperative in mitigating risk incidents. For example:

> I believe that for patients and for me, you achieve far better results when you enter into dialogue instead of immediately saying, "We are going to lock your door!". Such intervention is so invasive, while they actually ask for help and want to find solutions together. And then I try to appeal to the relationship we have to make agreements and to ask in all honesty whether the agreements are feasible for them. If patients answer, "It will not be possible", then I have to propose something else. And if they say, "You can trust me!", then I know it is safe.
>
> (Vandewalle et al., 2019b)

4.1.2 | Freedom and responsibility

Staff evaluated how much responsibility should be assigned to patients in decision-making to facilitate recovery, which involved balancing patient safety and autonomy (Vandewalle et al., 2020).

'It's all about transferring responsibility to the patients, that they get aware of their own knowledge, as they are experts by experience' (Lindgren et al., 2021).

Trust was particularly important in engendering patient autonomy, conceptualizing risk and shared decision-making (Gilje et al., 2005; Türkleş et al., 2018; Vandewalle et al., 2019a, 2019b, 2020). Staff described that they felt a lack of trust when patients were not open about their symptoms (Vandewalle et al., 2020).

Staff used restrictive interventions, which reduced patient freedoms, when in patients' best interest to keep them safe (Vandewalle et al., 2020). Staff acknowledged that restrictive practices did not guarantee patient safety (Gilje et al., 2005), which some staff found anxiety-provoking (Türkleş et al., 2018), while others appeared to accept this limitation:

'You can take the responsibility. You can take a lot, but the whole and full responsibility for another person you can never bear'. (Gilje et al., 2005).

Aggressive behaviours emerged from patients' freedom being taken away, such as not being allowed to leave the ward or the use of forced treatment (Moghadam et al., 2013; Stevenson et al., 2015). Staff expressed they were 'safe' targets for assaults because patients knew that staff would not retaliate (Zuzelo et al., 2012), and patients were regularly not held responsible for assaults, which contributed to their continuation (Dean et al., 2021; Hiebert et al., 2022).

4.2 | Theme 2: The function of risk behaviours

Understanding the function of risk behaviours was reported as important in providing appropriate care. This involved staff attempting to describe the reasons and context in which risk behaviours occurred, which facilitated staffs' empathy towards patients.

4.2.1 | Function of aggression

When aggression was perceived as unintentional, staff legitimized patients' violence as part of their illness and staff did not harbour negative feelings towards them (Hiebert et al., 2022). In numerous

studies, staff attempted to understand the behaviour in the context of the patient's illness to provide appropriate treatment, for example:

> I would tell myself that he was sick and that was the reason why he did this to me. Only by thinking in that way can I continue to care for him as usual.
>
> (Yang et al., 2016)

Due to lack of treatment options, patients for whom substance use or criminal activity was perceived to be the primary issue were seen to be inappropriately admitted into mental health wards (Hiebert et al., 2022; Kindy et al., 2005). Staff felt they were not the appropriate professionals to support these patients and found their aggressive behaviour more difficult to manage:

> because there are some incidents of violence that have nothing to do with psychiatry… like the delinquent violence and so on…you know… it's also the case of the addicted patients… there is a tendency to psychiatrize things that are not psychiatric.
>
> (Camuccio et al., 2012)

4.2.2 | Function of suicide and self-harm

Suicidal behaviour was described as tragic but understandable means to end suffering (Gilje et al., 2005; Hultsjo et al., 2018), a way to communicate distress to family and friends (Türkleş et al., 2018) and an accident related to self-harm (Hultsjo et al., 2018; James & Stewart, 2018). Understanding the function of suicide-influenced care:

> It's very insightful for me to explore what the function is of their suicidal expressions, and to attune my interventions to this… I notice that many patients do not necessarily want to die, but that something has to change in their life. It's something that overwhelms them, making suicide the only possible option.
>
> (Vandewalle et al., 2020)

Staff expressed they might have been able to prevent a patient's suicide if they better understood them (Rytterstrom et al., 2020). Patients' concealment of feelings and thoughts, isolation, lethal methods such as hanging, and concealing their suicidal behaviours were reported as indicators of suicidal behaviour rather than self-harm (Carlen & Bengtsson, 2007; Vandewalle et al., 2019b). Paradoxically, those who more openly expressed suicidal thoughts or self-harm were considered at less risk of suicide:

> Most of the self-harmers ask for help. They will go to a bridge and call for help… Whereas suicidal patients, they will normally behave quiet, they don't talk much, they make their plan and they make it.
>
> (James & Stewart, 2018)

Staff found understanding the function of self-harm challenging (Lindgren et al., 2021) and gave a variety of explanations for this behaviour including a cry for help or a way of dealing with distress (O'Donovan, 2007). Though staff differentiated between self-harm and suicidal behaviours, there were contradictions in their accounts, suggesting distinctions may be unreliable and inconsistent in practice (Hagen et al., 2017; James & Stewart, 2018; O'Donovan & Gijbels, 2006). Prejudice led staff to make generalizations about patients who self-harm, and staff considered them as a 'difficult group' (Lindgren et al., 2021), resulting in less empathy and poorer care to these patients (O'Donovan & Gijbels, 2006).

4.3 | Theme 3: Expectations of risk

Suicide was described as an unexpected event (Bohan & Doyle, 2008), however exposure to suicidal behaviour facilitated an understanding of its function, resulting in an increased expectation of its possibility (Alhamidi & Alyousef, 2022).

Staff expected aggression to occur (Bimenyimana et al., 2009; Oyelade & Ayandiran, 2018; Zuzelo et al., 2012), stating both aggression and self-harm were 'part of the job' (O'Donovan & Gijbels, 2006; Stevenson et al., 2015), and that verbal aggression was so common, it was often not reported (Hiebert et al., 2022). Staff believed managing assaults should not be part of their role and that different professionals such as security should manage them (Oyelade & Ayandiran, 2018). This led staff to question their professional identity:

> I didn't feel like a nurse. I felt like uh, I felt like an underpaid correctional officer. I didn't feel like this was nursing.
>
> (Kindy et al., 2005)

Aggression was expected in the presence of restrictive practices such as administration of forced medication and restraints (Moghadam et al., 2013). Staff had higher expectations of aggression for patients with certain diagnoses such as psychosis (Trenoweth, 2003; Wright et al., 2014). Staff identified numerous warning signs that enabled them to know when to expect aggression (Yang et al., 2016), and stated these signs are easier to interpret when the nurses know the patient well (Lantta et al., 2016). However, aggressive behaviours were sometimes unpredictable, occurring suddenly and spontaneously (Yosep et al., 2019; Zuzelo et al., 2012).

