The process of psychological recovery of unqualified nursing staff after a serious violent assault in a secure setting.

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Declaration

I confirm that the literature review, research report and service evaluation contained within this thesis have not been submitted For any other degree or to any other institution

Thesis summary

The process of psychological recovery of unqualified nursing staff after serious violent assault in a secure setting.

Thesis Abstract

This thesis is comprised of four parts: A literature review, a research study, a reflective critique of the research process and a service evaluation.

A systematic literature review was undertaken to appraise the current evidence relating to the factors associated with violence and aggression in adult psychiatric hospital inpatient settings. A systematic search of four databases; Scopus; PsychINFO Medline; CIHAHL and PsychArticle was conducted. Following the application of the inclusion criteria, ten papers were extracted and included in the review. Of these, eight were of quantitative methodology and two were qualitative studies. These ten papers provide an insight into the possible factors associated with violence and aggression towards nursing staff. Three main themes were identified: the environment, attitudes/interaction of staff, the patient's mental illness. The themes were important factors in the causes of violence but were interlinked highlighting the complex nature of violence towards nursing staff. The findings support the need for training for nursing staff and the development of on-going support and for organisations to consider both the environment and the restrictive procedures to help reduce violence and aggression towards nursing staff.

A research study was conducted to explore the psychological recovery of nursing staff in a secure mental health hospital setting in the UK who had experienced a violent assault in the previous fortnight. Study participants were five unqualified nursing staff/HealthCare Assistants (HCAs) who were interviewed on two occasions, immediately following the assault and at six months. All participants accessed the in-house Trauma Response service for help in coping with the effects of the assault which had been reported as level 3-5 on a Serious Untoward Incident matrix. Data were collected via in depth interviews and transcribed verbatim. Interpretative Phenomenological Analysis (IPA) was adopted which identified three overarching themes: Putting on a front, Organisational relationships and Recovery and moving-on. Recommendations include the development of team-based working to help de-stigmatise the impact of a serious violent assault and improving managerial response to violent assault and support on the hospitals wards. More specifically, the study recommends the acknowledgement within the organisational culture of the psychological impact of serious assaults on staff well-being. The implications of the findings are discussed in relation to the wider provision of trauma support for staff.

A reflective critique records the personal experiences of the author during the research and thesis process. It includes a description of the challenges and learning through the process of engaging in the academic and research process for this thesis.

Service evaluation recommendations describe the development of a trauma response service for nursing staff working in a secure mental health hospital.

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Word Count

Section	Abstract	Text
Part 1: Critical Literature Review	157 words	5,825 words
Part 2: Research report	187 words	11,004 words
Part 3: Reflective Critique		5,577 words
Part 4: Service evaluation		5,820 words
Total text word count		**28,226 words**

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Part 1

LITERATURE REVIEW

What factors are associated with violence and aggression towards nursing staff working in adult psychiatric hospital settings?

Abstract

A systematic literature review was undertaken to appraise the current evidence relating to the factors associated with violence and aggression in adult psychiatric hospital inpatient settings. A systematic search of four databases; Scopus; PsychINFO Medline; CIHAHL and PsychArticle was conducted. Following the application of the inclusion criteria, ten papers were extracted and included in the review. Of these, eight were of quantitative methodology and two were qualitative studies. These ten papers provide an insight into the possible factors associated with violence and aggression towards nursing staff. Three main themes were identified: the environment, attitudes/interaction of staff, the patient's mental illness. The themes were important factors in the causes of violence but were interlinked highlighting the complex nature of violence towards nursing staff. The findings support the need for training for nursing staff and the development of on-going support and for organisations to consider both the environment and the restrictive procedures to help reduce violence and aggression towards nursing staff.

Introduction

Violence towards nurses

Serious assaults on nursing staff are increasing year on year with 71% (43,699) of the annual incidents occurring in mental health services (NHS Protect, November 2013). These figures suggest that as many as twenty five per cent of mental health nurses in public sector hospitals are subject to a violent incident resulting in a serious injury (Eisenstark et al. 2007). Although the cost of sickness absence is estimated at £1.7 billion per year (Totman et al. 2011), the absence costs resulting from an assault at work are unrecorded. The number of assaults per year are recorded by NHS Protect, however sickness absence is not listed separately thus the real cost of absence due to assaults on staff in mental health units are not known: in light of the number of recorded assaults, they are likely to be high. In addition to the financial costs for the NHS and the physical harm caused to staff, such as broken limbs and concussion, there are other costs ensuing from patient assaults on staff including reduced staff morale, and the emotional and the psychological impact of assault can result in nursing staff not being able to return to work in this area of nursing.

Indeed, spending on secure services amounted to £1.2 billion in 2009/10, corresponding to 18.9% of all public expenditure in adult mental health care (Mental Health Strategies, 2010). Growth in spending on these services has been particularly rapid in recent years, having increased by 141% in real terms (i.e. after taking account of general inflation) between 2002/03 and 2009/10. This is equivalent to a growth rate of no less than 13.4% a year in real terms (National Mental Health Development Unit 2011; p15).

In 2012, NHS Protect required that all violent assaults on staff occurring in NHS Trusts are reported via a national database. In the UK, the National Audit of Violence found that a third of inpatients had been threatened or made to feel unsafe while in care (Royal College of Psychiatrists, 2007). This figure rose to 44% for clinical staff (psychologists, psychiatrists and occupational therapists), while nursing took the brunt of violence with 72% of staff reporting a violent incident by a patient. Understanding violence and aggression against psychiatric nursing staff is central to the management and reduction of violent assaults for both patients and staff.

Secure mental health units

The original impetus for the development of medium secure units came from the Emery Report, Ministry of Health, 1961. Growth in the number of units was small until the mid-1970s with the publication of the Butler Committee Report (Home Office/DHSS, 1975). An important development from the recommendations of this report was the 'provision, as a matter of urgency, of secure hospital units in each Regional Health Authority' (Rollin, 1976). This response aimed for a balanced approach for the person found guilty of a dangerous offence who was deemed to have a mental disorder, such as paranoid psychosis, and this allowed both for treatment and public protection. The 2007 Mental Health Act (MHA) made several key changes to the 1983 Mental Health Act, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales. Whereas the 1983 MHA focused on strengthening patients' rights to seek independent reviews of their treatment, the subsequent MHA is largely focused on public protection and risk management. The amended legislation extends the powers of compulsion and

introduces compulsory community treatment orders, making patients' compliance with treatment a statutory requirement (Community Care, 2008). One change is that people with personality disorders, those who are abnormally aggressive or have seriously irresponsible conduct could now be detained under the Act.

Patients within secure settings are liable to harm themselves and others and therefore need to be managed safely. Many of patients will be involved with the criminal justice system and have restrictions imposed by the Ministry of Justice. Secure services form part of the mental health pathway and provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Secure mental health services provide a range of secure wards and units which are locked and have a system of restrictions for common day items, for example, cigarettes, cutlery and chewing gum, which are known as contraband items. The environment of a ward will be accessed via security checks, air locks and locked doors. Many of the wards have minimal furniture and fixtures that are designed to reduce the potential for patients to harm them or others. Patients have restricted access to bedroom areas, food and drink, and they are not able to leave the ward. All activities and movement is risk accessed before a patient can undertake an activity or go outside to smoke. Wards always have a 25 metre fence to stop patients from absconding and to restrict public access. Nursing staff are responsible for enforcing the restrictions on secure wards which may increase the possibility of violence and aggression being directed at them.

