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VIOLENCE AGAINST HEALTH PROFESSIONALS IN THE CONTEXT OF A COMMUNITY CARE UNIT: A QUALITATIVE STUDY

VIOLÊNCIA CONTRA OS PROFISSIONAIS DE SAÚDE NO CONTEXTO DE UMA UNIDADE DE CUIDADOS NA COMUNIDADE: UM ESTUDO QUALITATIVO

VIOLENCIA CONTRA LOS PROFESIONALES DE LA SALUD EN EL CONTEXTO DE UNA UNIDAD DE ATENCIÓN COMUNITARIA: UN ESTUDIO CUALITATIVO

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ABSTRACT

Introduction: Providing care in the home and community implies contact with the population outside the institutional environment, which is often an unknown and unsafe context, prone to situations of violence. Violence is a phenomenon that has a major impact, not only on health, but also on organisations and the economy. The aim is to identify the needs felt by health professionals in a Community Care Unit in the Lisbon and Tagus Valley region, in the area of health professional safety, in the dimension of preventing violence against health professionals.

Methods: An exploratory, descriptive and cross-sectional study of a qualitative nature, using semi-structured interviews and content analysis, between June 2022 and April 2023. Convenience sample made up of health professionals who were part of the multidisciplinary team at this Unit, using pre-defined inclusion and exclusion criteria.

Results: There was little training on the subject of violence against health professionals. It was noted that situations of violence occurring within the scope of professional activity were undervalued, resulting in their underreporting, as well as a lack of knowledge regarding subsequent procedures.

Conclusion: It is crucial to train health professionals in Community Care Units on the phenomenon of violence against professionals in the context of their professional activity, as well as the subsequent procedures, namely notification, which will allow them to define strategies for dealing with this phenomenon.

Keywords: Community Health Services; Health Personnel; Home Care Service; Occupational Accidents Registry; Workplace Violence.

RESUMO

Introdução: A prestação de cuidados em contexto domiciliário e comunitário implica o contacto com a população fora do ambiente institucional, revelando-se um contexto muitas vezes desconhecido e pouco seguro, propenso a situações de violência. Esta traduz-se como um fenómeno de elevado impacto não só na saúde, como nas organizações e na economia. Pretende-se identificar as necessidades sentidas pelos profissionais de saúde de uma Unidade de Cuidados na Comunidade da região de Lisboa e Vale do Tejo, na área da segurança dos profissionais de saúde, na dimensão da prevenção da violência sobre os profissionais de saúde.

Métodos: Estudo exploratório, descritivo e transversal, de natureza qualitativa, com recur-

so a entrevistas semiestruturadas e análise de conteúdo, no período de junho de 2022 e abril de 2023. Amostra por conveniência constituída pelos profissionais de saúde que integravam a equipa multidisciplinar desta Unidade, mediante critérios de inclusão e exclusão pré-definidos.

Resultados: Verificou-se a escassa formação relativamente à temática da violência contra os profissionais de saúde. Constatou-se a desvalorização das situações de violência ocorridas no âmbito da atividade profissional, traduzindo-se numa subnotificação das mesmas, para além do desconhecimento relativamente aos procedimentos subsequentes.

Conclusão: É necessário capacitar e formar os profissionais de saúde das Unidade de Cuidados na Comunidade quanto ao fenómeno da violência sobre os profissionais no âmbito da atividade profissional, bem como dos procedimentos subsequentes, nomeadamente a notificação, permitindo definir estratégias para lidar com este fenómeno.

Palavras-chave: Notificação de Acidentes de Trabalho; Profissional de Saúde; Serviços de Assistência Domiciliar; Serviços de Saúde Comunitária; Violência no Trabalho.