4.4 | Theme 4: Risk as a relational concept

Staff understood, experienced and managed risk behaviours by describing the ways in which the patients' behaviour was causally related to their environment and other people.

4.4.1 | Environment

Staff regularly reported how individual patient risk was influenced by environmental factors. Minimizing access to risk items such as sharp objects (Trenoweth, 2003) and increased surveillance were reported as needed to ensure a safe environment (Türkleş et al., 2018). Staff noted walkie-talkies and alarms were only as useful as the staff operating them (Kindy et al., 2005).

Providing structure to patients' daily schedule was important for reducing self-harm (Lindgren et al., 2021; O'Donovan, 2007). Suicide intent increased during transitional periods such as handover or night shifts where there were fewer staff available (Alhamidi & Alyousef, 2022; Bohan & Doyle, 2008). The transition of a patient being admitted to the hospital increased the risk of aggression, especially if the patient had been forcibly taken into hospital (Bimenyimana et al., 2009; Oyelade & Ayandiran, 2018).

Staff reported how all risk behaviours could become 'contagious', where one case would cause more risk behaviours by other patients (Alhamidi & Alyousef, 2022; Lindgren et al., 2021; Moghadam et al., 2013). Patient-to-patient monitoring existed, where patients would report to staff if they had witnessed self-harm or a suicide attempt from another patient (Türkleş et al., 2018). There were cases of patients allying with an aggressive patient or with staff, and patients fighting each other over extortion-related threats (Lantta et al., 2016).

4.4.2 | Tuning in

In numerous studies, staff described 'tuning in' to their patients and environment, observing subtle non-verbal signs in patients' behaviours in order to assess risks. This was described as a unique skill developed through experience, which involved assessing risk in an experiential way. For example:

> As a psychiatric nurse, you work a lot with your intuitive senses. And these senses become more accurate over the years you work as a nurse. In the beginning when I worked, I did not use my senses so much and I did not feel things as well as I feel them now.
>
> (Vandewalle et al., 2019a)

Staff also reported a need to be emotionally and practically 'in sync' with their colleagues to enable consistent interventions when managing aggression (Camuccio et al., 2012), and self-harm (Wilstrand et al., 2007).

4.4.3 | Staff characteristics

Staff believed that physically large patients could commit more serious assaults and required management from physically strong nursing staff (Oyelade & Ayandiran, 2018). Some studies reported that female staff were at a greater risk of aggression from male patients (Camuccio et al., 2012; Zuzelo et al., 2012), while in Wright et al. (2014), staff reported that female staff had a 'calming influence'. Gender was the staff characteristic most frequently reported as being important to consider when evaluating risk. Patients also targeted particularly vulnerable staff or the same nurse they have attacked before (Oyelade & Ayandiran, 2018).

Numerous studies expressed the importance of acting calmly and transparently to mitigate risks of self-harm, suicide and aggression, which might contradict their inner feelings. For example:

> ...you manage to be professional to the patient, but you struggle a lot, you know, you have to – as a professional on the outside, and then you're being torn inside.
>
> (Hagen et al., 2017)

Staff also expressed difficulty in controlling their own desire to retaliate after being assaulted by patients and varied in their opinions about whether staff should disengage from conflict (Zuzelo et al., 2012) or physically retaliate (Bimenyimana et al., 2009).

Staff reported varied styles of how to assess risk (Vandewalle et al., 2020; Wilstrand et al., 2007), for example they differed on whether taking a paternalistic role was overstepping their professional boundary (Hagen et al., 2017). Many studies reported that instilling hope was important to mitigate risk of self-harm and suicide. However, staff reported that they themselves often felt hopeless in supporting these patients (Alhamidi & Alyousef, 2022; Bohan & Doyle, 2008).

4.5 | Theme 5: Navigating contradictions in care

Many factors staff described as being important to deliver safe care were contradictorily also described as being limiting and/or implemented insufficiently in actual practice.

4.5.1 | Procedures

In many studies, staff emphasized the benefits of having clear policies and procedures in place to assess and manage risk behaviours using specific interventions. Studies also stated procedures could be overly rigid, limiting staffs' ability to provide person-centred care. For example:

> Sometimes I spend more time reporting than being present with the person. That is a shame! I sometimes wonder what is most important, "What I write down or what I really do with that person?". Of course, I believe it is important that you write down things in case something happens, but I also believe that there are too many administrative tasks.
>
> (Vandewalle et al., 2019b)

Staff did not consistently report all incidents when they were assaulted because it was time-consuming and occurred frequently

(Hiebert et al., 2022). Staff felt hindered by the dominance of the medical model in the management of self-harm (O'Donovan, 2007; O'Donovan & Gijbels, 2006), but also reported lacking specific procedures to manage this behaviour (Lindgren et al., 2021).

Staff reported self-harm and suicidality may increase when a patient is considered fit for discharge, resulting in a prolonged admission with increased risk behaviours (Lindgren et al., 2021).

4.5.2 | Education

Staff reported substantial training for managing aggression and that exposure to violence enhanced their confidence in their abilities to manage further incidents. For example:

> I'm more confident in what I do now. I'm more confident in addressing things whereas before I might have avoided situations previously…and less naïve about what can really happen.
>
> (Stevenson et al., 2015)

Staff reported that they lacked the knowledge of how to support those who present with suicidal behaviour or self-harm and expressed a desire to have further education on these risks (Alhamidi & Alyousef, 2022; Lindgren et al., 2021). Some staff believed it was not their role to fully understand self-harm or suicide and that this should be left to other professionals such as psychologists or doctors (O'Donovan, 2007).