Psychological theories of aggression

A number of psychological theories seek to explain aggression and violence for example social learning theory (Bandura 1973; 2001) which suggests that aggression is learnt and maintained by operant conditioning, social referencing and self-reinforcement. Patients on secure wards will be exposed to aggression even if they are not aggressive and violent themselves. Social learning theory shows that aggressive behaviour can be learnt by observation and is not dependent upon one's own experience. For example, on the ward, patients can learn from others that aggression is a way of reacting to the restrictions or environment that the ward structure imposes.

By contrast, Novaco and Taylor (2005) suggest a cognitive theory of aggression which considers antecedent behaviour as important factors in the aggression of patients within secure hospitals: a recent study was conducted of patients with intellectual disabilities, who were once seen as lacking sufficient cognitive capacity or "insight", to benefit from Cognitive Behavioural Therapy (CBT). The authors state a substantial amount of clinical research has demonstrated the applicability of CBT anger treatment for this population in both hospital and community settings (Taylor & Novaco, 2005). In this approach a patient's thoughts and behaviour are challenged within a therapeutic relationship. It empowers the patients to learn and understand the impact of their aggression. It gives them strategies for managing aggressive reactions and an insight into the psychological process of aggression and how their thoughts have an impact upon behaviour.

Tedeschi and Felson (1996) 'have offered a reconceptualization of aggression which focuses on intentions and social motivation' (p173). Social interactionist theory focuses on intentions and social motivation and argues that 'human actions are always intentional and are instigated by social goals' (Tedeschi & Felson, 1996; p173). They propose three reasons for using threats. The first reason is to exercise control and influence over a person for example to enable material services, love and security. The second reason is to redress an injustice when angered by a behaviour they attribute to being a wrong doing. And lastly, they suggest self-presentational reasons which are when a person wants to establish an identity that is strong, courageous, and resolute.

The three psychological theories of aggression give insight into the complex issues underpinning aggression and violence and provide an explanatory framework for potential aggressive behaviour on wards where patients assault staff. These psychological theories of aggression can help to inform nurses of potential triggers to violent behaviour and ways of addressing or avoiding it.

The predictors of the causes of aggression and violence in mental health nursing

'Secure environments are among the most challenging arenas in which any registered nurse must work', Storey and Bradshaw (2000) highlighted that patients' mental disorder and offending patterns pose intense demands upon nurses as they are required to maintain empathic relationships while also focussing on risk management including the prevention and management of violence and aggression. It suggests that the complexities of severe mental health problems may account for the possible causes of violence and aggression directed towards mental health nurses. As discussed

previously, evidence from the Butler report, suggests the risk of violence by psychiatric patients towards nursing staff is a real problem.

This systematic review was conducted to identify and evaluate research papers by examining the predictors associated with the causes of violence and aggression towards nursing staff who work in an adult psychiatric hospital setting. In particular to understand the how the predictors were the cause of the violence and aggression directed at nursing staff by the patients in their care which result in threatened or actual physical harm.

Method

A systematic review was undertaken to inform understanding of the predictors of violence and aggression by secure mental health patients towards nursing staff. The systematic search for articles conducted within a date range of 1st January 2003to 24th September 2013 and were EBSCO Scopus, PsychInfo, PsychArticles, Medline and CIHAHL databases using combination of the search terms psychiat*, hospital*', violen*, aggressi*, inpatient*, in-patient*, mental*'in the abstract or title of the article. The selection of these search terms was based on discussions with two senior clinical psychologists working in the area of secure mental health and formed the bases of the searches undertaken.

Seven hundred and sixty eight relevant articles were found (see Appendix A), not excluding those which were duplicates, non-English and non-peered reviewed. After the removal of these papers four hundred and six articles remained. The exclusion

criteria were applied and two hundred and twenty one articles were removed. The abstracts of the remaining one hundred and eighty five studies were then read and the full-text of forty two articles were manually searched for relevance to the topic based on the following inclusion and exclusion criteria, (non-secure setting = 32, violence to general nurses = 5 and A&E department = 5). A total of ten articles were deemed appropriate for the review (see Appendix B, Data flow chart search).

Inclusion Criteria

Articles included were peer reviewed, published in English, and reported the predictors of the causes of violence and aggression to nursing staff who work in an inpatient secure psychiatric setting. Applied to adults over 18 years and were published between 2002 and 2014 this twelve year period was chosen to capture research studies in the period where there has been an increase of reported violence towards nursing staff in secure settings.

Exclusion criteria

Articles were excluded if they did not investigate the factors associated with causes of violence and aggression to nursing staff who work in an inpatient secure psychiatric setting. After the removal of duplicates, non- English and non-peered reviewed three hundred and fifty four articles remained.

Results

From the systematic search ten papers were selected as representative of research in this subject area. The rationale for reviewing findings from both qualitative and quantitative studies is the diverse range of evidence available: quantitative studies for providing data about the prevalence while qualitative data can yield generate concepts as suggested by Dixon-Woods et al (2005). Of the ten studies three were qualitative and seven were quantitative. The search ceased when only duplicates were obtained.

The data summary table (see Appendix C) provides an overview of the ten studies extracted. The methodological quality of each study was appraised according to methodological factors such as sampling, measures, results and study limitations. A quality appraisal tool Mixed Methods Appraisal Tool (MMAT) version 2011, Pluye et al (2011) was employed for appraisal of the qualitative and quantitative studies. MMAT has been designed for systematic literature reviews that include qualitative, quantitative and mixed methods studies. The MMAT was used to assess all ten studies. The seven quantitative studies were appraised under section four and the three qualitative studies were appraised under section one (see Appendix D for more detail). The MMAT scores each study on a four point scale (1-4). Eight of the papers scored 4 on MMAT (Bowers et al (2009); Dickens et al (2013); Duxbury and Whittingham (2004); Foster. (2006); Lawoko et al (2004); Ross et al (2011); Hinsby and Baker (2004) and Spokes et al (2000)) and two papers scored three (Pulsford et al (2013) and Meechan (2006). All papers were deemed appropriate for inclusion in this review.

The synthesis of data from different research paradigms is problematic. However, the inclusion of both quantitative and qualitative studies was discussed in supervision and deemed appropriate when employing the MMAT quality appraisal tool. These two approaches are used to combine the strengths of quantitative and qualitative methods and to compensate for their respective limitations as suggested by Pluye1 and Hong (2014).

Quantitative studies

Seven of the quantitative studies had different methodologies. These were included a study using cross-sectional design, a survey design, questionnaires and an observational scale. All studies focused on the causes of violence and aggression towards nursing staff working within a psychiatric in-patient hospital.

Participants and sample

Participants in the quantitative articles were patients and nursing staff within psychiatric settings. The sample sizes varied and in three of the quantitative studies staff and patients were participants; three studies included staff only and one study used patients' notes. The studies were conducted exclusively in developed countries: eight studies were located England, one in Sweden, and one in Australia.

Quantitative measures

Seven studies utilised a quantitative approach, of these one was a multivariate cross-sectional study of nursing reports of violence towards nursing staff. Three studies employed the Management of Aggression and Violence Attitudes scale (MAVAS) in both low and medium secure units (Dickens et al., 2013); a study with three acute wards (Duxbury et al 2004); and in a high secure ward (Pulford et al 2013). The 27 items in the MAVAS was developed by Duxbury (2002). The questionnaire scale encompasses statements concerning different causes of violence and different approaches to violence management. The correlation coefficient for test reliability of the MAVAS was 0.86. Lawoko et al (2004) utilised a Staff Observation Aggression Scale-Revised (SOAR) on five acute wards in the UK. (Foster et al. 2006) in a comparative study of nursing staff and patients on acute psychiatric wards in England and Sweden and employed a standardised questionnaire and consisted of 10 main questions with a number of sub-questions within it. A Cronbach alpha was used to test validity of questions in a study by (Lawoko et al., 2004). A cross sectional survey was employed assessing patient notes in a study by (Ross et al., 2011).