RESUMEN

Introducción: La prestación de cuidados en contexto domiciliario y comunitario implica el contacto con la población fuera del ámbito institucional, revelándose como un contexto muchas veces desconocido e inseguro, propenso a situaciones de violencia. Esto se traduce como un fenómeno de alto impacto en la salud, en las organizaciones y en la economía. El objetivo es identificar las necesidades percibidas por los profesionales de la salud en una Unidad de Ciuidados en la Comunidad en la región de Lisboa y Valle del Tajo, en el área de seguridad de los profesionales de la salud, en la dimensión de prevención de la violencia contra ellos.

Métodos: Estudio exploratorio, descriptivo y transversal, de naturaleza cualitativa, utilizando entrevistas semiestructuradas y análisis de contenido, de junio de 2022 a abril de 2023. La muestra por conveniencia consistió en los profesionales de la salud que formaban parte del equipo multidisciplinario de esta Unidad, según criterios de inclusión y exclusión predefinidos.

Resultados: Hubo poca capacitación sobre el tema de la violencia contra los profesionales de la salud. Se observó una desvalorización de las situaciones de violencia ocurridas en el ámbito de la actividad profesional, traduciéndose en subregistro de las mismas, además de un desconocimiento de los procedimientos posteriores.

Conclusión: Es necesario capacitar los profesionales de la salud de las Unidades de Cuidados en la Comunidad sobre el fenómeno de la violencia contra los profesionales en el ámbito

de la actividad profesional, así como los procedimientos posteriores, especialmente la notificación, para poder establecer estrategias para abordar este fenómeno.
Descriptores: Notificación de Accidentes del Trabajo; Personal de Salud; Servicios de Atención de Salud a Domicilio; Servicios de Salud Comunitaria; Violencia Laboral.

INTRODUCTION

Psychosocial risks in the workplace are a current and relevant challenge for workers' health and safety. These are related to the nature and conditions of professional activity, the risks present at work and the way health services and programmes are organised and managed[1], and are linked to problems at work such as stress and violence[2,3].

In the context of professional activity, violence is one of the most serious problems in the health sector and health professionals are at high risk of violence worldwide[4].

The International Labour Organisation considers violence and harassment to be a set of behaviours and practices considered unacceptable, or threats thereof, whether occurring once or repeatedly, and which result or may result in physical, psychological, sexual or economic harm[5]. Thus, violence is a complex and multi-causal phenomenon, resulting in harmful effects for professionals[3], in the short and long term, ranging from the intensity of physical injuries, to psychological trauma, as well as the occurrence of situations of temporary to permanent disability and even death[3,4]. However, the consequences are also felt at an economic level, through the costs related to altering the normal development of activities, reduced productivity, absenteeism, insurance premiums and the use of health services for follow-up after the situation has occurred[4,6].

It can be concluded that these situations negatively affect the provision, quality and accessibility of health care by health professionals[6,7], constituting an obstacle to the sustainability of services due to the possible repercussions on the organisation and working relationship, as well as on the professionals' own performance[8].

Although violence against health professionals is a strongly recognised problem, it is difficult to quantify due to underreporting. Although studies show high rates of violence against health professionals, statistically the reports show much lower data[9].

Professionals involved in institutional and non-institutional care are also affected[4].

The Community Care Units (CCU), which aim to improve the state of health of the population in their geographical area of intervention, have a strong context of activity at home and in the community[10], i.e. at a non-institutional level.

Due to the unique nature of said units, which provide care in home and community settings, a safe and healthy environment is important for health professionals working in this area, which highlights the phenomenon of violence against health professionals as part of their professional activity in these contexts as a relevant and ongoing problem.

Although there are several studies on workplace violence against health professionals in the home context, in reality there are no studies relating specifically to CCUs. Therefore, the aim of this study is to identify the needs felt by health professionals in a CCU in the Lisbon and Tagus Valley region, in the area of health professional safety, in the dimension of preventing violence against health professionals, by carrying out a Health Diagnosis of this target population. Based on the results obtained, the aim is to subsequently design and develop effective interventions aimed at responding to the needs felt by the target population, contributing to safe and healthy working environments.

MATERIAL AND METHODS

Type of study

This is a qualitative, exploratory, descriptive and cross-sectional study, using interviews and the content analysis technique.

