

**The Discrepancy Between Actual & Unreported Incidents of Violence in a
Learning
Disability Nursing Service**

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Abstract

This study reports on research carried out within the Learning Disability Division of a major Mental Health NHS Trust in the North of England, and relates to the discrepancy between the actual number of incidents of violence and aggression and those reported. The literature review demonstrated that violence is a particular issue for nurses, particularly those working in the areas of mental health and learning disability where studies have indicated that as many as one in five may be affected. A questionnaire was distributed to all learning disability nurses currently employed in the Trust, a total of 411, with a response rate in excess of 40%.

The study revealed that a discrepancy does exist between actual and reported incidents of violence within the Trust. It confirmed previous claims that the predominant difficulty is cultural, violence being regarded as part of the job and non-reporting primarily revolving around perceptions of incidents being considered 'minor', not worth the time to complete the paperwork. The paper concludes that more work is needed to achieve a united, consistent approach across the NHS, in order that a high quality, accessible service for people with learning disabilities and complex needs can be delivered without violence being considered an acceptable part of the job.

Key words: Violence; aggression; discrepancy; unreported; learning disabilities; minor.

Introduction

The issue of violence towards health care professionals has long been of concern, apparently 'firmly established as a high priority issue' (Whittington, 1997: 49) for more than a decade, with the zero tolerance campaign highlighting a historic under-reporting of incidents (Department of Health, 1999). The paucity of evidence has been a particular issue, acquiring an accurate picture being 'fraught with difficulties' (Turnbull, 1994: 8), there being few dissenters, however, to the observations by professional bodies that good records of incidents remain 'crucial to any preventative strategy' (Royal College of Nursing, 1998: 8) and accurate statistics constituting an 'essential part of risk management' (United Kingdom Central Council, 1998: 23).

Numbers of violent incidents against NHS staff have been estimated at 65,000 annually (Department of Health, 1999) rising to more than 84,000 two years later with incidents in mental health/learning disability Trusts between two and three times greater than other areas of care (Department of Health, 2001). Recent publication of incidents of physical violence against NHS staff reveal over 60,000 in acute and primary care Trusts (McGregor, 2006) and 43,000 in mental health/learning disability settings (Willis M, 2006). The establishment of the NHS Counter Fraud and Security Management Service (CFSMS) in 2003 sought, besides investigating fraud, corruption and security, to address the issue of violence (CFSMS, 2006).

The purpose of this article is to examine the literature on the reporting of violence, before presenting evidence from a research project investigating the extent of under-reporting in the learning disability division of one NHS Trust and the reasons attributed by survey respondents.

Literature Review

The boundaries between mental health and learning disability nursing occasionally overlap (Thompson & Mathias, 1998), some authors identifying a 'merging' of the two professional fields (Cottle, Kuipers, Murphy and Oakes, 1995; McDonnell and Reeves, 1996; Turnbull, 1996). The high incidence of mental ill health observed amongst people with learning disabilities has also attracted considerable attention (Gates, 1999). The development of NHS Partnership Trusts over recent years, comprising both mental health and learning disability components, has served to some extent to consolidate this relationship. It would appear, therefore, to be appropriate to examine the literature on violence in both areas of care, since the statistics are so entwined, before focusing more clearly on the learning disability sector.

There is an absence of consensus regarding the definition of violence in the context of healthcare (Needham et al., 2005), with some writers emphasising 'physical contact by a patient or client that results in feelings of personal threat' (Ryan & Poster, 1993: 38), others including 'any incident in which a person is abused, threatened or assaulted relating to their work' (Health & Safety Executive, 1998: 1), which is extended to involve 'an explicit or implicit challenge to their safety, well-being or health' to constitute zero tolerance (Department of Health 1999). More detailed analyses have seen violence categorized according to the level of physical injuries sustained (Health Services Advisory Committee, 1987), whether towards self, others or property, degree of physicality involved (Morrison, 1993), and emotional effects (UKCC, 2002), which include feelings of shock, anger, fear, frustration (Howard & Hegarty, 2003), powerlessness and insufficiency (Lundstrom et al., 2007).