Qualitative studies

Of the three qualitative studies, one had staff and patients as participants with a grounded theory method using interviews and focus groups with a social construction approach. Two studies used content analysis; one study had staff participants with an interview and questionnaires. The third study had patients only as participants with content analysis using an inductive approach.

Findings

The three main themes were found by becoming familiar with the literature. This process is where the categories provide a descriptive account of the data relating to predictors of violence towards nursing staff. Following Dixon-Woods et al (2005), the concepts were refined in supervision at an early stage of the synthesis. Braun and Clarke (2013) suggest the inclusion of both quantitative and qualitative studies to enable the review to be contextualised. The findings from quantitative studies provided data about the prevalence and qualitative studies data generated concepts and these were the environment/environmental and the attitudes/interaction of the staff and the internal/patient's mental health problems as predictors of causes of violence towards nursing staff.

Quantitative studies

Environment/environmental predictors of the causes of violence

The physical and restrictive environments were factors associated with the predictors of the causes of violence across seven quantitative studies. Bowers et al (2009) found that locked doors and high levels of staffing were associated with high levels of violence towards nursing staff. The restricted environment was a factor for increasing aggression; the findings revealed this was compounded by an inconsistent approach where some staff would leave doors unlocked. However, the findings suggest locking the ward door creates tense dialogue between staff and patients which can result in violence and aggression. Indeed a study which examined nursing staff notes, found

that locked doors and a restrictive environment were factors leading to aggression during the first weeks of admission (Ross et al. 2011). In a similar vein, Dickens et al (2013) suggested that patients accepted the need for a secure environment and were more amenable to environmental and situational variables which attempted to reduce aggression and violence. Lawoko et al (2004) found physical working conditions were crucial determinants in violence towards staff. For example, close proximity and personal physical contact were factors causing violence. This theme was described by Pulford et al (2013) where 105 out of 108 of the sample had been involved in violent incidents. Patients agreed with the statement 'if the physical environment was different, patients would be less aggressive' (Pulford et al 2013; p.300).

The physical environment and its management were identified in the eight studies as being factors which increased aggression and violence.

Attitudes/interaction of the staff

All the studies reported that attitudes and the style of interaction of the staff with patients were factors associated with violence towards nursing staff. Foster et al (2006) found the most frequently reported interaction in provoking aggression was the patient being denied something such as leave from the ward (29.5% of incidents). Having to deny patients something within a restricted environment was considered to require sophisticated interpersonal skills.

In a study of 136 acute psychiatric wards, Bowers et al (2009) found an association between staff group functioning, attitudes and aggressive behaviours.

Results showed that better team functioning and positive attitudes to difficult patients were associated with less patient aggression. Contributory factors, such as poor communication and staff not listening were identified by patients as precursors to aggression. By contrast, staff did not view interaction with patients as problematic, although they did acknowledge that there was room for improvement when managing aggression (Duxbury & Whittingham. 2004). Similar findings were revealed in a study by Dickens et al (2013). However, patients and staff did agree on the use of de-escalation and the need to improve communication. Pulford et al (2013) reported that both staff and patients agreed that 'poor communication between staff and patients leads to aggression' (Pulford et al., 2013, p 300) and that improved one to one relationships were an important factor for reducing aggression.

The interactions and attitudes of nursing staff had a direct impact upon the antecedents of aggression and violence for patients in these studies. Essential core skills such as clinical, personal characteristics and team work were competencies needed by the staff when managing and caring for patients on the ward. A positive attitude towards difficult patients and the ability to be able to de-escalate aggressive and violent behaviour was identified. Team work on the wards was seen as paramount for ensuring quality of care and patient experience.

Internal/patient's mental health problems

Lawoko et al (2004) reported a high frequency of violence in psychiatric settings because staff have to deal with seriously ill people with complex problems. Dickens et al (2013) found that patients and staff agreed about internal causes of

violence and aggression, with strong beliefs that patients would calm down if left alone. However, in contrast Duxbury and Whittingham, (2004) found nurses saw internal factors such as mental illness as a strong precursor to aggression in patients. Patients stated that some staff labelled patients as mad or bad and so responded accordingly. Internal factors were seen as the most likely cause of violence by nurses in this study. Duxbury and Whittingham (2005) suggest that a 'tendency to attribute causation to the other party was a bias' (p299). Pulford et al (2013) suggests that staff and patients agreed on an internal model of causes of aggression and violence 'there appear to be types of patient who are aggressive', (Pulford et al (2013, p300).

Qualitative studies

Environment/environmental causes of violence

In a study of patients and nurses Hinsby and Baker (2004) categorised findings as five themes: the construction of identity of the perpetrator of violence; nurses' dual role of caring and controlling; aspects of parentalism involved in control; following policies and procedures; and segregation from mainstream society. Both patients and staff agreed being 'out of control' was linked to violence with patients describing being in control as positive and lack of control was 'associated with both violence and mental illness' (Hinsby & Baker 2006, p343). In relation to control nurses felt justified because they were exercising control of violent behaviour and priority 'of safety on the ward. Controlling the environment of the ward as a factor, for example nurses described '[It's] a dual role between caring - and counting knives and forks!' (Hinsby & Baker 2004; p344) that could be used as weapons. The MSU was seen to have its own

culture of violence and nurses described the MSU as a more violent place than would be tolerated by outside settings, 'When they (new staff or visitors) first come in, they are shocked by what goes on, then they become accustomed to it if they've been in a long time' (Hinsby & Baker., 2004; p345).

The second qualitative study identified five themes: the environment, empty days, staff interactions, medication and personal characteristics of the patients. Environment in this study refers to the physical environment and the lack of personal space that patients had with long periods of time spent with other volatile patients. The environment on a MSU was found to be a factor that contributed in the causes of violence and aggression towards nursing staff on the ward due to lack of personal space and the restriction of the environment in this study (Meechan et al., 2006). The unpredictability of the patients in a closed environment was suggested as a source of stress and created a tension on the ward. One patient stated 'when you've got up to 25 people living together in one locked up unit, sooner or later sparks are going to fly' (Meechan et al., 2006). They also identified a tension between patients and staff with regard to the nurses' office which has glass windows and a locked office door which was designed for staff security. It was seen as restricting social interaction and therapeutic communication with patients (Meechan et al 2006., p23).

Attitudes/interaction of the staff

Patients agreed that 'boredom', 'empty days' and the lack of meaningful activities were factors in causing aggression for example; 'you wait all morning to get to the yard……and then there's nothing to do but walk around in circles…..and get on

each other's nerves' (Meechan et al., 2006, p21). Furthermore findings suggested that patients felt staff had a lack of empathy, one patient described an issue related to making a phone call to his girlfriend and because of the interaction said 'I find a lot staff bring it onto themselves, you feel like grabbing them and snapping their necks' (Meechan et al 2006., p21). Hinsby and Baker (2004) reported staff attitudes and interactions had an impact on the levels of violence and aggression and the dual role of caring and controlling. A patient in this study when describing the differences in style of the nurses' interaction said 'No, you can't do this, do that' but it is the way it is said, and the reasons for it given, that impacts on how you might react' (Hinsby & Baker, 2004; p345). The attitude of nursing staff towards patients and their ability to interact with the patients when conflict arises were important factors in the studies reviewed. This finding is supported by Spokes et al. (2002) who suggested that previous research focused only on patients with little attention to staff behaviour. The study focused upon the impact of the nursing staff and their colleagues' actions on the likelihood of an assault by a patient. Three core findings were clinical skills, personal characteristics and interpersonal skills. Nurses in this study saw team work as paramount in the management of violence with the importance of communication between staff and the ability to think and work as a team. Indeed 'acting alone' (Spokes et al., 2013, p205) was frequently cited by the staff as something which could lead to difficulties for individuals and the team.