The Consolidated criteria for reporting qualitative research (COREQ) checklist[11] was used as a methodological guide for this article.

Selection of participants

The participants in this study were health professionals from the CCU, and convenience sampling was used. The inclusion criteria were: a) providing direct care to the patient at the time of data collection, and b) not being absent from work. Two researchers (CL and MJB) determined all the eligible participants and then, from the list drawn up, one researcher (CL) personally invited each participant. The total number of participants that made up the sample was conditioned by the saturation of the information obtained. The participation of health professionals was voluntary and there was no recourse to monetary compensation or other offers to incentivise participation.

Context

The interviews were carried out face-to-face on the premises of the CCU, at a time agreed in advance, according to the availability of the participants. They only took place in the presence of a researcher (CL) and the participant.

Each interview lasted an average of 13 minutes with the duration varying between 7 and 25 minutes.

Data collection

Initially, a research strategy was carried out, noting that there was no data collection instrument that met the pre-established ambitions. A semi-structured interview script was therefore drawn up. The questions were constructed according to the objectives of the study and divided into four thematic parts:

- Part I – sociodemographic and professional characterisation of the CCU professionals, with closed-ended questions relating to gender, age, academic qualifications, total number of years of professional practice and in the CCU, intervention areas/projects in which they work in the CCU and training in the area of violence at work;
- Part II – characterisation of the context of care provision in the community: a) Do you consider that the context of care provision in the community can generate vulnerable, unsafe and violence-prone environments? b) What measures/behaviours do you adopt when providing care in the community to minimise the risk of generating vulnerable, unsafe and violence-prone environments?;
- Part III – Characterisation of the frequency and type of violence in the provision of care in the community: a) What do you understand by violence against health professionals? What kind of situations would you classify under this concept? b) In your professional activity, namely in the provision of care in the community, have you experienced any situations of violence? c) Can you explain what kind of situation, the number of times it occurred, briefly describing the situation, namely the context, the characterisation of the aggressor, as well as how you reacted? d) Do you think that having experienced this kind of situation has had an impact on your life? In what way? How did you try to overcome these consequences?; and
- Part IV – characterisation of the notification of a situation of violence in the provision of care in the community: a) After the situation you experienced did you notify anyone? b) If not, what were the reasons? c) If you did, how did you proceed and who did you notify? d) On a scale of 0 to 5, where 0 is not at all satisfied and 5 is very satisfied, how do you consider the situation was handled? And the outcome?

Each interview was audio-recorded and then duly transcribed.

The interview script was drawn up and the data collected and analysed between June 2022 and April 2023.

Analysing the data

With regard to the sociodemographic and professional characterisation of the participants, a descriptive statistical analysis was carried out, calculating the absolute and relative frequency, the mean and the standard deviation, using the Excel® software, namely version 2019 of Microsoft 365®. To analyse the data obtained from the open-ended interview questions, a qualitative approach was adopted by analysing the content of the speeches using Bardin's categorical analysis technique, following the three phases recommended by the author: 1) pre-analysis, in which a floating reading of the transcripts was carried out and editing procedures carried out; b) exploration of the material, with the authors coding the data independently and resorting to triangulation of researchers to minimise bias; 3) treatment of the results, inference and interpretation, with 4 categories and 12 subcategories emerging in an inductive way. No software was used to analyse the data from the open questions.

During the analysis process, the authors tried to ensure the objectivity and relevance of the categories, the validity, completeness, credibility and transferability of the data. And to this end held several discussions with each other about the findings and the methodological path.

The results were returned to the participants, who gave favourable feedback.

Ethical considerations

This study complied with the ethical requirements set out in the Declaration of Helsinki, as well as the guidelines in the document "Rules for the Submission of Research Protocols for Appraisal by Ethics Committees in the Lisbon and Tagus Valley Region"[12]. A favourable opinion was obtained from the Ethics Committee of the Lisbon and Tagus Valley Regional Health Administration, the CCU and the Executive Director of the Health Centre Grouping where the CCU is located.