The term challenging behaviour, developed in the late 1980s by Emerson, Cummings, Barrett, Hughes, McCool and Toogood (1988), has increasingly gained favour as a descriptive term in the field of learning disability and mental health. It has successfully transformed the service provider view of behaviours as residing within the individual towards an emphasis on it being a challenge to carers, but in the process has become 'vague and lacking clarity' (Tarbuck & Thompson, 1995: 30). The term is best restricted, therefore, to those with severe learning disabilities where the behaviour is complicated by issues of communication, measurability and subsequent exclusion. The term violence most accurately reflects the experience of staff in relation to the findings of the study described in this article.

Irrespective of the particular definition employed, though it should be inclusive of its emotional impact to be of any value, it is clear that learning disability and mental health settings are represented within the literature surrounding violence and aggression. Concerns about the implications of such studies exaggerating the relationship between learning disability and/or mental health and violence are well-founded and can give rise to distorted public perceptions. The point to be made is that we are referring to those individuals who are currently experiencing crises and receiving care within learning disability services, including assessment

and treatment, semi-secure or other clinical settings. The vast majority of people with learning disabilities and those experiencing mental health problems pose far more threat to themselves than they do to those caring for them, their peers or the general population. Research suggests that violent assaults occur every 11 days (Whittington, 1997), though some have suggested every three days (McMillan, 1998), with one study indicating four out of five nurses experienced an incident in the previous year (Kiely, McCafferty & McMahan, 1999). A recent study of violence in learning disability in-patient units found that 79% of staff had experienced violence (Chaplin, McGeorge & Lelliott, 2006).

Recording and Reporting

Recording of incidents of violence vary according to organisation (Vanderslott, 1998), though historically there is a tendency towards under-reporting (Department of Health, 2002) and underestimation in relation to health care is 'certain' (United Kingdom Central Council, 2002: 9). Government targets to reduce incidents by 30% over a 5-year period (Department of Health 1998) have been singularly unsuccessful, a renewed emphasis subsequently advocated in the areas of risk assessments, action plans, comprehensive reporting, staff training and follow-up staff support (National Audit Office, 2003). Such measures basically reiterated the guidelines of the Health and Safety at Work regulations, wherein inadequate risk assessment, that is, which had not been based on all available information (Vinstock, 1996), could result in enforcement action varying from improvement notices to criminal prosecution (Royal College of Nursing, 1998).

The creation of a safe environment for nursing care necessitates a written record of circumstances, 'which could jeopardise standards of practice' (Nursing & Midwifery Council, 2002), and recognition that more frequent entries should be made when patients/clients 'present complex problems, show deviation from the norm, require more intensive care than normal, are confused and disorientated or in other ways give cause for concern' (United Kingdom Central Council, 1993). Despite such long-established and ongoing concerns, under-reporting of violence appears to remain entrenched within health care settings (Royal College of Nursing, 1998; United Kingdom Central Council, 2002).

Discrepancies

The extent of under-reporting appears, therefore, to be the primary issue, one study of psychiatric settings found that only one incident in six was recorded (Lion et al., 1981), and a further one, based on video evidence, suggesting as many as 12 out of 13 incidents go unrecorded (Crownier et al., 1994). One theory for such gross non-reporting revolves around the erroneous, but deeply held, belief that nurses should be able to cope and not doing so constitutes failure (Royal College of Nursing, 1998). Other possibilities are worth examining:

Lack of time: A high incidence of workplace violence might preclude the recording of all incidents (Stark & Kidd, 1995), staff simply forgetting because of being too busy (Kiely et al., 1999), the danger of a vicious circle of escalation thereby becoming a real possibility (National Audit Office, 2003).

Lack of support: Despite claims of 43% of staff having been assaulted or harassed, less than half were reported because of confusion over inclusion criteria (Royal College of Nursing, 1998), though accurate completion of

documentation has since been identified as a priority (National Institute for Health & Clinical Excellence, (NICE) 2005). Staff might also be reluctant to report a patient they consider mentally unwell (Turnbull, 1994), an insufficient reason, however, to disregard important data (McGregor, 2006), and the need to take responsibility for one's actions is a corollary of promoting independence (Radcliffe & Cort, 2001: 24).

Classification of incidents as 'minor': The likelihood of reporting increases according to severity of the incident with 95% of those considered 'major', for example, being reported, in contrast to only 28% of incidents of verbal abuse (Kiely et al., 1999). Furthermore, tolerance of violence appears to be greater in learning disability and mental health settings (National Audit Office, 2003).