Internal/patients' mental health problems

Hinsby and Baker (2004) found a construct of identity of a violent patient as either 'illness or personality'. A patient described this 'when your mental state is all right you know the difference between 'right and wrong'; even if you are angry you can

control yourself. But when you are not stable and you are paranoid schizophrenic, little things spark you off' (Hinsby & Baker., 2004, p344). The internalised process of mental illness being a factor associated with violence was supported by Meechan et al (2006) who also found that aggression was attributed to mental illness factors rather than some desire among clients to be aggressive. In the patients' view, staff often lacked understanding with regards to their illness and treated them with a lack of empathy. But they also acknowledged the staff in these units having to care for difficult and dangerous patients. One patient said 'Some guys just let fly and…ah…it's hard to know what started it or what the hell was going on in their head' (Meechan et al., 2006, p22).

The findings suggest the importance of considering the interaction of a number of associated factors for the causes of violence towards nursing staff. The three themes described interact with each other: the environment which is designed to be restrictive, how the nurses interact with patients and the patients' internal mental health.

Discussion

The aim of this review was to identify and evaluate research papers to understand the predictors associated with the causes of violence and aggression towards nursing staff who work in an adult psychiatric hospital setting in the research literature. In particular to understand the causes of the violence and aggression directed at nursing staff by the patients in their care which result in threatened or actual physical harm. Three theoretical perspectives were used to synthesise these findings.

Environment was considered to be a contributing factor to violence and aggression on mental health wards (Richter & Whittington 2006). Such factors include the physical conditions on the ward for example locked doors. Wherein these physical restrictions are compounded by a cultural environment in which lack of personal space is common; moreover, this may be heightened by the frustrations of social interaction where communication between nurses and patients sometimes takes place through glass windows (Meehan, et al 2006, Bowers et al 2009, Ross et al 2011).

Bandura's (1973, 2001) social learning theory offers in understanding the causes of violence in the cultural environment. The requirements of living in close proximity mean that patients witness first-hand how other patients use aggression to manage situations to their benefit. When nurses refuse their requests, patients may mirror other patients' aggressive response to challenge the refusal.

A second underpinning framework is provided by Tedeschi and Feslson's (1996) theory of intentions and social motivation which proposes that patients' aggression may arise through social interaction with staff who have the power to impose disciplinary sanctions and withhold access to activities such as smoking or phone calls to family and partners. Together with these denials of patients' request, the manner in which staff interacted was also a source of frustration. Patients often reported that staff were not empathic and did not listen to them. This dual role of caring and controlling, constrained by available resources, constituted a tension for staff and patients. Boredom, empty days and lack of meaningful activity were also factors which could lead to aggression (Meehan et al 2006). Thus patients in a secure setting must adapt to a restrictive culture on the ward in addition to the loss of liberty and autonomy.

A third explanation for violence and aggression was attributed by nurses to internalised mental health problems. It may be safer for nurses to ascribe the cause of violence to the patients' mental health problems rather than the intentional behaviour of the patient. Freud's theory of repression suggests feelings of threat are an unconscious mechanism employed by the ego to keep disturbing or threatening thoughts from the conscious (Freud, 1961). More recently, Berwin and Andrews (2000) suggest that this has similarities to the observations of cognitive avoidance; it is not an unconscious reaction, rather the individual is aware but chooses to 'exclude information from consciousness that then become automatic and operates outside awareness' (Berwin and Andrews 2000, p617).

Meechan et al (2006) went further and suggested staff had a lack of clinical knowledge of mental illness. It may be that rather than stigmatising patients as violent, nurses, who were victims of violence, preferred to believe that the violence was caused by mental illness rather than a premeditated act. This functions as a psychological defence for nurses.

In summary, these theoretical explanations offer four contrasting frameworks for understanding the causes of violence and aggression in patients. Richter and Whittington (2006) suggest it is the environment, Bandura (1973) proposes social learning theory which suggests that close proximity is an important factor. Social motivation theory as described Tedeschi and Feslson (1996) informs understanding of the effect the attitudes and social interaction of the staff and patients. Finally, Berwin & Andrews (2000) cognitive avoidance theory helps inform understanding of the nurses view as violence is an internal factor of patients with mental health problems.

Limitations of the reviewed studies

In this review both quantitative and qualitative studies were reviewed.

Quantitative studies

Forensic and secure hospital patients may be more institutionalised because many have a history of incarceration in psychiatric settings before they are patients in secure mental health units. They may also be more aggressive and violent for reasons not hitherto identified, such as, they themselves could have been a victim of violence. Dickens et al (2013) restructured some of the factors on the MAVAS scale so it cannot be fully compared to the other two studies using the MAVAS scale in this review. Patients may have to behave in an aggressive or violent manner to maintain their own personal security and ward off other patients' aggression; the reviewed studies did not consider this issue. Length of stay by patients on the wards was not described in the studies, for longer stay patients these wards would become home and therefore the environment over longer periods of time could also be a factor in the causes of violence and aggression. Longer stay may also be associated with patients' group dynamics and the interpersonal relationships between patients and staff. Bowers et al (2009) suggested that the limitation was the cross sectional nature of the study which meant that correlations could not identify the direction of causality.

Qualitative studies

Meechan et al (2006) in a high secure unit was the sample were self-selecting and may not be reflect the population of patients in forensic units. It was further suggested that the participants were 'thought leaders' and had aggressive tones and language used was likely to restrict the more timid colleagues to contribute to the discussion at the focus group. In contrast the qualitative study by Hinsby and Baker (2006) the participants did not recount an incident in which they had been the main victim or perpetrator. The incidents were spoken about as originating from other patients but not them. No accounts of violence were reported in this sample. The reasons patients were admitted in this study were not clear and the reason for admission to a secure setting was not described.

Conclusion

This current review has located factors and which were predictors associated with violence and aggression by patients towards nursing staff on locked psychiatric wards. However, further research is needed into the causes of aggression and violence towards nursing staff working in secure hospital settings that includes a psychological theory of aggression and violence. These studies did not take account of the theory behind the violent assaults. The current review highlights the need to have studies that allow time for patients and nursing staff to discuss the interaction of the many challenges they both face daily. Nine of the studies did not put forward a psychological theory of aggression and violence and as such were unable to describe how environment factors interacted with the patients' experience of being on a secure ward.