4.5.3 | Resources

In the majority of studies, staff reported that adequate resources were imperative for good nursing practice and to reduce risks, but in practice, resources were limited. For example, lack of time, high workloads and insufficient staffing. Insufficient staffing resulted in increased risk of staff assault (Bimenyimana et al., 2009; Kindy et al., 2005; Zuzelo et al., 2012). Limited resources resulted in more frequent use of medication and seclusion to manage aggression and self-harm, and less time being spent engaging in therapeutic dialogues and activities (Lantta et al., 2016; Lindgren et al., 2021). This hindered patients' ability to develop alternative ways to cope with their emotions and resulted in increased self-harm (Lindgren et al., 2021).

4.5.4 | Management

Teamwork was frequently reported as essential to safely managing aggression. Staff stated they needed to work 'like a well-oiled machine' (Zuzelo et al., 2012), and that the visibility and input from senior staff improved safety (Dean et al., 2021). Suicide could occur from the disruption of continuity of teamwork, which 'tips over' a fragile patient into suicidal behaviour (Hultsjo et al., 2018).

Many studies reported a lack of support and understanding from senior colleagues and managers, for example:

> just dealing with the upper management and them not understanding what is actually going on is actually, like a war zone to tell the truth out there.
>
> (Kindy et al., 2005)

Managers would expect nursing staff to take on extra work in the absence of adequate resources but would not provide staff with additional support (Bimenyimana et al., 2009). Staff also expressed concerns that doctors and other senior staff contributed to the risk of aggression by not following treatment plans and worsening patient-staff dynamics (Kindy et al., 2005).

4.6 | Theme 6: The aftermath

Staff described numerous ways that risk behaviours negatively impact them and how this consequently impacted patient care.

4.6.1 | Emotional impact

Staff described fear and anxiety around suicide, self-harm and aggression. Anxiety around suicide reduced with more experience (Alhamidi & Alyousef, 2022). Whereas increased exposure to aggression resulted in increased anxiety (Camuccio et al., 2012; Dean et al., 2021; Yosep et al., 2019).

Staff reported a combination of sadness and relief after patient suicide, for example:

> But when she takes her life then… It is sad, but at the same time also sort of a – it is bad to say it, but…a little relief, because you may have been so tired and so angry at times too, right.
>
> (Hagen et al., 2017)

Staff reported frustration if a patient repeatedly engaged in self-harm, suicidal behaviour and aggression, notably when they had invested considerable time and effort caring for their patients. For example:

> I was quite angry with the woman who died due to all the help we'd given her, it was perhaps frustration at ourselves and that despite our best efforts we had failed her.
>
> (Alhamidi & Alyousef, 2022)

4.6.2 | Blame, guilt and inadequacy

Staff felt responsible for patient suicides and interpreted this as failing the patient and their family (Alhamidi & Alyousef, 2022;

Hagen et al., 2017). This resulted in staff doubting their professional capacity (Rytterstrom et al., 2020), and in many studies, staff reported feelings of guilt and inadequacy for all risk behaviours. Staff worried about litigation when a patient died or was restrained (Vandewalle et al., 2019b; Yosep et al., 2019). Numerous studies stated managers blamed staff for patient risk behaviours, for example:

> The nurse is being accused as always. Why did you neglect the patient, why did you not look after, why this, why that. If the patient dies, investigations begin. Almost nothing else but directly the nurse's fault is being questioned. Nobody says that he committed suicide because he was ill. Directly the nurse's fault is being questioned.
>
> (Türkleş et al., 2018)

4.6.3 | Debriefing

Many studies reported that staff debriefs resulted in them feeling supported by co-workers and management, for example:

> I think it's really important that we have time after the incidents to talk through what has happened with the other staff and to talk through how we could have handled things better or responded in a different way.
>
> (Alhamidi & Alyousef, 2022)

Participants explained that having debriefs with patients that self-harm to prevent further incidents (Lindgren et al., 2021). When staff were assaulted, they expressed the need for patients to apologize for their behaviour (Zuzelo et al., 2012). Staff also found it helpful to debrief with their own families and receive counselling after incidents (Bohan & Doyle, 2008). However, staff struggled to actively reach out for their own support (Rytterstrom et al., 2020), notably if they felt belittled and ashamed after an incident (Dean et al., 2021).

4.6.4 | Burnout and stress

Stress and burnout were reported for all risk behaviours, and most commonly for aggression. This resulted in a range of negative physical and psychological symptoms, some resembling post-traumatic stress disorder (Dean et al., 2021; Rytterstrom et al., 2020), which resulted in staff doubting their competencies (Hiebert et al., 2022), no longer caring about their role (Zuzelo et al., 2012), considering leaving the profession (Kindy et al., 2005; Oyelade & Ayandiran, 2018; Yosep et al., 2019), taking medication to manage their work stress (Alhamidi & Alyousef, 2022), absenteeism and excessive alcohol use (Bimenyimana et al., 2009). Participants in Yang et al. (2016) indicated that psychological trauma from assaults was more impactful than the physical injuries.

Staffs' fatigue and burnout contributed to an unsafe work environment, and participants worried that this would lead to further incidents and associated litigation (Kindy et al., 2005). They expressed little hope that their work environment would improve and were concerned that a serious aggressive incident was likely, which could result in a life-long injury (Stevenson et al., 2015).

5 | DISCUSSION

We identified six themes which represented nursing staffs' experiences of patient self-harm, suicide and aggression. Subthemes described important ways in which these risk behaviours converged and diverged in terms of their experience, management and impact.

Social contracts highlight the inherent ethical issues of inpatient care: it is an environment that promotes mental health and safety, but simultaneously enacts restrictions and surveillance, which has the potential to inflict further harm on both patients and staff (Campbell et al., 2019). It is known that nursing staff experience moral distress because of these ethical conflicts within practice (Burston & Tuckett, 2013), yet staff receive little training and support within this domain. Therefore, we recommend that specific education and training to support staffs' ethical decision-making should be implemented. Despite the social contract being frequently reported phenomena, there is little research on this issue, and current evidence for these interventions is poor (James et al., 2012; Puskar & Urda, 2011). Research identifying the connection between the therapeutic relationship and the conditional expectations that staff and patients make with each other is needed to develop an evidence base for what exactly makes this relationship effective.