Waste of time: The most significant issue is an anticipated lack of response from line managers (Kiely et al., 1999), particularly since 'firm backing' is considered so important in enhancing a safe environment (McMillan, 1998: 10). Nearly 30% of respondents considered it to be unproductive to report incidents of verbal aggression, which, perhaps surprisingly, increased to over 33% in the case of physical aggression. This is despite well documented concerns (for example, United Kingdom Central Council, 2002) relating to the need for accurate records in the workplace, and how these can directly influence qualitative changes to policies, training, procedures and practice. The importance of clinical audit has been recognised as the primary mechanism for improving quality (NICE, 2005). Furthermore, National Institute for Mental Health England (NIMHE) (2004) recommended all Trust Boards undertake an analysis of what constitutes the root cause(s) of violence and aggression, which should comprise information surrounding number of incidents, type, location and time, possible causes, injuries sustained and outcome of reviews. Such information should then be used to assess emergent themes, lessons learned, strategies proposed, implications for staff training and issues of ethnicity, age and gender.

Fear of repercussion: The use of physical restraint appears likely to discourage official reporting, and less than half such incidents from learning disability units included the names of those involved (UKCC 2002). The view of the 'prevailing organisational culture' seems to be significant in fostering the acceptability of issues such as coping alone, making mistakes, bad luck and being part of the job (Rees & Lehane, 1996: 47).

Consequences of exposure to violence

The cost of violence encompasses the victim, staff team and entire organisation (Department of Health, 1999), though the psychological and emotional effects of minor incidents, such as fear, anxiety and reduced confidence (Millington, 2005) can be the equal of major ones (Needham, 2005) involving the more obvious physical injury and subsequent medical attention (Devine, 2004). Other possible effects include poor sleep, increased reliance on cigarettes and alcohol (Royal College of Nursing, 1998), general health decline (Needham, 2005), with recovery sometimes taking years (Nursing & Midwifery Council, 2005). The implications for the service can include increased sickness and absenteeism, which may compromise service quality and workplace safety (CFSMS, 2006), increased litigation concerns (Devine, 2004) and subsequent difficulties in recruitment and retention (Millington, 2005).

Methodology

From the literature review, there were four key questions to be addressed by the research:

1. Does a discrepancy between actual and reported incidents of violence and aggression exist within the learning disability division of one particular NHS Trust?
2. What is the extent of any such discrepancy?
3. Why does such a discrepancy exist?
4. How can the situation be improved?

Design

The survey method was selected as the most appropriate approach, it being widely recognised as a standard method of collecting information (Hall & Hall, 1996). The primary goal in survey research is to predict accurately the characteristics or thoughts of a predefined group, if possible an entire population (Parahoo, 2006). This was the approach adopted here, a total population sample in order to gain access to all nurses currently employed in the learning disability service. A self-completed, structured questionnaire was selected as the most pertinent instrument for data collection, in terms of both eliciting the required information and acknowledging its sensitivity (Wellings et al., 1994). Issues of confidentiality and anonymity were paramount in the construction of the questionnaire, being considered more likely to encourage honesty of response (May, 2001). The questionnaire, comprising mainly forced-choice questions and a few open-ended ones for additional comments, was subsequently administered to all clinical staff members, qualified and unqualified, currently employed within the learning disability division; this total population constituted 411 individuals. The questionnaires were distributed to a total of 30 workplaces accompanied by a letter of explanation about the purpose of the research and the background of the researcher. The researcher was known to some of those surveyed, a sometimes useful and not inappropriate issue (McCull, 2001), and personal distribution is considered to prompt the highest response rates (Mateo & Kirchhoff, 1999). However, due to the constraints of time and finances, it was decided that distribution by Departmental Managers would be most effective, the accompanying letter personalizing distribution and preventing potential bias from the relationship between researcher and participant (Bell, 1999). Consent was implied by the right for non-response.

Procedure

For the pilot study, 50 questionnaires were distributed to 3 workplaces employing 10% of the total proposed participants (Abbott & Sapsford, 1998), and 38 responses were received. There were no significant concerns raised about the construction of the questionnaire so it was decided that the same tool would be used unaltered for the main survey distribution.