Authorisation was sought to carry out the interview, including audio recording, and informed consent was obtained and signed in advance. Participants were informed in advance of the possibility of declining to take part at any time, without any prejudice to them.

In order to maintain anonymity, the interviews were duly coded. They were then faithfully transcribed. The characteristics of the place where the interviews took place were taken into account in order to ensure privacy, anonymity and confidentiality.

RESULTS

Characteristics of the participants

The sample consisted of 8 health professionals, corresponding to 44.44% of the eligible target population (Table 1[7]).

Eight interviews were carried out, all of whom were from the nursing profession. The participants were predominantly female (87.5 per cent). At the time of the interview, the average age was 43 (with a standard deviation of 6.61), ranging from 35 to 51. The majority had more than a Licentiate degree, namely a postgraduate degree, a speciality degree and a master's degree, with an equitable distribution of 25% of each of the above qualifications.

The average length of total professional experience was 20.25 years (with a standard deviation of 6.45), ranging from 10 to 27 years. In the area of community care, the average length of professional experience was 7.25 years (with a standard deviation of 4.17), ranging from 1 to 12 years, and around 37.5 per cent of the participants had been working in the area of community care for less than 5 years.

The majority worked in the Integrated Continued Care Teams (62.5 per cent), followed by the School Population (25 per cent) and finally the area of Children and Young People at Risk or Vulnerable (12.5 per cent).

Only 1 (12.5 per cent) of the 8 participants said they had attended professional training in the area of violence at work, but this had taken place more than 10 years ago and in a work context other than the CCU.

Categories and subcategories

The second part of the interview produced a total of 4 categories and 12 subcategories (Chart 1↗).

a) Perception of context

1. Description of the perception of the context

All the participants agreed that the context of providing care in the community could generate vulnerable, unsafe and violence-prone environments, justifying it with the feeling of lack of protection (E1, E2, E3, E5, E7) "*You can't control the environment*" (E2) and "*We're entering their space and they have more power*" (E3), the fear of the unknown and the feeling of insecurity (E1, E2, E3, E4, E6, E7, E8) "*You don't know who's in there*" (E2), aggravated by the context of "*Multiculturalism*" (E1) and "*Social neighbourhoods*" (E7) in the municipality where they worked, i.e. providing care in the community presented a greater risk of exposure to situations of insecurity and violence because it involved travelling to spaces without direct protection.

2. Measures adopted in these contexts

In order to minimise the risk, relational/communicational behaviours and defensive behaviours were mentioned. In the latter, the number of 2 professionals was mentioned whenever possible (E2, E3, E7, E8), the organisation of appointments (E1, E2, E3, E5, E7) "*We organise it in terms of timetables*" (E2), "*Prior warning that the visit is going to take place*" (E5), managing resources by "*taking a mobile phone*" (E2 and E7), "*Going with the identified van*" (E2) and adopting a defensive posture that allows them to visualise the environment (E5), anticipating risks.

b) Concept of violence

1. Nature

Most of the participants characterised violence according to its nature, complementing it with the typology: Psychological violence through verbal aggression (E1, E2, E3, E7, E8) and Physical violence (E1, E2, E3, E7, E8).

2. Type

The nature of interpersonal violence was also mentioned, when it manifests itself at an institutional level: "*Violence towards users, violence towards the team itself, and violence towards superiors*" (E4) and "Users towards health professionals or interprofessionals" (E6).

c) Experiencing violence

1. Nature of violence

Situations of physical violence (E2, E3) and psychological violence (E1, E2, E4, E6, E7, E8) were mentioned, the latter essentially through insults *"More inappropriate or more aggressive language"* (E1), intimidation *"Coming to lean on us"* (E2) and threats *"They would come to me (...) with that threatening tone"* (E6).

2. Context

Exploring where the situation occurred, it essentially happened at the patient's home (E2, E3) and when telephone contact was made (E6, E8).

