HOVIS – The Hertfordshire/Oxfordshire Violent Incident Study

K. SPOKES¹ MSC BSC(HONS), K. BOND² RMN, T. LOWE³ MPhil BSC(HONS) PGCEA RMN, J. JONES⁴ PhD BA(HONS), P. ILLINGWORTH⁵ MA BSC(HONS) Dip CBT Ed RN ILTM, N. BRIMBLECOMBE⁶ MSC BSC(HONS) Dip NEBSMS RMN & N. WELLMAN⁷ MSC BA(HONS) RMN

¹Research Assistant, ²General Manager and ⁶Nurse Advisor, West Herts Community Health NHS Trust, St Albans, ³Lecturer/Practitioner, Oxford Mental Healthcare NHS Trust & Oxford Brookes University, Warneford Hospital, Headington, Oxford, ⁴Research Fellow, RCN Institute, Radcliffe Infirmary, Woodstock Road, Oxford, ⁵Senior Lecturer, University of Hertfordshire, College Lane, Hatfield, Herts, ⁷Consultant Nurse, Berkshire Healthcare NHS Trust, Fair Mile Hospital, Cholsey, Oxon, UK

Correspondence: Nigel Wellman
Berkshire Healthcare NHS Trust
Fair Mile Hospital
Cholsey
Oxon OX10 9HH
UK


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Violence in psychiatric inpatient units is a major and growing problem. Research interest has primarily focused on patient characteristics. The role of staff factors and the antecedents of violent incidents has been neglected, despite the fact that staff factors and behaviour may be more readily amenable to change than patient characteristics. The HOVIS study sought to obtain the views of a sample of mental health nurses in current clinical practice about staff-related factors, which they perceive to contribute to, or protect against, the occurrence of violent incidents. A total of 108 nurses working in psychiatric acute admission, intensive care and low secure units, in two NHS Trusts were interviewed using a specially designed semistructured interview schedule. These nurses identified a variety of behaviours, clinical skills, personal characteristics and interpersonal skills that they believe impact on the occurrence of violent incidents. These findings are discussed in relation to their possible training and managerial implications.

Keywords: clinical skills, interpersonal skills, personal characteristics, psychiatric inpatients, staff-factors, violence

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Introduction

Despite much interest and concern with levels of violence within psychiatric inpatient settings, staff factors and behaviour have received little attention until recently. Over the last three decades, research has concentrated largely on the perpetrator, with some scrutiny of the environment in which care takes place; however, relatively little work has examined the victims of assaults, or the nature of their interactions with patients.

Where staff victims have been studied this has often consisted of the calculation of rates of assault (BCS 1996, Unison 1996, HSE 1997) or of comparisons between psychiatric staff and other groups (Love & Hunter 1996). Some studies have offered views as to potential deficits in staff training (Collins 1994) but relatively few have considered the complex relations between staff and clients, and the possible impact of staff behaviour on the incidence of violence. It is easy to see reasons for a reluctance to study the issues in this way and there have been understandable
objections to the culture of ‘blaming the victim’ (Engle & Marsh 1986).

Much of the earlier research on inpatient violence considered patient factors which may be linked with violence and identified several characteristics, including age (Fottrell 1980), gender (Fottrell 1980, Tardiff & Sweillam 1982) and diagnoses such as schizophrenia and manic depression (Hodgkinson et al. 1985, Pearson 1986). However, Swett & Mills (1997) found that age, sex and psychiatric diagnosis did not predict assaultive behaviour towards staff. Differences in study design may explain these discrepancies, or interactions with other variables may be responsible. A recent review (Royal College of Psychiatrists 1998) offered the view that there is little or no conclusive evidence with regard to either perpetrator or environmental factors. More recently, the research focus has moved towards the study of victims of violence to identify potential characteristics and behaviours which may increase their risks.

There have been attempts to identify socio-demographic staff factors that predict assaults on staff. However, Lanza et al. (1991b) found only marital status to be predictive of those staff who are assaulted. Convey (1986) and Carmel & Hunter (1989) found that nursing assistants and untrained staff generally experienced more assaults than other nursing grades. In contrast, Whittington & Wykes (1996a), who included a non-assaulted control group, concluded that student nurses and charge nurses were more likely to be victims than other grades. One possible explanation for these differences might be that grade itself is not predictive of assaults on staff but that some aspect of the role, based loosely on grade, puts nurses in potentially more vulnerable situations.