The remaining 361 questionnaires resulted in 154 responses, 42% of the total constituting a degree of respectability, though variability is so great that a typical response rate is difficult to assess (Cormack, 2000). The relatively high rate can probably be attributed to the literature review finding of a high number of NHS staff being affected in some way by violence and aggression.

Data Analysis

The Statistical Package for the Social Sciences (SPSS), a specialised quantitative computer analysis programme advocated by some writers (Cormack, 2000), was used to tabulate the data collected.

Ethical Approval

Approval was sought from the Local Research Ethics Committee and the University Faculty Ethics Committee, both of which were content for the research to go ahead once a number of issues were satisfactorily addressed. These related to the title of the study clearly including the words violence and aggression, the provision of information to Departmental Managers outlining their role of facilitation, which would also be likely to enhance response rates, and the provision of pertinent direction for support should any respondents be distressed through their participation. A further alteration concerned the provision of information to participants regarding how to return the questionnaire and a statement relating to the right not to participate or withdraw at any point.

Results

Tables 1-3 provide some background information about the survey participants. Table 1 shows the amount of time spent working within learning disability nursing services, Table 2 the range of services in which they were employed and Table 3 the employment bandings of different members of staff. The composition of response rates was an accurate reflection of the service structure, 40% working as community nurses, 30% from residential and respite, and 25% from specialist assessment and treatment and secure services. Nearly 30% of respondents had more than 20 years experience working as nurses for people with learning disabilities, a further 30% between 11 and 20, 20% between 5 and 10, and 18% less than five years. Half of the respondents were employed on Band 3, 20% on Band 6 and 10% Band 7.