Staff sought to assess the function of patients' risk behaviours in order to provide good quality care. To manage aggression, nursing staff focused on collaboration with each other, while the management of self-harm and suicide focused on collaboration with patients. Shared decision-making with families was not reported in this review, despite this being increasingly encouraged in mental healthcare and demonstrating efficacy for improving mental health outcomes (Meis et al., 2013). Assessment of risk behaviours was influenced by the characteristics of the staff themselves. Similarly to a review by Doedens et al. (2020), gender was the most frequently reported staff characteristic associated with attitudes towards using restrictive practices. Significant variations in risk management across studies may be socially or culturally influenced, such as whether staff should disengage from conflict or physically retaliate.

Staff demonstrated sympathy towards both suicide and aggression when it occurred in the context of illness. However, staff also reported patients should be held accountable for assaults they believed did not occur in the context of mental illness. There exist contradictory beliefs regarding which professional body is responsible for unlawful activity of mental health patients (Bayney & Ikkos, 2003). Similarly to Baby et al. (2014), this review highlights the need for legal systems to support nursing staff's position that violence should not be tolerated in inpatient mental health care,

challenging the perception the violence is 'part of the job'. This aligns with the Department of Health and Social Care (2018) zero-tolerance approach to patient violence and to ensure offenders are treated culpable for their actions. Exposure to risk behaviours facilitated learning and development. However, a variety of negative psychological and physical symptoms were reported, which is consistent with previous reviews (Clua-García et al., 2021; Hilton et al., 2022; Shao et al., 2021). This Review demonstrated that fear and anxiety around suicide reduced with more experience, but increased exposure to aggression resulted in increased anxiety. The frequent exposure to aggression resulted in normalization of aggression and unreported incidents. Staff should be incentivized and given sufficient time and resources to accurately document all risk behaviours, as the misrepresentation of the frequency and impact of aggression potentially hinders service improvement.

Nursing staff reported being blamed for risk behaviours, despite reporting having insufficient resources to manage them and having limited control of patient behaviours. Managers, service providers and nursing staff must come to a shared understanding about the causal process of risk behaviours. Research suggests that accurately defining the role of mental health nurses within the workplace improves their capacity to manage risk behaviours (Hercelinskyj et al., 2014) and doing so will help identify the extent to which they can be held accountable for risk behaviours occurring.

Staff demonstrated clear approaches for the management of aggression. They demonstrated less clarity in approaches to manage self-harm, struggling to demarcate it from suicidal behaviour. Furthermore, they developed negative attitudes towards self-harm behaviour. This is consistent with previous literature (McHale & Felton, 2010), and provides evidence for why such patients report bad experiences of their care (Harris, 2000; Warm et al., 2002). Despite increased education and awareness regarding self-harm, negative attitudes towards it have persisted (Saunders et al., 2011), and there exists little research on the long-term benefits of self-harm training (O'Connor & Glover, 2017). More research is needed to determine why staff develop negative attitudes towards self-harm, and the relationship between these attitudes and clinical practice.

Given there exists little research into the effectiveness of current strategies for mitigating suicide and self-harm, such as increased observations (James et al., 2012), staff should be supported and provided training to offer alternative person-centred strategies that are in line with clinical guidelines. As increased self-harm is correlated with suicide attempts, a better understanding and treatment of self-harm may also mitigate suicide risk.

It is known that staff attitudes, characteristics and understanding can influence risk behaviours in inpatient care (Bowers, Simpson, & Alexander, 2003), which is consistent with the findings in this review. These interactions have been shown to result in conflicting perspectives in staff and patients during incidents of aggression (Fletcher et al., 2021), and self-harm (Bosman & van Meijel, 2008). Research is required to understand the patient perspective of these risk behaviours as compared to nurses, and models must draw on the experience of both staff and patients for designing effective interventions.

Currently, risk assessments within psychiatric services primarily focus on patient factors, and they demonstrate poor predictive value for patients' risks to themselves and others (Wand, 2011). This review illustrates that nursing staff conceptualize the occurrence of risk behaviours as a product of the patients' relationship with other factors such as their environment and the staff. Future research could be aimed towards operationalizing this understanding and embedding it in formalized risk assessments to inform positive risk taking.

Models that seek to interpret risk as a relational concept in inpatient psychiatry exist (Cutcliffe & Riahi, 2013; Hamrin et al., 2009), and 'Safewards' serves as an example used by psychiatric wards that includes a specific domain on interpersonal relationships (Bowers, 2014). However, these models are otherwise largely absent in clinical practice.

5.1 | Strengths and limitations

This review involved a robust search strategy that followed relevant guidelines for meta-synthesis (Tong et al., 2012). The review synthesized nursing staffs' experiences of a variety of different high-risk behaviours, which is a novel area in qualitative psychiatric research. A substantial number of eligible papers were retrieved for data analysis. All studies demonstrated valuable insights. Studies were obtained from a diverse range of countries and cultures, which enables the possibility of achieving a high level of abstraction that is aimed for in synthesizing qualitative literature (Britten et al., 2002).

Due to the scope of this work, an independent reviewer was only able to complete a proportion of the screening process and the quality appraisal. Many studies were excluded because they did not meet the sample criteria, or because they were mixed method studies or grey literature. Though this increased the specificity of the results, some potentially valuable qualitative studies may have been excluded. Due to language limitations, only papers in English were retrieved. In some studies, it was unclear if nurses were reporting their perceptions of high-risk behaviours in the absence of having any actual experience of them. The construction of analytical themes is a result of interrogating the descriptive themes against the review's primary and secondary questions. The analytical themes are therefore directly relevant to this review, but it is acknowledged that a different external framework would produce a different analysis.

5.2 | Conclusions

Inpatient nursing staff experience frequent exposure to suicide, self-harm and aggression. Each of these high-risk behaviours involve a variety of phenomena that qualitatively converge and diverge in the ways that they are experienced and managed. Table 3 presents a summary of this Review's implications. Notably, this review indicates the prioritization for staff training in the management of self-harm, increased support for staff working in environments with high

TABLE 3 Summary of implications.