A number of studies reported that assaults occur when there is an interaction between staff and patients, for example when patients are requested to take medication (Lanza & Carifio 1991; Cheung et al. 1997) and when staff touch patients during restraint (Soloff 1983, Whittington & Wykes 1996b). Further studies suggest that the quality of the staff–patient interaction may be important; for example, Rice et al. (1989) and Ray & Subich (1998) found that staff members’ locus of control, anxiety and authoritarian styles were associated with rates of staff assaults. Other studies reported that aversive stimulation and verbal hostility (Whittington & Wykes 1996b, Cheung 1997) and the use of coercion (Olofsson et al. 1998, Morrison 1992) were linked to patient aggression. Morrison (1989) noted that the majority of incidents were associated with staff setting limits, and Lancee et al. (1995) also suggested that limit-setting styles were important. Differences were also identified in nurses’ attributions of blame (Poster & Ryan 1989) and staff attitudes, fears and expectations (Black et al. 1994, Poster 1996) in relation to the occurrence of incidents. Other relationships between violence towards staff and staff attitudes and behaviour were found to relate to nurses’ judgments about seclusion and restraint (Holzworth 1999) and nurses’ responses to rule-breaking behaviour (Crichton 1997).

From these studies it is clear that the interaction between staff and patients is an important area for further investigation. Overall, focusing on the interaction between staff and patients might lead to a clearer understanding of why assaults against staff occur and how they might be avoided. There appears to be a strong case for further exploration of the staff factors and behaviours involved in such interactions in order to identify aspects that would be amenable to change and to design effective training in the management of violence and potential violence.

Within the above literature, a number of terms have been used to denote violence towards staff, including aggression, assaults and untoward incidents. Further differences can be seen in definitions of violence; for example, whether they include verbal abuse, physical assault or degree of injury. For the purposes of this study the following definition of violence was used:

The intentional infliction of harm on one person by another, resulting in psychological and/or physical injury.

**Aim of the study**

The aim of the study was to obtain the views of a sample of mental health nurses about staff behaviours and other factors, which they perceive to contribute to, or reduce, inpatient violence. The implications of the findings were to be considered in relation to clinical practice, education and training.

**Methods**

The study was conducted on 13 psychiatric inpatient units, comprising 10 adult acute admission wards, two psychiatric intensive care units and one low-secure unit on five hospital sites within two NHS Trusts in Oxfordshire and Hertfordshire. The relevant Local Research Ethics Committees approved all procedures in advance. The target population was the nursing staff, both qualified and unqualified (n = approximately 350), within these units. All nursing staff on these units were informed of the study by letter and after a minimum of 24 h, were approached by the field researcher (K.S.) who gave a verbal explanation of the study and determined if they were willing to participate. Staff who wished to enter the study signed a consent form and were then interviewed using a specially developed Staff Interview Form (SIF, see Appendix 1). Participants also
completed two questionnaires: first the State Trait Anger Expression Inventory (STAXI; Spielberger et al. 1983) and then the RAMAS Anger Assessment Profile (RAAP; O’Rourke & Hammond 1989). Data from the STAXI and the RAAP will be reported separately and are not discussed further in this paper. The SIF, STAXI and RAAP had previously been piloted on two wards, which were not used in the main study. The interview and questionnaires together took approximately 1 h to complete.

All study participants were allocated an anonymous code-number and participants’ names were not used on the SIF or the questionnaires. To ensure confidentiality, the keys to the code numbers were held by members of the research team external to the organizations employing the participating nurses. Immediately after completion of each interview, the field researcher completed three visual analogue scales rating rapport, non-verbal communication and the subject’s perceived openness. The researcher also rated the quality of the interview on a four-point scale from ‘high quality’ to ‘unsatisfactory’. All of the interviews were of acceptable quality based on the ratings of the field researcher and similarly; no interviews were excluded from analysis because of concerns about the openness or reliability of the subjects.