Table 1: Years worked in nursing people with learning disabilities

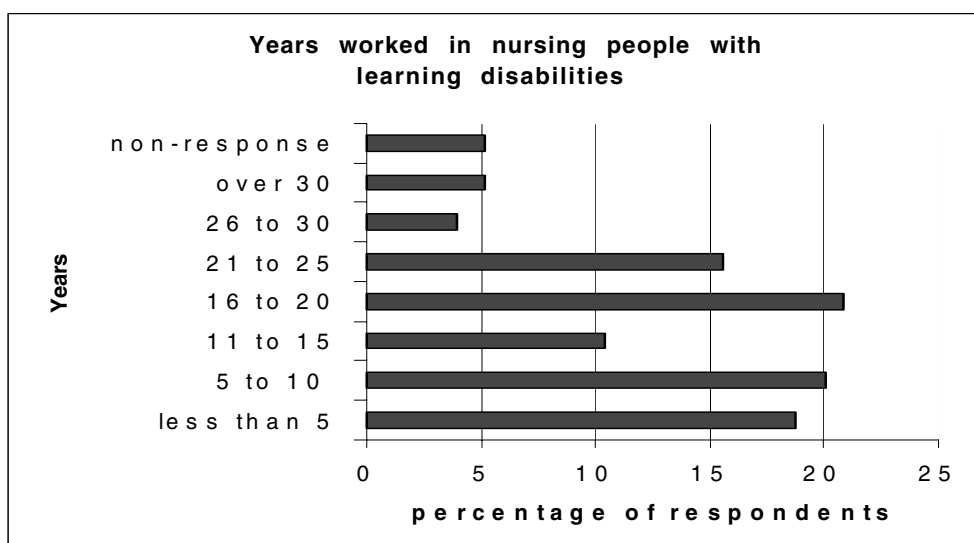


Table 2: Service composition of participants

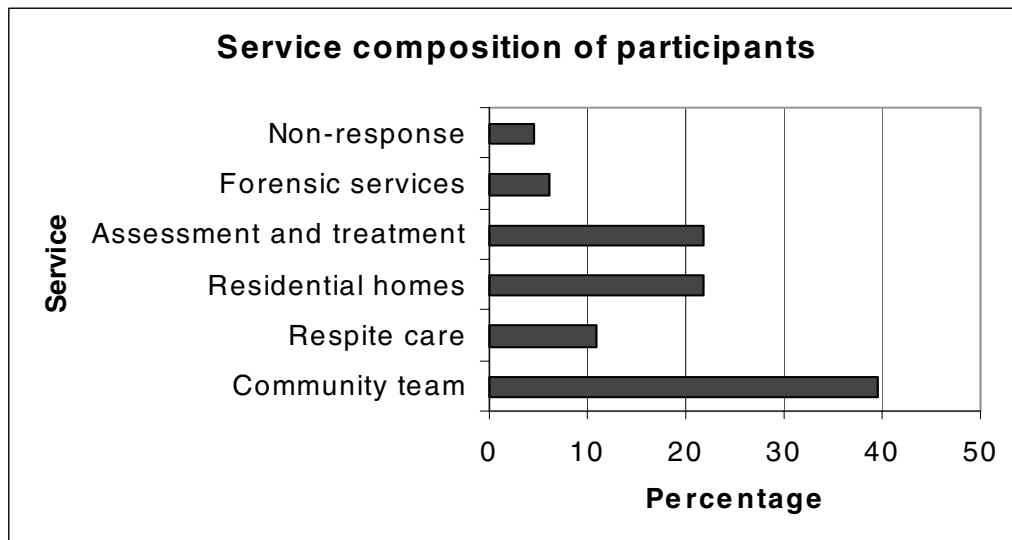


Table 3: Bandings of staff

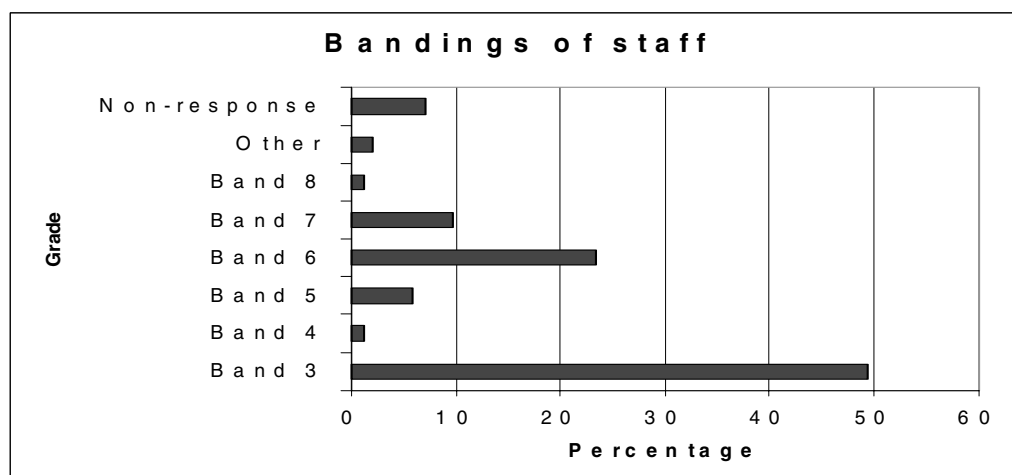


Table 4 illustrates the reasons provided by respondents surrounding their non-reporting of violence and aggression. The most statistically significant reason related to incidents being considered to be ‘minor’, particularly verbal, with 72.6% choosing this response. In the case of non-reporting of physical violence, 42.9% responded. This second most common response was ‘other’, which largely consisted of respondents commenting that violence and aggression was ‘part of the job’. Of the other stated options for not reporting verbal aggression, 23.8% stated it was due to ‘lack of time’, 11.1% a ‘lack of support’, 29.6% a ‘waste of time’ and 5% ‘fear of repercussions’. In terms of physical violence 14.3% reported ‘lack of time’, 5.3% a ‘lack of support’, 33.3% ‘waste of time’ and 5.3% ‘fear of repercussions’.

Table 4: Comparison of the reasons why respondents did not report incidents of verbal and physical violence and aggression