3. Aggressor

Violence was reported by the patient's family member or legal representative (E1, E2, E6, E8) and by the patient himself (E3, E8).

4. Reaction to the situation

The participants' reactions to the situation were quite diverse. From self-defence *"Keeping my distance"* (E6) and *"Unconsciously I've already observed the whole physical space"* (E6), to asking the aggressor to stop (E1, E4, E5, E7), to confrontation *"I ended up countering what she said"* (E2) and devaluing the situation and/or trying not to overlap/impose (E2, E3). Afterwards, there were situations of dialogue with the team and/or the manager (E2).

5. Impact of the situation

Although some of the participants said that these situations had no impact on their lives *"No, it hasn't had any consequences"* (E1), *"I didn't feel it affected me"* (E4), most of them said that they felt anxiety, stress, irritability, sadness and frustration in the short and medium term (E2, E4, E6, E7, E8), which affected the way they provided care to other patients *"The way I was to the [other] patients afterwards"* (E8). Some participants also said it was a learning moment for future situations (E4, E6). Only one participant said that at the time he felt a change *"in terms of professional satisfaction"* (E7).

6. Later coping strategies

Some participants mentioned the verbalisation of feelings between teams (E3, E7), as well as the victim's excusing the aggressor *"Thinking that the behaviour has nothing to do with us (...) it's the person themselves who is exhausted"* (E8). Some participants also said it was a learning moment for future situations (E4, E6). Another strategy to ensure continuity of care consisted of transferring care of the patient to another CCU team (E2).

d) Incident notification

1. Reasons for not being carried out

The form of notification mentioned in the interviews consisted of informing the line manager (E2) and most of the participants said they hadn't notified the situation because they didn't value it (E1, E3, E6, E7) "*I thought it might be an exaggeration on my part*" (E6) and "*We think it's normal, that it's part of the job*" (E7), as well as a feeling of lack of time (E8) and lack of knowledge about procedures, namely how to carry out a notification (E8).

2. Satisfaction

The participant who said he had notified his line manager of the situation said he was satisfied with the way the situation was handled and the outcome.

DISCUSSION

This study sought to expose violence against health professionals in CCUs as a highly relevant, complex and worrying social phenomenon. As a result, it was possible to identify the needs felt by health professionals in a CCU, in terms of violence against health professionals, which were grouped into 4 categories.

In the category of perception of the context, the participants mentioned a feeling of low security when carrying out their work in a home environment, which is in line with some of the determinants and factors associated with violence that have already been mentioned, such as working alone in non-institutional environments or in isolated areas[13,14,15] and the location of the users' homes in unsafe neighbourhoods or with high crime rates are also mentioned as factors associated with violence[13-14].

To prevent violence, the literature suggests training in communication skills, ensuring adequate security resources and infrastructure in health centres and financial investment to equip the services[14,16] with adequate means of travel, and participants have already adopted these strategies.

With regard to the category of the *concept of violence*, there was a classification of its nature, essentially physical violence and psychological violence, the latter essentially through verbal aggression.

In fact, in the category of *situations of violence experienced by* the participants, physical violence was mentioned, as was psychological violence. When people think of violence, they quickly associate it with physical violence, given the visible effects it causes. But physical violence is less frequent than psychological violence, the latter in the form of verbal aggression[17]. From this perspective, it can be assumed that the ease with which verbal violence is carried out may increase its incidence.

From this perspective, Cenk's study in 2019[17] also shows similarities with our study: insults and shouting, combined with intimidation and threats, were the most common forms of verbal aggression, while pushing and throwing objects were the most common forms of physical violence. Other studies corroborate said data, where exposure to verbal aggression (psychological violence) was the most reported, followed by physical violence and, although in the minority, sexual violence/harassment[18,19,20]. Verbal aggression, which is the most common form of violence, is often manifested through intimidation and threats, specifically through the use of tone of voice[19,21,22,23].