• Improved understanding of the function of patients' risk behaviours enables staff to provide better care
• Self-harm is the risk that is the most poorly understood and managed risk behaviour, therefore staff training on this risk should be prioritized
• Services should increase personal and professional support to staff, especially where incidents of aggression are high
• A clearer delineation of role of nursing staff may highlight areas for training and support
• Staff would benefit from specific training to improve their interpersonal relationships with patients
• Research is needed to better understand the efficacy of social contracts in mental healthcare
• Staff would benefit from legal support to enable better management of ethical conflicts and maintain a zero-tolerance policy towards violence
• Risk is understood by staff as a relational concept, and this should be operationalized in service provision

incidences of aggression and the operationalization of risk as a relational concept.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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REFERENCES

Alhamidi, S. A., & Alyousef, S. M. (2022). Perceptions of mental health nurses toward caring for suicidal hospital inpatients in Saudi Arabia. *Death Studies*, *46*(5), 1166–1175. https://doi.org/10.1080/07481187.2020.1801894

Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. (2015). Understanding patient-to-worker violence in hospitals: A qualitative analysis of documented incident reports. *Journal of Advanced Nursing*, *71*(2), 338–348. https://doi.org/10.1111/jan.12494

Baby, M., Glue, P., & Carlyle, D. (2014). "Violence is not part of our job": A thematic analysis of psychiatric mental health Nurses' experiences of patient assaults from a New Zealand perspective. *Issues in Mental Health Nursing*, *35*(9), 647–655. https://doi.org/10.3109/01612840.2014.892552

Bayney, R., & Ikkos, G. (2003). Managing criminal acts on the psychiatric ward: Understanding the police view. Advances in psychiatric treatment: The Royal College of Psychiatrists'. *Journal of Continuing Professional Development*, *9*(5), 359–367. https://doi.org/10.1192/apt.9.5.359

Bimenyimana, E., Poggenpoel, M., Myburgh, C., & van Niekerk, V. (2009). The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution. *Curationis (Pretoria)*, *32*(3), 4–13. https://doi.org/10.4102/curationis.v32i3.1218

Bohan, F., & Doyle, L. (2008). Nurses' experiences of patient suicide and suicide attempts in an acute unit: Suicide and attempted suicide in an acute unit can have a devastating effect on staff and other patients. Fiona Bohan and Louise Doyle describe nurses' experiences of such events and their perceptions of the support they were given after the incident. *Mental Health Practice*, *11*(5), 12–16. https://doi.org/10.7748/mhp2008.02.11.5.12.c6338

Bolster, C., Holliday, C., Oneal, G., & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *Online Journal of Issues in Nursing*, *20*(1), 81–87. https://doi.org/10.3912/OJIN.Vol20No01Man02

Bosman, M., & van Meijel, B. (2008). Perspectives of mental health professionals and patients on self-injury in psychiatry: A literature review. *Archives of Psychiatric Nursing*, *22*(4), 180–189. https://doi.org/10.1016/j.apnu.2007.07.006

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards: Safewards: Description of the model. *Journal of Psychiatric and Mental Health Nursing*, *21*(6), 499–508. https://doi.org/10.1111/jpm.12129

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: The tompkins acute ward study. *Journal of Mental Health (Abingdon, England)*, *14*(6), 625–635. https://doi.org/10.1080/09638230500389105

Bowers, L., Simpson, A., & Alexander, J. (2003). Patient-staff conflict: Results of a survey on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology*, *38*(7), 402–408. https://doi.org/10.1007/s00127-003-0648-x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, *7*(4), 209–215. https://doi.org/10.1258/135581902320432732

Brunero, S. J., Jeon, Y. H., & Foster, K. (2015). The journey of positioning self as both mental health nurse and qualitative researcher: A critical reflection. *Journal of Psychiatric and Mental Health Nursing*, *22*(7), 543–548. https://doi.org/10.1111/jpm.12238

Burston, A. S., & Tuckett, A. G. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. *Nursing Ethics*, *20*(3), 312–324. https://doi.org/10.1177/0969733012462049

Busch, I. M., Moretti, F., Purgato, M., Barbui, C., Wu, A. W., & Rimondini, M. (2020). Psychological and psychosomatic symptoms of second victims of adverse events: A systematic review and meta-analysis. *Journal of Patient Safety*, *16*(2), e61–e74. https://doi.org/10.1097/PTS.0000000000000589

Campbell, V. L., Foley, H. L., Vianna, K. W., & Brunger, F. (2019). Folie du système? Preventing violence against nurses in in-patient psychiatry. *Psychiatric Quarterly*, *90*(2), 413–420. https://doi.org/10.1007/s11126-019-09636-1

Camuccio, C. A., Chambers, M., Valimaki, M., Farro, D., & Zanotti, R. (2012). Managing distressed and disturbed patients: The thoughts and feelings experienced by Italian nurses. *Journal of Psychiatric and Mental Health Nursing*, *19*(9), 807–815. https://doi.org/10.1111/j.1365-2850.2011.01857.x

Carlen, P., & Bengtsson, A. (2007). Suicidal patients as experienced by psychiatric nurses in inpatient care. *International Journal of Mental Health Nursing*, *16*(4), 257–265. https://doi.org/10.1111/j.1447-0349.2007.00475.x

Carroll, C., & Booth, A. (2015). Quality assessment of qualitative evidence for systematic review and synthesis: Is it meaningful, and if so, how should it be performed? *Research Synthesis Methods*, *6*(2), 149–154. https://doi.org/10.1002/jrsm.1128

Clark, L. L., Shurmer, D. L., Kowara, D., & Nnatu, I. (2017). Reducing restrictive practice: Developing and implementing behavioural support plans. *British Journal of Mental Health Nursing*, *6*(1), 23–28. https://doi.org/10.12968/bjmh.2017.6.1.23

Clua-García, R., Casanova-Garrigós, G., & Moreno-Poyato, A. R. (2021). Suicide care from the nursing perspective: A meta-synthesis of

qualitative studies. *Journal of Advanced Nursing*, *77*(7), 2995–3007. https://doi.org/10.1111/jan.14789