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Appendix A

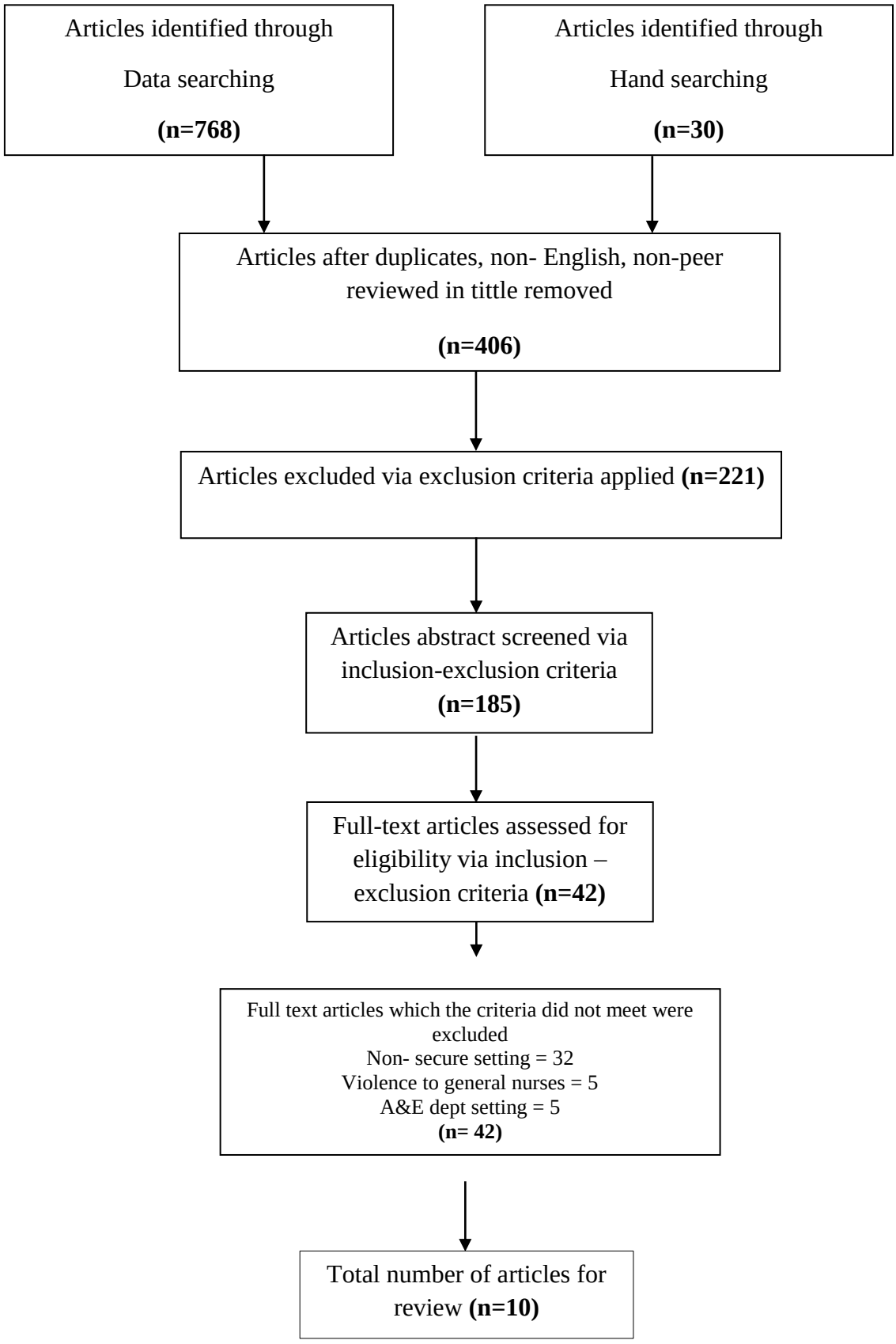
Database	Rationale	Search terms	Number of articles
EBSCO	To gain access to journals with a psychological view.		
Scopus		Psychiat*+hospital*+ aggressi*+staff	289
		Psychiat*+ inpatient*+ aggressi*+staff	160
		Psychiat*+ inpatient*+ causes+ aggressi*	29
		Psychiat*+ inpatient+ violen* +staff	134
		Psychiat*+ inpatient*+ violen* +nurses	76
			(688)
Psychinfo	To gain access to journals with psychological view	Psychiat*+hospital*+ aggressi*+staff	9
		Psychiat*+ inpatient*+ aggressi*+staff	24
		Psychiat*+ inpatient*+ causes+ aggressi*	0
		Psychiat*+ inpatient+ violen* +staff	6
		Psychiat*+ inpatient*+ violen* +nurses	1
			(40)

Psycharticle	To gain access to journals with psychological view	Psychiat*+hospital*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ causes+ aggressi*	0
		Psychiat*+ inpatient+ violen* +staff	0
		Psychiat*+ inpatient*+ violen* +nurses	0
Medline	To gain access to journals with psychological view	Psychiat*+hospital*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ causes+ aggressi*	0
		Psychiat*+ inpatient+ violen* +staff	0
		Psychiat*+ inpatient*+ violen* +nurses	0 No further articles received
CIHAHL	To gain access to journals with psychological view	Psychiat*+hospital*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ aggressi*+staff	0
		Psychiat*+ inpatient*+ causes+	0

		aggressi*	
		Psychiat*+ inpatient+ violen* +staff	0
		Psychiat*+ inpatient*+ violen* +nurses	0 No further articles received
		Total number	**768**
		Less Duplicates	362
		Total articles	406
		Articles following Exclusion	221
		Abstracts Read	185
		Full-text Read	42
		Relevant articles	**10**

Appendix B

Data search flow chart



Appendix C

Summary of Studies

Quantitative studies						
Author, year and title	Participants (age, sex)	Aim of the study	Study design	Measures used	Results	Study Limitations
Bowers et al (2009) Identifying key factors associated with aggression on acute Inpatient psychiatric Wards. **MMAT Quality Appraisal score = 4**	136 acute psychiatric wards in 26 NHS Trusts including patients and staff.	To assess the relationship of patient violence to other variables: patient characteristics, features of the service and physical environment, staff factors, use of containment methods and other patient behaviours.	Multivariate cross-sectional design.	The Patient-staff Conflict Checklist (PCC-SR). Attitudes to Containment Measures Questionnaire (ACMQ). Attitude to Personality Disorder Questionnaire (ACMQ). Team Climate Inventory (TCI). Multifactor Leadership Questionnaire.	Findings suggest high levels of aggression were associated with detained patients. With the high level of turnover of patients and locked wards were associated with high levels of violence towards nursing staff and the restrictions the staff employed to manage the ward. Conflict domain ($p<0.001$) Special observation ($p<0.001$) Staff demographics domain ($p<0.001$)	The cross-sectional nature of the study no firm conclusions could be drawn about what proportion of aggressive incidents have a potential cause. There was insufficient evidence available to draw conclusions about the nature of the link between staffing numbers and violence. found that patients' The significant of the correlations cannot identify the direction of causality and therefore firm conclusion cannot be drawn because they are subject to a variety of different interpretations.

Dickens. G. et al (2013) Causes and management of aggression in a forensic mental health service: Perspectives of nurses and patients. **MMAT Quality Appraisal score = 4**	Staff n=72 (38 qualified and 34 Healthcare assistances). Patients n=98 Within a forensic mental health service	To compare the attitudes held by patients and staff about the causes and management of aggression.	A prospective, cross-sectional, comparative survey design.	The MAVAS incorporates 27 statements about the causes of violence and approaches to tis management. Internal, external and situational/interaction factors.	Results showed the environment was linked to violence towards nursing staff. Patients in this study were more realistic regarding the need for a secure. Patients and staff agreed on items ($p<0.001$) environment ($p<0.01$). Male patients tended to agree about violence ($p<0.05$). The null hypothesis was rejected ($p < 0.01$).	The patient sample from a low and medium secure could not be compared to patients in a high-security setting. Authors suggest that women were over represented as they showed slightly different attitude to the male patient group. Authors would not recommend the MAVAS because they could not add or remove items.
Duxbury and Whittingham (2004). Causes and management of patient aggression and violence: staff and patient perspectives. **MMAT Quality Appraisal score = 4**	80 mental health in-patients and 80 mental health nurses in three different mental healthcare wards. 5 mental health in-patients and 5 mental health nurses participated in follow up interviews.	Reports staff and patients perspectives on the causes of patient aggression and the way it is managed.	A survey design employing the Management of Aggression and Violence Attitude Scale (MAVAS) (Duxbury 2003) and follow-up interviews were conducted with 5 from each sample group.	The MAVAS incorporates 27 statements about the causes of violence and approaches to tis management. Internal, external and situational/interaction factors.	Three main themes: Internal factors- nurses saw mental illness as a strong precursor to aggression. External factors- patient feeling like prisoners and staff suggesting really difficult structural environment. Interactional/situational factors- poor communication and ineffective listening skills. Comparison of staff and patients views was ($p<0.0001$).	The sample comprised of only 3 acute inpatient wards and therefore may not be representative of mental health wards. It was a small convenience sample. The authors report that MAVAS was a new instrument and is therefore problematic regarding validity and reliability.