Data in the literature indicates that the aggressor is most often the patient themselves[17,20,24,25] or the patient's carer/family member, followed by the patient themselves[19], the latter being the case in our study. This may be due to the type of projects that are developed in this CCU.

Professionals who work in isolation are at greater risk of experiencing violence, which can have both physical and psychological consequences[4,26]. These effects were also mentioned by the participants in our study. Stress, anxiety, fear, anger and feelings of guilt stand out, in other words, victimisation[23,27,28], as well as a decrease in job satisfaction[4,23,27] and a negative effect on work motivation[4]. On the other hand, it's essential to emphasise that professional performance itself and, consequently, the quality of care provided, is affected when and after situations of violence occur in the context of professional activity[4,18,21,28], with a direct and indirect economic impact on institutions.

Strategies for dealing with these situations later on, also expressed by the participants, included expressing emotions such as crying or anger, interpreting thoughts and actions that may have led to the conflict (and sometimes excusing the aggressor), and establishing skills for dealing with a similar situation in the future, i.e. as a learning moment. The support of colleagues and superiors is a valuable resource for the recovery process[28,29]. One of the participants indicated that a patient had subsequently been transferred to another care team within the CCU; in fact, OSHA[14] suggests, as a strategy to be applied in the field of workplace violence, the suppression of a dangerous situation by eliminating or replacing it with another safer working practice, which can include transferring a patient between teams or even between institutions.

Finally, in the category of *reporting the incident*, the participants corresponded to what is reported in the literature: despite the high prevalence of violence against professionals working in home and community settings and the recognition of the seriousness of this phenomenon, there is an underreporting of these incidents[30,31,32].

In our study, under-reporting was notorious. Studies identify the most frequent reasons for not reporting as the perception that it would be useless, believing that nothing would be done; attributing low significance to the incident; attributing violence as part of the job and lack of knowledge about reporting procedures[10,24,25,32], situations also reported in our study. OSHA[14] also points to the perception that violence is tolerable and that reporting incidents has no effect as a risk factor for workplace violence.

Despite the fact that one of the participants had notified its line manager, in reality, failure to notify through the various existing means contributes to under-reporting, making it difficult to quantify these situations and, on the other hand, not benefiting professionals in terms of their rights, namely in terms of workplace violence being considered an accident at work, psychological and legal support, among others[7].

In view of the results obtained in this study, it is clear that it is crucial to intervene with professionals by adopting various strategies. One of these strategies could centre on training courses to raise awareness of the phenomenon of violence in the health sector, as well as strengthening knowledge about the procedures to adopt in the event of violence in the context of professional activity. Another strategy will be to hold regular training meetings, whenever necessary, to discuss and reflect on situations of violence in the context of professional activity.

Due to the nature of the care provided – in a home and community context – it may be beneficial to carry out other complementary training courses in the area of communication skills (in order to reduce and resolve situations of conflict and violence) and in the recognition and prevention of situations of violence, as well as the appropriate management of these situations.

From an organisational/institutional point of view, the strategy will involve drawing up a sectoral procedure to standardise the form of intervention to be adopted by CCU health professionals in the event of an episode/case of violence within the scope of their professional activity.

This study has some limitations. On the one hand, it is based on self-described and memory--conditioned data, which increases the risk of bias due to recall of events. On the other hand, convenience sampling was used, so the results may incorrectly represent the population and, consequently, present bias. Therefore, generalising this study to CCUs may not be advisable. However, our results are in line with the literature for other areas of the health sector, and there is no evidence to suggest a different situation.

Finally, a difficulty in carrying out this study, as well as in comparing it with the existing literature, is the scarcity of studies relating to this specific type of care context, despite the fact that violence is frequent in home environments[15].

CONCLUSION

Violence in the workplace is an occupational hazard that has a significant impact on the health and well-being of health professionals.

After analysing the results obtained, it was observed that they are in line with various conclusions validated in other studies. Unfortunately, the small sample size and the specificity of the context mean that the results cannot be generalised, although they do corroborate many others.