The researchers were aware that the interviews covered sensitive topics and might have a cathartic effect for some of the respondents. In anticipation of this, the field researcher (K.S.) was briefed on dealing with distress and on the support mechanisms available to respondents. To maintain confidentiality in dealing with such issues, the field researcher was regularly supervised by a member of the research team external to the organization employing the nurse respondents.

The responses given by each participant during the semistructured interviews were recorded in note form and transcribed by the field researcher. The interview data were analysed using standard content analysis (Strauss & Corbin 1990); the data were coded and then organized into topics and recurring themes were identified. These themes were then brought together into higher order themes, which represented the main themes of the interviews. Due to the large volume of data collected, the QSR NUD*IST software package (Version 4.0, QSR 1997) was used to assist with this process. After the completion of the interviews and preliminary analysis of the interview data, all subjects who had participated in the study were invited to join one of three focus groups, which were held in order to cross-validate the findings of the interview study. The findings of the focus groups will be reported separately. The demographic data was analysed using the Statistical Package for Social Sciences (SPSS for Windows V9.0, SPSS Inc., 1998).

Subjects
One hundred and eight staff members took part in the study: 68 of these (63%) were qualified mental health nurses and 40 were unqualified care assistants. The ethnicity of the sample was 80% white European, 12% Asian and 8% African-Caribbean and the mean age of the subjects was 35 years (range 19–58). On average, the subjects had been employed in their current positions for 44 months (range: 1 month–28 years; see Table 1).

Results
Of the 108 staff interviewed, 105 stated that they had been involved in one or more violent incidents at work. When asked what had led to the incident(s), the following responses were most often given: that the incident was related to administration of medication \( n = 16 \) or to detention under the Mental Health Act \( n = 15 \). Other responses included: staff intervening in a patient–patient interaction \( n = 11 \), patients responding to delusions \( n = 11 \), that the incident was drug- or alcohol-related \( n = 10 \) or due to staff employing limit-setting techniques with patients \( n = 10 \).

When asked about themselves, all the respondents said that they had particular strengths and skills for dealing with violence. However, 95 (88%) identified that they also had weaknesses in dealing with violence and 13 (12%) that they did not. Of the staff interviewed, 104 (96%) stated that their colleagues had strengths and skills for dealing with violent incidents. Similarly, 91 (84%) staff identified their colleagues as having weaknesses when dealing with violent incidents.

Seventy-five (69%) respondents felt that some staff were assaulted more often than others, 33 (30%) did not. Likewise, 63 (58%) respondents said that some individuals were assaulted less often than most, while 45 (42%) thought this was not the case.

Table 1
Staff respondents by nursing grade

<table>
<thead>
<tr>
<th>Nursing grade</th>
<th>Males (n)</th>
<th>Females (n)</th>
<th>Total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Unqualified Care Assistant)</td>
<td>8</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>B (Unqualified Care Assistant)</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>C (Unqualified Care Assistant)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D (Staff Nurse)</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>E (Senior Staff Nurse)</td>
<td>14</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>F (Sister/Charge Nurse)</td>
<td>12</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>G (Ward Manager)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>H (Team Leader)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>47</strong></td>
<td><strong>61</strong></td>
<td><strong>108</strong></td>
</tr>
</tbody>
</table>
When describing their own actions as leading or contributing to an incident, a number of responses were given. The types of actions described included goal prevention \((n = 17)\), being confrontational \((n = 16)\) and giving medication \((n = 11)\). For the same question about their colleagues’ actions, 82 said they had contributed to an incident and 26 said that their colleagues’ actions had not led to an incident. Actions described as contributing to an incident included being rude or making personal comments \((n = 26)\) and being confrontational \((n = 12)\).

When asked for suggestions for colleagues’ training needs, only two respondents were not able to respond. The most common types of training given were Strategies for Crisis Intervention and Prevention (SCIP; OMRDD 1988) training \((n = 50)\), theoretical training \((n = 33)\) and interpersonal skills training \((n = 34)\). SCIP is an approach that emphasizes verbal and non-verbal de-escalation techniques as well as promoting non-aversive physical holds. It should be noted that SCIP was the official training programme for both Trusts at that time, but that some staff had undertaken Home Office-approved Control and Restraint (C&R) training.

### Main findings

The main findings of this study are that the nursing staff interviewed believed that a number of staff factors affect the likelihood of a violent incident occurring. The central focus of this paper is on those staff skills, behaviour and other factors which respondents identified as being significant or important in relation to the occurrence of violent incidents.