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., & Appleby, L. (2005). Suicide after deliberate self-harm: A 4-year cohort study. *The American Journal of Psychiatry*, *162*(2), 297–303. https://doi.org/10.1176/appi.ajp.162.2.297

Critical Appraisal Skills Programme. (2017). *CASP (Qualitative Research) Checklist*. https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Cruess, R. L., Cruess, S. R., & Sylvia, R. (2008). Expectations and obligations: Professionalism and Medicine's social contract with society. *Perspectives in Biology and Medicine*, *51*(4), 579–598. https://doi.org/10.1353/pbm.0.0045

Cutcliffe, J. R., & Riahi, S. (2013). Systemic perspective of violence and aggression in mental health care: Towards a more comprehensive understanding and conceptualization: Part 1: Systemic views of violence and aggression. *International Journal of Mental Health Nursing*, *22*(6), 558–567. https://doi.org/10.1111/inm.12029

Dean, L., Butler, A., & Cuddigan, J. (2021). The impact of workplace violence toward psychiatric mental health nurses: Identifying the facilitators and barriers to supportive resources. *Journal of the American Psychiatric Nurses Association*, *27*(3), 189–202. https://doi.org/10.1177/10783903211010945

Delaney, J., Cleary, M., Jordan, R., & Horsfall, J. (2001). An exploratory investigation into the nursing management of aggression in acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*, *8*(1), 77–84. https://doi.org/10.1111/j.1365-2850.2001.00350.x

Department of Health and Social Care. (2018). *Stronger protection from violence for NHS staff. GOV.UK*. Retrieved from https://www.gov.uk/government/news/stronger-protection-from-violence-for-nhs-staff

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., Shaw, R. L., Smith, J. A., & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*(1), 27–44. https://doi.org/10.1177/1468794106058867

Dixon-Woods, M., Booth, A., & Sutton, A. J. (2007). Synthesizing qualitative research: A review of published reports. *Qualitative Research*, *7*(3), 375–422. https://doi.org/10.1177/1468794107078517

Doedens, P., Vermeulen, J., Boyette, L.-L., Latour, C., & de Haan, L. (2020). Influence of nursing staff attitudes and characteristics on the use of coercive measures in acute mental health services—A systematic review. *Journal of Psychiatric and Mental Health Nursing*, *27*(4), 446–459. https://doi.org/10.1111/jpm.12586

Finch, K., Lawrence, D., Williams, M. O., Thompson, A. R., & Hartwright, C. (2022). A systematic review of the effectiveness of Safewards: Has enthusiasm exceeded evidence? *Issues in Mental Health Nursing*, *43*(2), 119–136. https://doi.org/10.1080/01612840.2021.1967533

Fletcher, A., Crowe, M., Manuel, J., & Foulds, J. (2021). Comparison of patients' and staff's perspectives on the causes of violence and aggression in psychiatric inpatient settings: An integrative review. *Journal of Psychiatric and Mental Health Nursing*, *28*(5), 924–939. https://doi.org/10.1111/jpm.12758

Gilje, F., Talseth, A. G., & Norberg, A. (2005). Psychiatric nurses' response to suicidal psychiatric inpatients: Struggling with self and sufferer. *Journal of Psychiatric and Mental Health Nursing*, *12*(5), 519–526. https://doi.org/10.1111/j.1365-2850.2005.00855.x

Hagen, J., Knizek, B. L., & Hjelmeland, H. (2017). Mental health Nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Archives of Psychiatric Nursing*, *31*(1), 31–37. https://doi.org/10.1016/j.apnu.2016.07.018

Hallett, N., Huber, J. W., & Dickens, G. L. (2014). Violence prevention in inpatient psychiatric settings: Systematic review of studies about the perceptions of care staff and patients. *Aggression and Violent Behavior*, *19*(5), 502–514. https://doi.org/10.1016/j.avb.2014.07.009

Hamrin, V., Iennaco, J., & Olsen, D. (2009). A review of ecological factors affecting inpatient psychiatric unit violence: Implications for relational and unit cultural improvements. *Issues in Mental Health Nursing*, *30*(4), 214–226. https://doi.org/10.1080/01612840802701083

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. *Qualitative Research*, *12*(4), 402–442. https://doi.org/10.1177/1468794111432992

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*, *10*(2), 164–173. https://doi.org/10.1177/104973200129118345

Haw, C., Hawton, K., Houston, K., & Townsend, E. (2001). Psychiatric and personality disorders in deliberate self-harm patients. *British Journal of Psychiatry*, *178*(1), 48–54. https://doi.org/10.1192/bjp.178.1.48

Hercelinskyj, G., Cruickshank, M., Brown, P., & Phillips, B. (2014). Perceptions from the front line: Professional identity in mental health nursing. *International Journal of Mental Health Nursing*, *23*(1), 24–32. https://doi.org/10.1111/inm.12001

Hiebert, B. J., Care, W. D., Udod, S. A., & Waddell, C. M. (2022). Psychiatric Nurses' lived experiences of workplace violence in acute Care psychiatric units in Western Canada. *Issues in Mental Health Nursing*, *43*(2), 146–153. https://doi.org/10.1080/01612840.2021.1956656

Hilton, N. Z., Addison, S., Ham, E., Rodrigues, N., & Seto, M. C. (2022). Workplace violence and risk factors for PTSD among psychiatric nurses: Systematic review and directions for future research and practice. *Journal of Psychiatric and Mental Health Nursing*, *29*(2), 186–203. https://doi.org/10.1111/jpm.12781

Hultsjo, S., Wardig, R., & Rytterstrom, P. (2018). The borderline between life and death: Mental healthcare professionals' experience of why patients commit suicide during ongoing care. *Journal of Clinical Nursing*, *28*(9–10), 1623–1632. https://doi.org/10.1111/jocn.14754

Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & De Girolamo, G. (2015). Prevalence and risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis. *PLoS One*, *10*(6), e0128536. https://doi.org/10.1371/journal.pone.0128536

James, K., & Stewart, D. (2018). Blurred boundaries – a qualitative study of how acts of self-harm and attempted suicide are defined by mental health practitioners. *Crisis*, *39*(4), 247–254. https://doi.org/10.1027/0227-5910/a000491