Foster et al (2006) Aggressive behaviour on acute psychiatric wards: severity and management. **MMAT Quality Appraisal score = 4**	56 staff registered nurses and healthcare assistants on five wards in one hospital.	Investigates the nature and prevalence of inpatient aggressive behaviour towards staff and other patients.	Staff Observation Aggression Scale – revised (SOAS-R)	SOAS-R provides an aggression score from 0 (least severe form of aggression) to 22 points (most severe form of aggression).	There were 254 incidents of aggression recorded. Staff were most commonly targeted and were involved in 57% of incidents ($p< 0.05$). Seclusion rate s Patients to staff ($P> 0.05$). The most frequent provocation of the aggression was the patient being denied something such as leave from the ward (29% of incidents). The most frequent means used by patients was verbal aggression (60% of incidents), the most frequent outcome for the victim was feeling threatened (59% of incidents), and verbal interventions were used most frequently to manage the aggressive behaviour (43%). Conclusion. It is estimated that in a 12 month period at the hospital in this study 145 aggressive incidents which involved staff. 11 staff caused pain, experienced an injury or needed treatment. Suggests a 1 in 10 chance of receiving an	The study took place in one hospital in an inner city area and may not be representative. Incident reports were completed by only one person, in cases of the staff the victim which may have affected the objectivity of their accounts. Some incidents were not reported and therefore data was missed which included verbal aggression.

					injury as a result of patient aggression.	
Lawoko et al (2004) Violence towards psychiatric staff: a comparison of gender, job, and environmental characteristics in England and Sweden. **MMAT Quality Appraisal score = 4**	England n=800 psychiatric staff. Sweden n=1090 psychiatric staff.	Compares the nature of violence encountered by nurses and psychiatrics.	Questionnaire. One in English and one in Swedish.	Comparative study	Results showed that nurses are more exposed to violence and aggression than psychiatrists. Did not find that female mental health workers are more at risk. Higher levels of violence and aggression in England services compared with Sweden ($p<0.005$). Need for developing support post incident for staff and for younger staff targeted by patients. Environment and physical working conditions identified as important ($P<0.001$). Identified those who are victims of violence at work experience more psychological problems.	As a cross-sectional study, it was not possible to draw firm conclusions regarding a causal link. Generalizations are difficult as both English and Swedish data was collected in urban areas. This was compounded by subjective reporting by nurses and psychiatrist. The sample demographic of two counties in England may not be representative of the rest of England.
Pulsford et al (2013) Aggression in a high secure hospital: staff and patient attitudes. **MMAT Quality Appraisal score = 3**	301 nursing staff 97 inpatients	To ascertain and compare the beliefs of staff and patients in a high secure hospital as to the causes aggressive and	Questionnaire Management of Aggression and Violence Scale (MAVAS).	The MAVAS incorporates 30 statements about the causes of violence and approaches to tis management. Internal, external and	109 nursing staff (36% return rate) 26 inpatients (27% return rate). Environment – restrictive environments caused aggression and violence. Attitudes and interactions – 1:1 relationships reduced	The study was conducted in a high secure hospital and findings may not generalize to other settings. Relatively low return rate for both staff and patients.

		violent incidents.		situational/interaction factors.	aggression. Patients and staff agreed patients were aggressive because they were ill. Patients supported the use of medication when needed because of aggression. Belief it is difficult to prevent patients becoming violent ($p<0.021$).	
Ross et al (2011) Conflict and containment events in inpatient psychiatric units. **MMAT Quality Appraisal score = 4**	522 in patients in psychiatric hospital.	To describe the types and frequency of conflict behaviours by patients in the first two weeks of admission to an acute psychiatric unit.	A cross sectional survey of conflict and containment events.	Nursing notes were assessed for 522 patients in the first 2 weeks of admission, in 82 wards in 31 hospitals in the South of England.	Factor analysis revealed six patterns of conflict behaviour, which were related to containment methods and patients demographic factors. Factor 1 'angry refusing' included verbal and physical aggression to others. Locked doors, restrictive environment did increase aggression.	The study only used the first weeks of admission. This may not be a long enough period to assess patient violent behaviour. It is not usual for patients to be settled in the first weeks on a new ward. Nurse reports are not always consist and therefore may not be a reliable source of data.
Qualitative studies						
Hinsby and Baker (2004). Patient and nurse accounts of violent incidents in a	4 male nurses 4 male patients at London Medium	Explored patient's and nurse's accounts of violent incidents.	Grounded theory.	Semi structured interviews of staff and patients which were recorded and transcribed.	Core category- control. Themes: Construction of identities. Care and control. Parents and children. Segregation and	The participants did not recount an incident in which they had been involved, it was not their experience that they described.

Medium Secure Unit. **MMAT Quality Appraisal score = 4**	Secure unit.				the outside. Staff attitudes and interactions had an impact on the levels of violence and aggression towards nursing staff.	
Meehan et al (2006) Aggressive behaviour in the high-secure forensic setting: the perceptions of patients. **MMAT Quality Appraisal score = 3**	22 male and five female clients (patients).	To elicit perceptions, factors leading to aggressive behaviour and strategies to reduce the risk of such behaviour.	Five focus groups.	Transcription of focus groups. Content analysis and inductive approach to produce categories which were clustered into themes.	Results: Five themes; environment, empty days, staff interactions, medication and personal characteristics of the patients. Identified 5 strategies; early invention, justice issues: dealing with aggressive patients, activities to relieve boredom, patient control and staff attitudes.	The sample was self-selecting and therefore is unlikely to be representative of the population of forensic patients in forensic units. The aggressive tone and language used by some participants is likely to have restricted more timid colleagues to contribute. Biased identified within the focus group of the most articulate patients providing comments. Asking staff they views would have offered a more balanced view.
Spokes et al., (2002). HOVIS – The Hertfordshire/Oxfordshire Violent Incident Study. **MMAT Quality Appraisal score = 4**	350 nursing staff in 13 psychiatric inpatient units.	To obtain the views of staff of the causes and reduction of inpatient violence.	3 x Questionnaires	Staff Interview Form (SIF). State Trait Anger Expression Inventory (STAXI). RAMAS Anger Assessment Profile (RAAP).	105 of the 108 sample had been involved in violent incidents at work. Describes three core themes: Clinical Skills. Interpersonal skill. Personal characteristics. Team work finding report the importance of communication between staff. Acting alone was frequently reported as leading to difficulties.	This study deals with the views of the staff only and does not take account of the patients. Raises issues of are the interviews an example of real world issues. 108 sample of nurses represented only 29% total n=approximately 350) and therefore may not be representative.

Appendix D

Mixed Methods Appraisal Tool (MMAT) – Version 2011 For dissemination, application, and feedback: Please contact pierre.pluye@mcgill.ca, Department of Family Medicine, McGill University, Canada.

The MMAT is comprised of two parts (see below): criteria (Part I) and tutorial (Part II). While the content validity and the reliability of the pilot version of the MMAT have been examined, this critical appraisal tool is still in development. Thus, the MMAT must be used with caution, and users' feedback is appreciated. Cite the present version as follows.