All respondents described themselves and/or their colleagues as having a number of skills and weaknesses in relation to the prevention and management of violent incidents. Each theme represented either a positive or negative influence on the potential outcome of an incident. A total of 27 attributes were identified as having a positive role, and 19 a negative role in the prevention and management of violent incidents. Respondents’ statements about themselves and their colleagues were subsequently re-categorized into three main higher order themes: clinical skills, personal characteristics and interpersonal skills.

#### Clinical skills

A number of strengths and weaknesses respondents identified were re-categorized into the higher order theme clinical skills. These included use of techniques such as distraction and physical skills, which are part of nursing training. Other clinical skills include professional experience, nursing grade, giving medication and length of service (Tables 2 and 3).

#### Interpersonal skills

The second theme into which elements about strengths and weaknesses were organized was interpersonal skills. Respondents’ statements in this instance involved an intrinsic interaction between staff and other individuals, which might involve verbal or non-verbal communication. These included talking to others, providing explanations and having a rapport with patients (Tables 4 and 5).

#### Personal characteristics

The third theme into which statements about strengths and weaknesses were categorized was personal characteristics.
### Table 3
Clinical skills

<table>
<thead>
<tr>
<th>Total</th>
<th>No.</th>
<th>Own weaknesses</th>
<th>No.</th>
<th>Colleagues' weaknesses</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training courses</td>
<td>67</td>
<td>'I have no formal mental health training' 'training in the causes of aggression'</td>
<td>43</td>
<td>'not had the relevant training' 'conversion from general nursing training'</td>
<td>24</td>
</tr>
<tr>
<td>Physical skills</td>
<td>46</td>
<td>'not equipped with the relevant physical skills, C &amp; R would be useful' 'I need a C &amp; R update, have no confidence in SCIP due to my size'</td>
<td>26</td>
<td>'ready to jump-in, early use of physical skills' 'lack of training in SCIP'</td>
<td>20</td>
</tr>
<tr>
<td>Teamworking</td>
<td>30</td>
<td>'not all of the team are SCIP trained' 'lack of clear organizational structure'</td>
<td>11</td>
<td>'not knowing other staff, procedures, who to call, etc.' 'acting alone, not part of a team'</td>
<td>19</td>
</tr>
<tr>
<td>Lack of experience</td>
<td>30</td>
<td>(no response)</td>
<td>0</td>
<td>'inexperience, unqualified staff' 'coming from other backgrounds'</td>
<td>30</td>
</tr>
<tr>
<td>Practice</td>
<td>25</td>
<td>'because incidents are rare there is no practice and I forget what to do' 'need to practice scenarios'</td>
<td>16</td>
<td>'new staff, no experience' 'not used to things, forgotten now'</td>
<td>9</td>
</tr>
<tr>
<td>Grade</td>
<td>22</td>
<td>(no response)</td>
<td>0</td>
<td>'unqualified, bank staff' 'newly qualified or untrained staff'</td>
<td>22</td>
</tr>
<tr>
<td>Knowledge</td>
<td>19</td>
<td>'don't know the clients' 'lack of knowledge of legal issues and the MHA'</td>
<td>7</td>
<td>'lack of knowledge, ward experience' 'not knowing the patient's history'</td>
<td>12</td>
</tr>
</tbody>
</table>