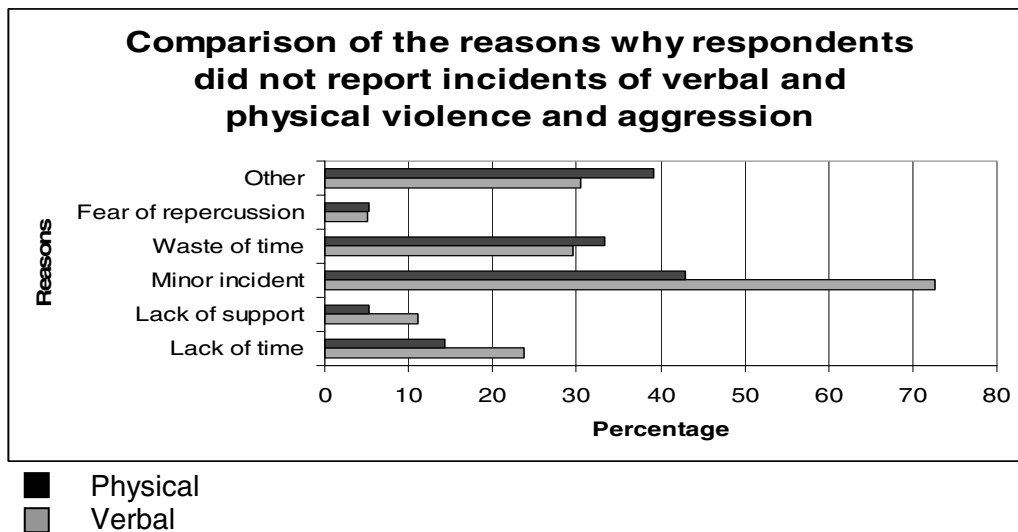


Table 5 relates to the perceived level of support respondents considered was available from various sources specifically comprising colleagues, managers, employing organisation, and initiatives such as state legislation, policies and local procedures. The issue of support relates primarily to lack of feedback from line managers following an incident, more than 4 out of 5 respondents having received no acknowledgement that anything had occurred. Nearly half did not feel supported by the organisation, though more than 90% did feel supported by colleagues, 68% by managers and nearly 75% by the process in place.

Table 5: Level of support perceived

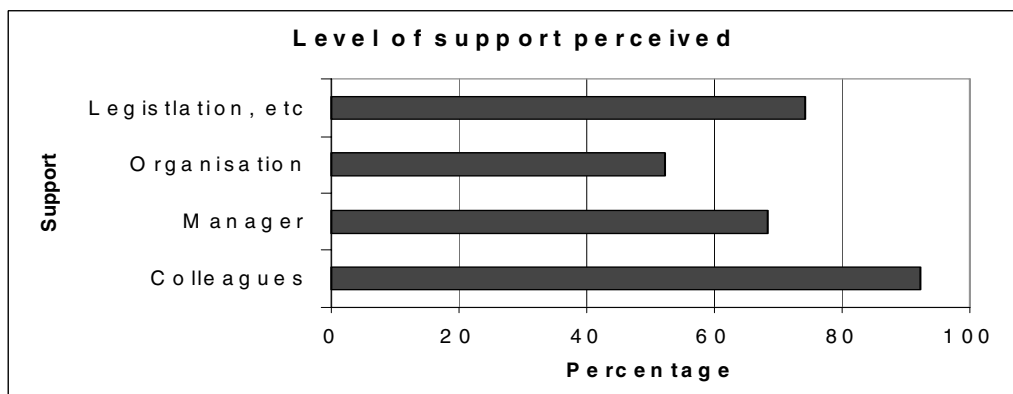
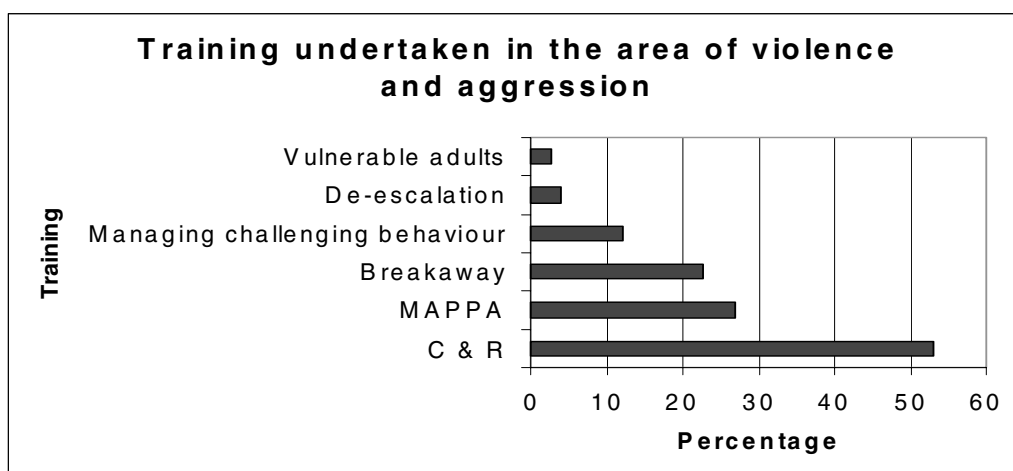