Considering the results of the interviews, it can be seen that the different types of violence experienced in the context of their professional activity are directly related to the work process, the interpersonal relationships established, as well as the context in which the professional activity is carried out. Psychological violence, especially verbal violence such as threats and intimidation, was the most commonly experienced; however, physical violence, although described in a less expressive way, was still present. However, health professionals revealed that they did not value the impact and effects of situations of violence within the scope of their professional activity, which explains the underreporting, as well as their lack of knowledge of the procedures to adopt in the event of violence against health professionals within the scope of their professional activity.

Due to the unique nature of care services in home and community settings, the importance of a differentiated approach, in this case that of a nurse, is emphasised, with a view to developing strategies that promote the well-being and health of health professionals in their workplace, while carrying out their duties.

It is therefore suggested that different strategies be used from both a professional and organisational point of view, taking into account the type of institution and the type of healthcare provided there.

Listening to and protecting health professionals, instilling a feeling of zero tolerance towards situations of violence in the course of their professional activity and promoting the reporting of situations of violence in the course of their professional activity, will make it possible to obtain more data on this reality, targeting and optimising the interventions to be carried out, especially in such specific and little-studied areas as the provision of health care in home and community settings.

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Table 1 – Sociodemographic and professional characterisation of the CCU sample.

Socio-demographic and professional variables	Frequency	Percentage %
1 Gender		
Female	7	87,5
Male	1	12,5
2 Age (age group)		
31-40 years old	3	37,5
41-50 years old	4	50
51-60 years old	1	12,5
Minimum	35	
Maximum	51	
Average age	43	
Standard deviation	6,61	
3 Academic qualifications (higher)		
Bachelor	1	12,5
Licentiate degree	1	12,5
Postgraduate studies	2	25
Master's Degree	2	25
Other	2	25
4 Number of years of professional practice		
6-10 years	1	12,5
11-15 years	2	25
16-20 years	2	25
21-25 years old	1	12,5
26-30 years	3	37,5
Minimum	10	
Maximum	27	
Average number of years	20,25	
Standard deviation	6,45	
5 Number of years of professional practice in the Community Care Unit		
1-5 years	3	37,5
6-10 years	2	25
11-15 years	3	37,5
Minimum	1	
Maximum	12	
Average number of years	7,25	
Standard deviation	4,17	
6 Intervention areas/projects in which it mainly works		
Integrated Continuing Care Teams	5	62,5
In the School Population	2	25
In Reproductive Health	0	0
Of Children and Young People at Risk or Vulnerable	1	12,5
Other	0	0
7 Have you attended any training courses on violence at work?		
Yes	1	12,5
No	7	87,5
7.1. If so, for how long?		
Less than 10 years	0	0
More than 10 years	1	100

Chart 1 – Content analysis of the interviews .↖

Category	Sub-category	Registration unit
Perception of context	Description of the perception of the context	• Lack of protection
		• Fear of the unknown
		• Insecurity
	Measures adopted in these contexts	• Relational/communicational behaviour
		• Defensive behaviour
Concept of violence	Nature	• Physical violence
		• Psychological (verbal) violence
	Type	• Interpersonal violence (at institutional level)
Experiencing violence	Nature of violence	• Physical violence
		• Psychological violence
	Context	• User's home
		• Not in person (telephone contact)
		• Another location
	Aggressor	• User's family member / legal representative
		• User
		• Other
	Reaction to the situation	• Self-defence
		• Asking the aggressor to stop
		• Confrontation
		• Devaluing the situation
		• Trying not to overlap/impose
		• Dialogue with the team and/or manager
	Impact of the situation	• Anxiety/stress/irritability/sadness
		• Concern for others
		• Quality of care
		• Professional satisfaction
		• Irrelevant /no impact
	Later coping strategies	• Verbalising feelings
		• Excusing the aggressor
		• Learning moment
Incident notification	Reasons for not realising	• Devaluing the situation
		• Lack of time
		• Lack of knowledge about procedures
	Satisfaction	• Referral
		• Outcome