### Table 4
Interpersonal skills

<table>
<thead>
<tr>
<th>Total</th>
<th>No.</th>
<th>Own skills</th>
<th>No.</th>
<th>Colleagues' skills</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal skills</td>
<td>149</td>
<td>'knowing how to talk to people, not shouting' 'calm, hypnotic voice, low tone'</td>
<td>81</td>
<td>'the way they talk to people, calm voice, lowered tone' 'speaking quietly, not shouting, asking questions nicely'</td>
<td>68</td>
</tr>
<tr>
<td>Rapport</td>
<td>80</td>
<td>'having a good rapport with patients' 'focus on rapport-building after events'</td>
<td>40</td>
<td>'getting on with people, having a laugh' 'utilizing the person with the best rapport [with the patient]'</td>
<td>40</td>
</tr>
<tr>
<td>Giving explanations</td>
<td>74</td>
<td>'I'm good at explaining situations' 'trying to explain that I am on their side'</td>
<td>47</td>
<td>'debriefing staff and patients involved' 'taking time to explain things to patient'</td>
<td>27</td>
</tr>
<tr>
<td>Observation skills</td>
<td>60</td>
<td>'observing behaviour' 'seeing things building up'</td>
<td>44</td>
<td>'assessing the signs, prepared to act' 'recognizing the antecedents of violence, anticipating violence'</td>
<td>16</td>
</tr>
<tr>
<td>Rationalising</td>
<td>52</td>
<td>'trying to rationalize, defining the problem' 'using persuasion and negotiation skills'</td>
<td>31</td>
<td>'talking to patients, giving them a sense of reality' 'putting a different angle on things'</td>
<td>21</td>
</tr>
<tr>
<td>Backing off</td>
<td>39</td>
<td>'know when to back away, when to remove myself from the situation' 'not approaching, knowing when to ignore behaviour'</td>
<td>31</td>
<td>'allowing patient time to cool off' 'backing off and keeping their distance'</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 4 represents a number of interpersonal skills respondents identified in themselves and their colleagues. Number in brackets represents the number of times each theme was mentioned.

### Table 5
Interpersonal skills

<table>
<thead>
<tr>
<th>Total</th>
<th>No.</th>
<th>Own weaknesses</th>
<th>No.</th>
<th>Colleagues' weaknesses</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>54</td>
<td>'could be more confrontational, verbally, too diplomatic' 'too confrontational, forceful, raised voice'</td>
<td>17</td>
<td>'poor communication skills, shouting and screaming at patients' 'barking at people'</td>
<td>36</td>
</tr>
<tr>
<td>Rude and patronising</td>
<td>18</td>
<td>(no response)</td>
<td>0</td>
<td>'way of speaking, rude and shouting' 'not diplomatic making personal comments'</td>
<td>18</td>
</tr>
<tr>
<td>Non-verbal skills</td>
<td>15</td>
<td>'nonverbal skills training' 'showing my fear'</td>
<td>7</td>
<td>'staring people out' 'pointing their fingers at people'</td>
<td>8</td>
</tr>
<tr>
<td>Listening skills</td>
<td>4</td>
<td>(no response)</td>
<td>0</td>
<td>'not listening to patients'</td>
<td>4</td>
</tr>
</tbody>
</table>
These statements represented staff factors including physical characteristics, personality traits and individual behaviours (Tables 6 and 7).

### Discussion

The nurses who participated in the study were willing to acknowledge the impact of their own and their colleagues’ actions on the likelihood of assault. They suggested a number of strengths and weaknesses in their own and others’ approach to care which in their view had an effect on the incidence of violence. This study identified three core themes that were perceived by the participants as being involved in the occurrence of violent incidents: clinical skills, personal characteristics and interpersonal skills. Figure 1 shows a model of these strengths and weaknesses in relation to the management and prevention of violent incidents, derived from the main findings of the staff interviews. The Figure indicates that each theme has some distinct characteristics, whilst also sharing attributes, which overlap with other areas to form a system of interrelated abilities and characteristics. The content within the themes may vary between individuals but is common to all nurses. Overall, it represents the combination of staff factors, which the staff believed contribute to or reduce the likelihood of a violent incident occurring.

Clinical skills as a term could be generally described as relating to skills, attitudes, knowledge and behaviour which are affected by personality characteristics or interpersonal skills. However, in this model the term is applied to those aspects which are intrinsic to the nursing role. These skills are relatively easy to modify and are usually accepted as being improved upon by experience; for example, through observation of skilled colleagues or via train-
ing courses. In relation to this issue, the results reveal that a large number of nursing staff placed great value on teamwork and saw team working as a vital skill in the management of violence. Their accounts stressed the importance of communication between staff members, as well as thinking and working as a team member. In particular, acting alone was frequently cited as something which could lead to difficulties. In some cases, this was simply because of the consequent vulnerability of the staff members and the lack of communication. With others, it interfered with the balance that could otherwise be achieved in the team approach. For example, one respondent reported that ‘people who go off and don’t tell anyone what they’re doing can end up in situations they can’t handle’ (Nurse 8).