Table 6 shows respondent replies surrounding training undertaken relating to violence and aggression, 11.5% replying that they had received none at all. Of the 88% who had received training, 53% had undertaken control and restraint (C&R), 27% Multi-Agency Public Protection Arrangements (MAPPA), 22.6% breakaway techniques, 12.2% attended a 'Managing Challenging Behaviour' workshop, 3.9% de-escalation and 2.6% 'vulnerable adults' training.

Table 6: Training undertaken in the area of violence and aggression



Limitations to the Study

The findings of the research are restricted to the learning disability division of one particular NHS Trust, there being no survey conducted of those nursing staff employed in the mental health service. The extent to which the findings can be generalized to other learning disability NHS care is difficult to determine, there being sometimes significant variation in workforce composition and service structure between areas. A further study would be necessary to find out whether findings would be similar for nursing and direct care workers in the non-NHS sector for people with learning disabilities.

Discussion

The data collected reveal that three-quarters of respondents (74.7%) had experienced aggressive or violent behaviour in the workplace, which is consistent with the findings of other studies discussed earlier and higher than official estimates (for example, McGregor, 2006). The study reported in this article, however, suggests gender to be less of a factor in determining the threat of violence being translated into reality, women having an increased likelihood of being the recipients of physical aggression. This is complicated, however, in terms of the learning disability service studied, by the length of time of service, women being almost twice as likely to remain for more than 10 years. Another significant factor of immediate concern is that of the impact of qualification, previous studies finding a positive correlation between no formal qualification and susceptibility to violent behaviour on the part of patients (Vanderslott, 1998; McKenzie et al., 2003). Those individuals in this study within higher employment bandings, but retaining significant service user contact, were actually more likely to experience verbal and physical aggression. The exact reasons for this were difficult to determine, though the markedly increased length of service of the qualified staff provides far greater opportunity for violence to be experienced. The working circumstances of most qualified nurses, whereupon it is more likely that they encounter difficult circumstances in conditions of increased security (for example, assessment and treatment or secure settings), may also be significant. Interestingly, staff felt supported, more than two thirds by their managers, nearly three-quarters by policies, legislation and procedures, with less than one in ten feeling let down by colleagues. The system, therefore, appears to be quite good in making sure that those affected by incidents of aggression are not isolated and

consumed with feelings of guilt or fear. The problems, therefore, are perhaps more convoluted, nebulous and uncertain, reflective not of an uncaring system but one that has not internalised its own rhetoric.

A 'waste of time'/A 'minor' Incident

The notion that reporting incidents of violence and aggression in the workplace might constitute a 'waste of time' appears to run deep within the culture of services, and is, perhaps, connected to issues relating to what is valued, individually, by colleagues and by the organisation. There will always be conflicting demands on the time of a practitioner, and, irrespective of what is documented as good practice, in terms of fulfilling policies and procedures, it is only when such practice is rewarded consistently as an ongoing part of the working day that a cultural change will begin to emerge. It remains a significant problem, however, that a third of respondents considered it not worth reporting a physical assault despite the evidence that this is imperative as a first step in reducing incidents of violence and aggression.

The most significant reason for non-reporting relates to the nebulous notion of 'minor', whereby large numbers of staff consider a degree of violence, particularly verbal, to be an acceptable part of the job. Nearly three-quarters of respondents regarded it reasonable to be verbally abused; racist and sexist language employed casually because the target is regarded as fair game, vicious and damaging profanities issued for little other reason than its okay to do so. Despite multiple campaigns and general use of the term zero tolerance, nurses working with people with learning disabilities continue to regard a certain amount of abuse, including almost half respondents in the context of physical violence, to be 'part of the job'. The combination of the vulnerability of the client group, poor understanding of the longer-term consequences of being abused in this way, and the paradoxical power of the term 'minor' in determining individual responses appears to maintain a culture of a certain level of violence being okay. Maybe it is time to reconsider the term minor as a description of violence, since each incident affects the individual at some level, despite common misconceptions, a 'little scar' remains after every instance of abuse, whether verbal or physical. Unfortunately, the expectation that employees working in difficult situations should accept a degree of violence and aggression persists across time and remains influential in services. There is a competitive element to non-reporting, some continuing to take pride in the amount of difficulty they can be subjected to without complaint, even embracing their injuries rather than acknowledging the damaging impact on themselves and their work. This is the legacy of a macho culture in working with individuals with a propensity for violence, one that has eroded in part but not disappeared, and one that presents an invidious challenge to those implementing more progressive approaches.