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.* Retrieved on [date] from http://mixedmethodsappraisaltoolpublic.pbworks.com. Archived by WebCite® at http://www.webcitation.org/5tTRTc9yJ

Purpose: The MMAT has been designed for the appraisal stage of complex systematic literature reviews that include qualitative, quantitative and mixed methods studies (mixed studies reviews). The MMAT permits to concomitantly appraise and describe the methodological quality for three methodological domains: mixed, qualitative and quantitative (subdivided into three sub-domains: randomized controlled, non-randomized, and descriptive). Therefore, using the MMAT requires experience or training in these domains. E.g., MMAT users may be helped by a colleague with specific expertise when needed. The MMAT allows the appraisal of most common types of study methodology and design. For appraising a qualitative study, use section 1 of the MMAT. For a quantitative study, use section 2 or 3 or 4, for randomized controlled, non-randomized, and descriptive studies, respectively. For a mixed methods study, use section 1 for appraising the qualitative component, the appropriate section for the quantitative component (2 or 3 or 4), and section 5 for the mixed methods component. For each relevant study selected for a systematic mixed studies review, the methodological quality can then be described using the corresponding criteria. This may lead to exclude studies with lowest quality from the synthesis, or to consider the quality of studies for contrasting their results (e.g., low quality vs. high).

Scoring metrics: For each retained study, an overall quality score may be not informative (in comparison to a descriptive summary using MMAT criteria), but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as *, **, ***, and ****. For qualitative and quantitative studies, this score can be the number of criteria met divided by four (scores varying from 25% (*) -one criterion met- to 100% (****) -all criteria met-). For mixed methods research studies, the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 25% (*) when *QUAL=1 or QUAN=1 or MM=0*; it is 50% (**) when *QUAL=2 or QUAN=2 or MM=1*; it is 75% (***) when *QUAL=3 or QUAN=3 or MM=2*; and it is 100% (****) when *QUAL=4 and QUAN=4 and MM=3* (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).

Rationale: There are general criteria for planning, designing and reporting mixed methods research (Creswell and Plano Clark, 2010), but there is no consensus on key specific criteria for appraising the methodological quality of mixed methods studies (O'Cathain, Murphy and Nicholl, 2008). Based on a critical examination of 17 health-related systematic mixed studies reviews, an initial 15-criteria version of MMAT was proposed (Pluye, Gagnon, Griffiths and Johnson-Lafleur, 2009). This was pilot tested in 2009. Two raters assessed 29 studies using the pilot MMAT criteria and tutorial (Pace, Pluye, Bartlett, Macaulay et al., 2010). Based on this pilot exercise, it is anticipated that applying MMAT may take on average 15 minutes per study (hence efficient), and that the Intra-Class Correlation might be around 0.8 (hence reliable). The present 2011 revision is based on feedback from four workshops, and a comprehensive framework for assessing the quality of mixed methods research (O'Cathain, 2010).

Conclusion: The MMAT has been designed to appraise the *methodological quality* of the studies retained for a systematic mixed studies review, not the quality of their *reporting* (writing). This distinction is important, as good research may not be 'well' reported. If reviewers want to genuinely assess the former, companion papers and research reports should be collected when some criteria are not met, and authors of the corresponding publications should be contacted for additional information. Collecting additional data is usually necessary to appraise *qualitative research and mixed methods studies*, as there are no uniform standards for reporting study characteristics in these domains (www.equator-network.org), in contrast, e.g., to the CONSORT statement for reporting randomized controlled trials (www.consort-statement.org).

Authors and contributors: Pierre Pluye[1], Marie-Pierre Gagnon[4], Frances Griffiths[1] and Janique Johnson-Lafleur[1] proposed an initial version of MMAT criteria (Pluye et al., 2009). Romina Pace[1] and Pierre Pluye[1] led the pilot test. Gillian Bartlett[1], Belinda Nicolau[3], Robbyn Seller[3], Justin Jagosh[1], Jon Salsberg[2] and Ann Macaulay[1] contributed to the pilot work (Pace et al., 2010). Pierre Pluye[1], Émilie Robert[5], Margaret Cargo[6], Alicia O'Cathain[7], Frances Griffiths[7], Felicity Boardman[7], Marie-Pierre Gagnon[2], Gillian Bartlett[1], and Marie-Claude Rousseau[8] contributed to the present 2011 version.

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Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	□ Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	□ Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

Types of mixed methods study components or primary studies	Methodological quality criteria
1. Qualitative Common types of qualitative research methodology include: A. Ethnography The aim of the study is to describe and interpret the shared cultural	**1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?** E.g., consider whether (a) the selection of the participants is clear, and appropriate to collect relevant and rich data; and (b) reasons why certain potential participants chose not to participate are explained.
behaviour of a group of individuals. B. Phenomenology The study focuses on the subjective experiences and interpretations of a phenomenon encountered by individuals.	**1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?** E.g., consider whether (a) the method of data collection is clear (in depth interviews and/or group interviews, and/or observations and/or documentary sources); (b) the form of the data is clear (tape recording, video material, and/or field notes for instance); (c) changes are explained when methods are altered during the study; and (d) the qualitative data analysis addresses the question.
C. Narrative The study analyzes life experiences of an individual or a group. D. Grounded theory Generation of theory from data in the process of conducting research (data collection occurs first). E. Case study In-depth exploration and/or explanation of issues intrinsic to a particular case. A case can be anything from a decision-making	**1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?** E.g., consider whether the study context and how findings relate to the context or characteristics of the context are explained (how findings are influenced by or influence the context). "For example, a researcher wishing to observe care in an acute hospital around the clock may not be able to study more than one hospital. (…) Here, it is essential to take care to describe the context and particulars of the case [the hospital] and to flag up for the reader the similarities and differences between the case and other settings of the same type" (Mays & Pope, 1995). The notion of context may be conceived in different ways depending on the approach (methodology) tradition. *
process, to a person, an organization, or a country. F. Qualitative description There is no specific methodology, but a qualitative data collection and analysis, e.g., in-depth interviews or focus groups, and hybrid thematic analysis (inductive and deductive). Key references: Creswell, 1998; Schwandt, 2001; Sandelowski, 2010.	**1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?** * E.g., consider whether (a) researchers critically explain how findings relate to their perspective, role, and interactions with participants (how the research process is influenced by or influences the researcher); (b) researcher's role is influential at all stages (formulation of a research question, data collection, data analysis and interpretation of findings); and (c) researchers explain their reaction to critical events that occurred during the study. The notion of reflexivity may be conceived in different ways depending on the approach (methodology) tradition. E.g., "at a minimum, researchers employing a generic approach [qualitative description] must explicitly identify their disciplinary affiliation, what brought them to the question, and the assumptions they make about the topic of interest" (Caelli, Ray & Mill, 2003, p. 5).

Types of mixed methods study components or primary studies	Methodological quality criteria
2. Quantitative randomized controlled (trials) Randomized controlled clinical trial: A clinical study in which individual participants are allocated to intervention or control groups by randomization (intervention assigned by researchers). Key references: Higgins & Green, 2008; Porta, 2008; Oxford Center for Evidence based medicine, 2009.	**2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?** In a randomized controlled trial, the allocation of a participant (or a data collection unit, e.g., a school) into the intervention or control group is based solely on chance, and researchers describe how the randomization schedule is generated. "A simple statement such as 'we randomly allocated' or 'using a randomized design' is insufficient". *Simple randomization:* Allocation of participants to groups by chance by following a predetermined plan/sequence. "Usually it is achieved by referring to a published list of random numbers, or to a list of random assignments generated by a computer". *Sequence generation:* "The rule for allocating interventions to participants must be specified, based on some chance (random) process". Researchers provide sufficient detail to allow a readers' appraisal of whether it produces comparable groups. E.g., blocked randomization (to ensure particular allocation ratios to the intervention groups), or stratified randomization (randomization performed separately within strata), or minimization (to make small groups closely similar with respect to several characteristics).
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)? *The allocation concealment protects assignment sequence until allocation.* E.g., researchers and participants are unaware of the assignment sequence up to the point of allocation. E.g., group assignment is concealed in opaque envelops until allocation. *The blinding protects assignment sequence after allocation.* E.g., researchers and/or participants are unaware of the group a participant is allocated to during the course of the study.
	2.3. Are there complete outcome data (80% or above)? E.g., almost all the participants contributed to almost all measures.
	2.4. Is there low withdrawal/drop-out (below 20%)? E.g., almost all the participants completed the study.