Respondents also emphasized training needs, both in terms of new knowledge and of means of coping with actual physical violence. Taking these responses as a whole, one of the implications for training is that nurses should, as far as possible, be released for training in teams rather than as individuals.

Interpersonal skills were frequently identified by respondents, in particular in relation to abilities in communication and in the development of relationships. These skills may be considered as the most important staff factors as they relate to the development of therapeutic relationships that are central to the clinical role in nursing. Although some of the responses were about generalized communication, respondents emphasized the ability to express things in an appropriate way; for example, ‘the way they [colleagues] talk to people’ (Nurse 87) and ‘building a rapport with the patient’ (Nurse 55). Respondents had the greatest difficulty putting these remarks into distinct elements, for example, ‘I don’t know what it is...some people have a manner about them, which just seems to calm people down’ (Nurse 51). This theme is in keeping with the traditional view of core mental health nursing skills such as being able to engage, to develop trust and to form relationships that are therapeutic and hence of primary importance.

Personal characteristics included demographic factors such as age, gender and ethnicity in addition to relatively stable features such as physical characteristics and personality traits. However, in this context, respondents were most concerned about the importance of staff remaining calm and in control of themselves. For example, one respondent said, when talking about colleagues ‘they [colleagues] remain calm, being in charge of the situation, self-controlled and giving the appearance of being calm and in control’ (Nurse 105). This seemed to be linked to self-awareness, in the sense that skilled nursing staff were regarded as being able to monitor how they presented themselves, and model a calm concern.

The model outlined in Figure 1 suggests a relationship between these three themes and this relationship may have implications for the possibilities for change. For example, a nurse’s clinical skills may be enhanced by improvements in his/her interpersonal skills and this might be relatively easy to achieve through training or supervision. However, interaction with personality factors might work against such a change.

As this model suggests, both strengths and weaknesses in each of these areas may have a positive or negative influence on events. The respondents’ statements made about personal characteristics suggest that personal characteristics and interpersonal skills interact to produce common problems in the nursing management of violence and potential violence in two distinct ways. Firstly, according to reports of their colleagues’ weaknesses, there appear to be some nurses with authoritarian personalities who tend to be over-controlling in their behaviour and, secondly, that some individuals experience fear, anxiety and lack of confidence leading to passivity and inaction (see Table 7). As reported earlier, we know that many of the situations which create the potential for violence originate in the aversive nature of many aspects of the nursing role (Whittington & Wykes 1996b; Soloff 1983). It seems that the weaknesses identified above are particularly relevant to such situations, many of which involve issues of control. For example, some staff may be temperamentally inclined to try to exert too much control over their patients, thus exacerbating a situation that the patient finds uncomfortable or unpleasant. Others may be reluctant to engage in interactions which are potential triggers for conflict and may, through this avoidance, ignore the real need for explanation and negotiation of boundaries. However, there is little evidence available to indicate what the correct level of
control might be and this issue clearly needs further careful investigation.

One of the original objectives of HOVIS was to identify factors amenable to change through training and education. Interpersonal skills training was identified by the respondents as a major training need for their colleagues and there is some evidence that interpersonal skills can be improved by training. For example, authoritarian behaviour may be modifiable through training, particularly if the training is sanctioned by high-status sources such as senior managers (Deux & Wrightsman 1988). It is possible that confidence and self-esteem may be improved by the successful completion of a course involving role-play of conflict scenarios. This type of training model was suggested by the respondents as a specific training need ($n = 16$, $15\%$).

Recent approaches to the study of personality have accepted that both trait and situational effects may have a bearing on expression of these characteristics (Mischel & Shoda 1995). It seems possible therefore that there might be scope for change through training, increased self-awareness and supervision, although a small minority of individuals that are at a pathological extreme may continue to present unnecessary provocation to patients and remain a challenge to their colleagues. It is clear that much remains to be learned about the relationship between these themes and, in particular, the extent to which the effects of personality can be modified through training and education. It is important to first identify a reliable method for measuring these characteristics and subsequently to identify means of modifying them.