Training in the Prevention of Violence

Risk assessments have gradually been integrated into care systems, and the importance of effective policies, procedures and staff training constitute the framework within which individuals must work (CFSMS, 2006). It is well documented that action plans help to identify, analyse and rectify problems in accordance with the risk assessment, which should include reporting of all violent incidents (National Audit Office, 2003). The need for support and counselling, post-incident, is again well-established, but not necessarily well implemented as

a strategy, and there is good reason for such a service to be provided independently of the organisation and available 24 hours a day (NMC, 2005).

This study indicates that the training received varies considerably amongst recipients, it clearly being a concern of the service since approaching 90% had undertaken some form of instruction. The extent of variation was a concern, however, conventional C & R, MAPPA training, breakaways and de-escalation techniques sitting uneasily together. This is consistent with previous studies (NIMHE, 2004); in fact the zero tolerance campaign (NHS, 1999) recommended that all front-line staff should have skills in the arena of non-physical intervention, such as recognizing triggers, communication skills, cultural and diversity awareness, verbal de-escalation, knowledge on the reporting and recording of incidents, by March 2008. The CFSMS (2006) strategy of formulating a national syllabus for conflict resolution should address this issue at its root, but how it addresses the cultural problems discussed here remains contentious. Furthermore, it is clear that it is technique rather than strength that is important, all the evidence accentuating this point, yet the legacy of the culture of physically strong males required to work with potentially violent individuals remains strong.

Conclusion

The literature around violence directed towards nursing staff consistently indicates a significant degree of under-reporting with some variation between the proposed reasons: perceived lack of time or support, fear of repercussions, waste of time or categorization as 'minor'. There seems to be little evidence from the literature to support the suggestion that any of the organisational levels (management, policy and peers) are unresponsive to nurses following verbal or physical assault. Similarly, concern about authority-related consequences, such as disciplinary action or job insecurity, appear not to constitute an issue. The literature clearly demonstrates a significant discrepancy between actual and reported incidents of violence and aggression. The study reported here confirmed this ongoing tendency towards under-reporting, whilst accentuating that having policies and procedures in place does not necessarily ensure staff compliance. The issue is clearly not specific to learning disability services, but does appear firmly entrenched in this area, perhaps reflecting the greater tolerance for aggression with this client group within the context of challenging behaviour approaches previously discussed. The zero tolerance campaign sought to highlight the unacceptability of violence in any circumstances and achieved some degree of success, but there needs to be greater co-ordination of the various elements of a comprehensive strategy. These include:

- accurate risk assessments;
- good, consistent training, reflective of a broad consensus, and with regular updates;
- knowledge of the physical and psychological consequences of exposure to violence;
- effective record keeping with an emphasis on this information informing care delivery;
- individual awareness of the imperative of professional responsibility;
- provision of independent staff support services following incidents of violence;
- regular post-incident reviews;
- informative feedback to all involved;
- recognition of the importance of the multi-disciplinary and multi-agency framework.

The significance of this last point was recognised within the NIMHE report (2004), wherein '(t)he main deficiency emerging from recent high profile cases has been the failure of the police, local health services and related agencies such as social services to work together effectively' (p.22). The irony appears to be that those working with vulnerable clients groups, such as those with learning disabilities and/or mental health problems, are well aware of the need for each of the factors listed above. Unfortunately, however, such knowledge in and of itself does not enhance the likelihood of service responses ensuring that they have an effective framework addressing all such issues. The problem surrounds the question of successful implementation, particularly changing the culture so that any degree of violence, whether verbal or physical, is both regarded and treated as completely unacceptable regardless of the circumstances.

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