James, K., Stewart, D., & Bowers, L. (2012). Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature: Self-harm within inpatient services. *International Journal of Mental Health Nursing*, *21*(4), 301–309. https://doi.org/10.1111/j.1447-0349.2011.00794.x

Jun, J., Ojemeni, M. M., Kalamani, R., Tong, J., & Crecelius, M. L. (2021). Relationship between nurse burnout, patient and organizational outcomes: Systematic review. *International Journal of Nursing Studies*, *119*, 103933. https://doi.org/10.1016/j.ijnurstu.2021.103933

Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: Nurses' experiences in psychiatric units with high risks of assault. *Archives of Psychiatric Nursing*, *19*(4), 169–175. https://doi.org/10.1016/j.apnu.2005.05.002

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An original method to synthesize qualitative literature in psychiatry. *Frontiers in Psychiatry*, *8*, 269. https://doi.org/10.3389/fpsyt.2017.00269

Langsrud, K., Linaker, O. M., & Morken, G. (2007). Staff injuries after patient-staff incidences in psychiatric acute wards. *Nordic Journal of Psychiatry*, *61*(2), 121–125. https://doi.org/10.1080/08039480701226104

Lantta, T., Anttila, M., Kontio, R., Adams, C. E., & Välimäki, M. (2016). Violent events, ward climate and ideas for violence prevention among nurses in psychiatric wards: A focus group study. *International Journal of Mental Health Systems*, *10*(27), 27. https://doi.org/10.1186/s13033-016-0059-5

Large, M. M., Chung, D. T., Davidson, M., Weiser, M., & Ryan, C. J. (2017). In-patient suicide: Selection of people at risk, failure of protection and the possibility of causation. *BJPsych Open*, *3*(3), 102–105. https://doi.org/10.1192/bjpo.bp.116.004309

Lindgren, B.-M., Molin, J., & Graneheim, U. H. (2021). Balancing between a person-Centred and a common staff approach: Nursing Staff's experiences of good nursing practice for patients who self-harm. *Issues in Mental Health Nursing*, *42*(6), 564–572. https://doi.org/10.1080/01612840.2020.1817206

Marangos-Frost, S., & Wells, D. (2000). Psychiatric nurses' thoughts and feelings about restraint use: A decision dilemma. *Journal of Advanced Nursing*, *31*(2), 362–369. https://doi.org/10.1046/j.1365-2648.2000.01290.x

McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of Psychiatric and Mental Health Nursing*, *17*(8), 732–740. https://doi.org/10.1111/j.1365-2850.2010.01600.x

Meis, L. A., Griffin, J. M., Greer, N., Jensen, A. C., MacDonald, R., Carlyle, M., … Wilt, T. J. (2013). Couple and family involvement in adult mental health treatment: A systematic review. *Clinical Psychology Review*, *33*(2), 275–286. https://doi.org/10.1016/j.cpr.2012.12.003

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: A comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*(1), 579. https://doi.org/10.1186/s12913-014-0579-0

Moghadam, M. F., Pazargadi, M., & Khoshknab, M. F. (2013). Iranian Nurses' experiences of aggression in psychiatric wards: A qualitative study. *Issues in Mental Health Nursing*, *34*(10), 765–771. https://doi.org/10.3109/01612840.2012.737893

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., Shekelle, P., & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews*, *4*(1), 1. https://doi.org/10.1186/2046-4053-4-1

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212. https://doi.org/10.1177/1049732315588501

National Health Service (NHS). (2019). *NHS long Term Plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Nijman, H., Bowers, L., Oud, N., & Jansen, G. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive Behavior*, *31*(3), 217–227. https://doi.org/10.1002/ab.20038

O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. *Psychology and Psychotherapy*, *90*(3), 480–501. https://doi.org/10.1111/papt.12113

O'Donovan, A. (2007). Pragmatism rules: The intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. *Journal of Psychiatric and Mental Health Nursing*, *14*(1), 64–71. https://doi.org/10.1111/j.1365-2850.2007.01044.x

O'Donovan, A., & Gijbels, H. (2006). Understanding psychiatric nursing Care with nonsuicidal self-harming patients in acute psychiatric admission units: The views of psychiatric nurses. *Archives of Psychiatric Nursing*, *20*(4), 186–192. https://doi.org/10.1016/j.apnu.2005.12.007

Oyelade, O. O., & Ayandiran, E. O. (2018). Violence Management in a Nigerian Psychiatric Facility: Psychiatric-mental health Nurses' current practices and their effectiveness. *Journal of Psychosocial Nursing and Mental Health Services*, *56*(11), 37–45. https://doi.org/10.3928/02793695-20180503-02

Puskar, K., & Urda, B. (2011). Examining the efficacy of No-suicide contracts in inpatient psychiatric settings: Implications for psychiatric nursing. *Issues in Mental Health Nursing*, *32*(12), 785–788. https://doi.org/10.3109/01612840.2011.599476

QSR International Pty Ltd. (2018). *NVivo qualitative data analysis software (version 12)*. Retrieved from https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Royal College of Psychiatrists (RCP). (2017). Standards for Inpatient Mental Health Services. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/rcpsych-core-standards-inpatient-mental-health-services.pdf?sfvrsn=2d474631_2

Royal College of Psychiatrists (RCP). (2022). *Restrictive practices – Learning from the collaborative*. National Collaborating Centre for Mental Health.

Rytterstrom, P., Ovox, S. M., Wärdig, R., & Hultsjo, S. (2020). Impact of suicide on health professionals in psychiatric care mental health-care professionals' perceptions of suicide during ongoing psychiatric care and its impacts on their continued care work. *International Journal of Mental Health Nursing*, *29*(5), 982–991. https://doi.org/10.1111/inm.12738

Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2011). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders*, *139*(3), 205–216. https://doi.org/10.1016/j.jad.2011.08.024

Shao, Q., Wang, Y., Hou, K., Zhao, H., & Sun, X. (2021). The psychological experiences of nurses after inpatient suicide: A meta-synthesis of qualitative research studies. *Journal of Advanced Nursing*, *77*(10), 4005–4016. https://doi.org/10.1111/jan.14885

Singhal, A., Ross, J., Seminog, O., Hawton, K., & Goldacre, M. J. (2014). Risk of self-harm and suicide in people with specific psychiatric and physical disorders: Comparisons between disorders using English national record linkage. *Journal of the Royal Society of Medicine*, *107*(5), 194–204. https://doi.org/10.1177/0141076814522033

Smith, J. A., Larkin, M., & Flowers, P. (2021). *Interpretative phenomenological analysis: Theory, method and research*. Sage Publications.