A further issue is in relationship to the effects of training and education, on the one hand, and experience on the other. To what extent do nurses learn from training and educational initiatives designed to prepare them for the challenges which they encounter in practice, and to what extent do they learn from the experience of doing the work and observing other more skilled practitioners? The two important learning approaches within practice are modelling and mentoring. The modelling process could be said to have broken down to some extent with changes in skill mix in recent years and requires the presence of skilled and experienced practitioners to act as exemplars of good practice. Mentoring and clinical supervision represent another important learning resource which may have been neglected because of staffing difficulties.

A limitation of the study is that it deals with the views of staff only, and does not take into account the views of patients. Some commentators have also raised doubts as to whether research interviews truly reflect the real world, because respondents may give a ‘moral’ response or, alternatively, one perceived to be acceptable to the researcher (Silverman 1985), and secondly because they do not offer complete anonymity. For example, it might be expected that respondents would give examples of clinical skills which they had been taught during training or which were in accordance with organizational policy. An attempt was made to minimize such effects by the use of an independent interviewer and a system of rating the trustworthiness of the contribution of each respondent. However, the consistency of respondents in acknowledging the influence that their behaviour and that of their colleagues had on the occurrence of violent incidents would seem to allay these fears.

A second limitation is the representativeness of the sample of the psychiatric nursing population interviewed. The 108 staff members interviewed represented 29% (total $n = $ approximately 350) of the total psychiatric nursing staff working within the acute admission, intensive care and low-secure units of the two Trusts at the time of the study. However, it is not possible to say how representative this sample was of the views of psychiatric nursing staff across the UK.

**Conclusion**

Three staff-related themes were identified by the nursing staff interviewed as having relevance to the incidence of inpatient violence. Whilst the development of clinical skills remains the central focus of psychiatric nursing training, personal characteristics and interpersonal skills were perceived to have a strong influence, and personnel selection and staff deployment within teams might be important. The nature of the nursing role involves judgments about levels of control, and personal characteristics such as authoritarianism or lack of initiative are likely to be significant. Although there are questions over the extent to which these characteristics may be modified, interpersonal skills training combined with skilled supervision might be effective, and this was perceived as the major training need. The effects of such training on factors such as over-control or self-confidence should be formally tested by the implementation of the appropriate training methods. Further research could also be directed at the interface between the themes, and at the ways in which nurses learn. The next stage of the project could be to design a training intervention which takes these factors into account and which can be subsequently evaluated.

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Healthcare NHS Trust for their support and funding for this study. We would also like to thank all those who participated in the study or whose support helped it to happen for their time, attention, trust and goodwill.

References


Appendix 1

HOVIS: Staff Interview Form

Time started:

Introduction

In this study we are interested in your experiences of, and your views about, a number of factors related to the occurrence of violent incidents in inpatient units. We are doing this because we think this information may be useful in helping to understand, prevent and manage future incidents. Any information you give us will be treated with the strictest confidence, it will only be used for research purposes and will not be revealed to anyone outside of the research team. We would like to ask you a few questions about yourself and your experiences, and then move on to ask you more general questions related to the occurrence and management of violent incidents and your work environment. For the purposes of this investigation we have defined a violent incident as ‘the intentional infliction of harm to one person by another, resulting in psychological and/or physical injury’.

1. Date:
2. Interviewer initials:
3. Subject code:
4. Gender: M/F
5. Height (tick box as applicable)
6. Weight (tick box as applicable)

<table>
<thead>
<tr>
<th>&lt;4'9''</th>
<th>4'9''–5'0''</th>
<th>5'1''–5'4''</th>
<th>5'5''–5'8''</th>
<th>5'9''–6'0''</th>
<th>6'1''+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;7 stone</td>
<td>7–9 stone</td>
<td>9–11 stone</td>
<td>11–13 stone</td>
<td>13–15 stone</td>
<td>15–17 stone</td>
</tr>
</tbody>
</table>