Smith, S. E. (2002). Perceptions of service provision for clients who self-injure in the absence of expressed suicidal intent. *Journal of Psychiatric and Mental Health Nursing*, *9*(5), 595–601. https://doi.org/10.1046/j.1365-2850.2002.00512.x

Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. *BMC Nursing*, *14*(1), 35. https://doi.org/10.1186/s12912-015-0079-5

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Timberlake, L. M., Beeber, L. S., & Hubbard, G. (2020). Nonsuicidal self-injury: Management on the inpatient psychiatric unit. *Journal of the American Psychiatric Nurses Association*, *26*(1), 10–26. https://doi.org/10.1177/1078390319878878

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research. *BMC Medical Research Methodology*, *12*(181), 1–8. https://doi.org/10.1186/1471-2288-12-181

Too, L. S., Spittal, M. J., Bugeja, L., Reifels, L., Butterworth, P., & Pirkis, J. (2019). The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies. *Journal of Affective Disorders*, *259*, 302–313. https://doi.org/10.1016/j.jad.2019.08.054

Trenoweth, S. (2003). Perceiving risk in dangerous situations: Risks of violence among mental health inpatients: Perceiving risk in

dangerous situations. *Journal of Advanced Nursing*, *42*(3), 278–287. https://doi.org/10.1046/j.1365-2648.2003.02617.x

Türkleş, S., Yılmaz, M., & Soylu, P. (2018). Feelings, thoughts and experiences of nurses working in a mental health clinic about individuals with suicidal behaviors and suicide attempts. *Collegian (Royal College of Nursing, Australia)*, *25*(4), 441–446. https://doi.org/10.1016/j.colegn.2017.11.002

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E., & Verhaeghe, S. (2019a). Contact and communication with patients experiencing suicidal ideation: A qualitative study of nurses' perspectives. *Journal of Advanced Nursing*, *75*(11), 2867–2877. https://doi.org/10.1111/jan.14113

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E., & Verhaeghe, S. (2019b). "Promoting and preserving safety and a life-oriented perspective": A qualitative study of nurses' interactions with patients experiencing suicidal ideation. *International Journal of Mental Health Nursing*, *28*(5), 1119–1131. https://doi.org/10.1111/inm.12623

Vandewalle, J., Deproost, E., Goossens, P., Verfaillie, J., Debyser, B., Beeckman, D., Van Hecke, A., & Verhaeghe, S. (2020). The working alliance with people experiencing suicidal ideation: A qualitative study of nurses' perspectives. *Journal of Advanced Nursing*, *76*(11), 3069–3081. https://doi.org/10.1111/jan.14500

Walsh, G., Sara, G., Ryan, C. J., & Large, M. (2015). Meta-analysis of suicide rates among psychiatric in-patients. *Acta Psychiatrica Scandinavica*, *131*(3), 174–184. https://doi.org/10.1111/acps.12383

Wand, T. (2011). Investigating the evidence for the effectiveness of risk assessment in mental health Care. *Issues in Mental Health Nursing*, *33*(1), 2–7. https://doi.org/10.3109/01612840.2011.616984

Warm, A., Murray, C., & Fox, J. (2002). Who helps? Supporting people who self-harm. *Journal of Mental Health (Abingdon, England)*, *11*(2), 121–130. https://doi.org/10.1080/096382301200041533

Weltens, I., Bak, M., Verhagen, S., Vandenberk, E., Domen, P., van Amelsvoort, T., & kker, M. (2021). Aggression on the psychiatric ward: Prevalence and risk factors. A systematic review of the literature. *PLoS One*, *16*(10), e0258346. https://doi.org/10.1371/journal.pone.0258346

Wilstrand, C., Lindgren, B.-M., Gilje, F., & Olofsson, B. (2007). Being burdened and balancing boundaries: A qualitative study of nurses' experiences caring for patients who self-harm. *Journal of Psychiatric and Mental Health Nursing*, *14*(1), 72–78. https://doi.org/10.1111/j.1365-2850.2007.01045.x

Wright, K. M., Duxbury, J. A., Baker, A., & Crumpton, A. (2014). A qualitative study into the attitudes of patients and staff towards violence and aggression in a high security hospital. *Journal of Psychiatric and Mental Health Nursing*, *21*(2), 184–188. https://doi.org/10.1111/jpm.12108

Yang, C.-I., Hsieh, W.-P., Lee, L.-H., & Chen, S.-L. (2016). Assault experiences: Lessons learned from mental health nurses in Taiwan: Mental health nurses' assault experiences. *International Journal of Mental Health Nursing*, *25*(3), 225–233. https://doi.org/10.1111/inm.12203

Yosep, I., Mediani, H. S., Putit, Z., Hazmi, H., & Mardiyah, A. (2019). Mental health Nurses' perspective of work-related violence in Indonesia: A qualitative study. *International Journal of Caring Sciences*, *12*(3), 1871–1878.

Ziegenbein, M., Anreis, C., Brüggen, B., Ohlmeier, M., & Kropp, S. (2006). Possible criteria for inpatient psychiatric admissions: Which patients are transferred from emergency services to inpatient psychiatric treatment? *BMC Health Services Research*, *6*(1), 150. https://doi.org/10.1186/1472-6963-6-150

Zuzelo, P. R., Curran, S. S., & Zeserman, M. A. (2012). Registered Nurses' and behavior health Associates' responses to violent inpatient interactions on behavioral health units. *Journal of the American Psychiatric Nurses Association*, *18*(2), 112–126. https://doi.org/10.1177/1078390312438553

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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