6. Weight (tick box as applicable)

7. Ethnic group:
8. Work location:
9. Age:
10. Grade:
11. Job title:
12. For how long:
13. State qualifications, if any:
14. If qualified, date qualified:
15. Other relevant work experience? (If yes, describe):
16. Have you had any training in the management of aggression such as SCIP, C&R, ENB 956, ENB 770, anything else? Yes/No
17. If yes, specify.
18. Have you been involved in a violent incident? Yes/No
19. When were you last involved in a violent or aggressive incident? Was this within:
   1) the last week Yes/No
   2) the last month Yes/No
   3) the last six months Yes/No
   4) the last year Yes/No
   5) more than a year ago Yes/No
   6) never Yes/No
20. If yes to any of the above:
   20. Can you described what happened and why?
   PROMPT: What were the events which you believe led to the incident?
21. Do you feel that you have any particular strengths or skills in relation to the management of aggression? Yes/No
   If yes, specify.
   PROMPT: Is there anything that you have found to help you deal with a difficult situation?
22. Do you feel that you have any particular weaknesses or training needs in relation to the management of aggression? Yes/No
   If yes, specify.
   PROMPT: For example, have you been involved in an incident when you felt you did not deal with the situation well?
23. Have you ever been injured in a violent incident? Yes/No
   If yes:
24. What happened, how badly were you hurt, how did you feel about your work after that incident?
   PROMPT: Do you have any unresolved issues as a result of a particular incident?
25. Is there anything about the physical environment of your ward or unit that you feel may contribute to the development of aggressive incidents? Yes/No
   If yes, specify.
   PROMPT: For example, this could be something structural or things like fixtures and fittings.
26. Is there anything about the physical environment of your ward or unit which you feel may help forestall, contain or limit the development of aggressive incidents? Yes/No
   If yes, specify.
   PROMPT: Again, this could be something structural or things like fixtures and fittings.
27. Do you think any of your colleagues are particularly skilled in the prevention and/or management of aggression? Yes/No
   If yes, proceed to question 28; if no, skip to question 29.
28. Without identifying any individuals, what is it about these particularly skilled colleagues that you think is most important in this area?
PROMPT: Can you expand?
29. Do you think any of your colleagues have particular weaknesses or problems in relation to the prevention and/or management of aggression? Yes/No
If yes, proceed to question 30; if no, skip to question 31.
30. Without identifying any individuals, what is it about these colleagues that you think is particularly problematic in this area?
PROMPT: Can you expand?
31. Without identifying particular individuals, do you think any of your colleagues are assaulted more often than most? Yes/No
If yes:
32. Why do you think that is the case?
33. Without identifying particular individuals, do you think any of your colleagues are assaulted less often than most? Yes/No
If yes:
34. Why do you think that is the case?
35. Can you think of any specific instances where your actions may have directly led to, or contributed to, the occurrence of a violent incident? Yes/No
If yes:
36. What happened?
PROMPT: For example, this may have been something you said or didn’t say, an action you did or didn’t take.
37. Without identifying particular individuals, can you think of any specific instances where the actions of your colleagues may have directly led to, or contributed to the occurrence of a violent incident? Yes/No
If yes:
38. What happened?
PROMPT: For example, this may have been something you said or didn’t say, an action you did or didn’t take
39. I have already asked you about your training needs in relation to violence, but we would also like to know what training and education you feel that your colleagues as a group could benefit from, in relation to the management of aggression and violence.
40. Lastly, we would like to know if you have any additional points you would like to make, or any other things you would like to say about your experience of violent and aggressive incidents in your work?

Time finished:
Thank the subject for his/her time trouble and co-operation and ask him or her if he/she would mind if we came back to them at a later date to discuss further any of the issues or points they have raised.

Interviewer Rated Section
Complete this section as soon as possible after you have finished interviewing the subject.
Complete it in private and away from the subject.
Interviewer: Any special distinguishing features or characteristics of this subject’s physical appearance, communication style or behaviour: Yes/No
If Yes, describe below (record only things you observe/hear yourself).
Interviewer: How good a rapport did you establish with the subject?

0 1 2 3 4 5 6 7 8 9 10
Poor Average Good

Interviewer: Rate the subjects eye-contact and nonverbal communication

0 1 2 3 4 5 6 7 8 9 10
Poor eye-contact & non-verbal communications Average/Non-remarkable Very Good eye-contact/ non-verbal

Interviewer: When answering the questions how open and forthcoming do you think the respondent was?

0 1 2 3 4 5 6 7 8 9 10
Not at all open About Average Very Open

Rate the overall quality of this interview: 0 = High Quality:
1 = Generally Reliable
2 = Questionable
3 = Unsatisfactory
Interviewer: Write a brief review of the form and content and reliability of the interview.