Types of mixed methods study components or primary studies	Methodological quality criteria
3. Quantitative non-randomized Common types of design include (A) non-randomized controlled trials, and (B-C-D) observational analytic study or component where the intervention/exposure is defined/assessed, but not assigned by researchers. A. Non-randomized controlled trials The intervention is assigned by researchers, but there is no randomization, e.g., a pseudo-randomization. A non-random method of allocation is not reliable in producing alone similar groups. B. Cohort study Subsets of a defined population are assessed as exposed, not exposed, or exposed at different degrees to factors of interest. Participants are followed over time to determine if an outcome occurs (prospective longitudinal). C. Case-control study Cases, e.g., patients, associated with a certain outcome are selected, alongside a corresponding group of controls. Data is collected on whether cases and controls were exposed to the factor under study (retrospective). D. Cross-sectional analytic study At one particular time, the relationship between health-related characteristics (outcome) and other factors (intervention/exposure) is examined. E.g., the frequency of outcomes is compared in different population sub-groups according to the presence/absence (or level) of the intervention/exposure. Key references for observational analytic studies: Higgins & Green, 2008; Wells, Shea, O'Connell, Peterson, et al., 2009.	**3.1. Are participants (organizations) recruited in a way that minimizes selection bias?** At recruitment stage: For cohort studies, e.g., consider whether the exposed (or with intervention) and non-exposed (or without intervention) groups are recruited from the same population. For case-control studies, e.g., consider whether same inclusion and exclusion criteria were applied to cases and controls, and whether recruitment was done independently of the intervention or exposure status. For cross-sectional analytic studies, e.g., consider whether the sample is representative of the population.
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes? At data collection stage: E.g., consider whether (a) the variables are clearly defined and accurately measured; (b) the measurements are justified and appropriate for answering the research question; and (c) the measurements reflect what they are supposed to measure. For non-randomized controlled trials, the intervention is assigned by researchers, and so consider whether there was absence/presence of a contamination. E.g., the control group may be indirectly exposed to the intervention through family or community relationships.
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), **are the participants comparable, or do researchers take into account (control for) the difference between these** **groups?** At data analysis stage: For cohort, case-control and cross-sectional, e.g., consider whether (a) the most important factors are taken into account in the analysis; (b) a table lists key demographic information comparing both groups, and there are no obvious dissimilarities between groups that may account for any differences in outcomes, or dissimilarities are taken into account in the analysis.
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?

Types of mixed methods study components or primary studies	Methodological quality criteria
4. Quantitative descriptive studies Common types of design include single-group studies: A. Incidence or prevalence study without comparison group In a defined population at one particular time, what is happening in a population, e.g.,	**4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?** E.g., consider whether (a) the source of sample is relevant to the population under study; (b) when appropriate, there is a standard procedure for sampling, and the sample size is justified (using power calculation for instance).
frequencies of factors (importance of problems), is described (portrayed). B. Case series A collection of individuals with similar characteristics are used to describe an outcome.	**4.2. Is the sample representative of the population understudy?** E.g., consider whether (a) inclusion and exclusion criteria are explained; and (b) reasons why certain eligible individuals chose not to participate are explained.
C. Case report An individual or a group with a unique/unusual outcome is described in details. Key references: Critical Appraisal Skills Programme, 2009; Draugalis, Coons & Plaza, 2008.	**4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?** E.g., consider whether (a) the variables are clearly defined and accurately measured; (b) measurements are justified and appropriate for answering the research question; and (c) the measurements reflect what they are supposed to measure.
	4.4. Is there an acceptable response rate (60% or above)? The response rate is not pertinent for case series and case report. E.g., there is no expectation that a case series would include all patients in a similar situation.

Types of mixed methods study components or primary studies	Methodological quality criteria
5. Mixed methods Common types of design include: A. Sequential explanatory design The quantitative component is followed by the qualitative. The purpose is to explain quantitative results using qualitative findings. E.g., the quantitative results guide the selection	**5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?** E.g., the rationale for integrating qualitative and quantitative methods to answer the research question is explained.
of qualitative data sources and data collection, and the qualitative findings contribute to the interpretation of quantitative results. B. Sequential exploratory design The qualitative component is followed by the quantitative. The purpose is to explore, develop and test an instrument (or taxonomy), or a conceptual framework (or theoretical model). E.g., the qualitative findings inform the quantitative data collection, and the quantitative results allow a generalization of the qualitative findings.	**5.2. Is the integration of qualitative and quantitative data (or results) relevant to address the research** **question (objective)?** E.g., there is evidence that data gathered by both research methods was brought together to form a complete picture, and answer the research question; authors explain when integration occurred (during the data collection-analysis or/and during the interpretation of qualitative and quantitative results); they explain how integration occurred and who participated in this integration.
C. Triangulation design The qualitative and quantitative components are concomitant. The purpose is to examine the same phenomenon by interpreting qualitative and quantitative results (bringing data analysis together at the interpretation stage), or by integrating qualitative and quantitative datasets (e.g., data on same cases), or by transforming data (e.g., quantization of qualitative data). D. Embedded design The qualitative and quantitative components are concomitant. The purpose is to support a qualitative study with a quantitative sub-study (measures), or to better understand a specific issue of a quantitative study using a qualitative sub-study, e.g., the efficacy or the implementation of an intervention based on the views of participants. Key references: Creswell & Plano Clark, 2007; O'Cathain, 2010.	**5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results)?**

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Part 2

The process of psychological recovery of unqualified nursing staff after a serious violent assault in a secure setting.

Abstract

This study explored the psychological recovery of nursing staff in a secure mental health hospital setting in the UK who had experienced a violent assault in the previous fortnight. Study participants were five unqualified nursing staff/HealthCare Assistants (HCAs) who were interviewed on two occasions, immediately following the assault and at six months after. All participants accessed the in-house Trauma Response service for help in coping with the effects of the assault which had been reported as level 3-5 on the Serious Untoward Incident matrix. Data were collected via in depth interviews and transcribed verbatim. Interpretative Phenomenological Analysis (IPA) was adopted which identified three overarching themes: Putting on a front, Organisational relationships; and Recovery and moving-on. Recommendations include the development of team-based working to help de-stigmatise the impact of a serious violent assault and improving managerial response to violent assault and support on the hospitals wards. More specifically, the study recommends the acknowledgement within the organisational culture of the psychological impact of serious assaults on staff well-being. The implications of the findings are discussed in relation to the wider provision of trauma support for staff.

Introduction

Violent assaults on staff in secure mental health context

Violence against mental health staff has been increasing. Indeed NHS Protect reported an 8.7% rise in incidents from 63,199 in 2012/13 to 68,683 in 2013/14 physical assaults against staff in England (NHS Protect 2013/2014). The nature of violent assaults ranges from being punched and kicked, to injuries that result in broken limbs and other serious injuries that have a life changing impact on staff (Nolan et al 2009, Howard & Rose & Leverson 2009, Anderson & West 2011). Less is known of the impact of these injuries reported to NHS Protect and private and charitable organisations have no current mechanisms for reporting levels of assaults on staff.

A serious violent assault by patients within secure mental health services may have both short term and long-term impact upon staff, patients and the organization which has been reported in the sickness absence organistaional and compensation injury payments data. For staff working 12 hour shifts during the days or nights with violent and aggressive patients, there is a daily risk of being assaulted. Howard et al (2009, p539) found that there was an increased burnout in staff significantly correlated with 'increased perceived exposure to physical violence and reduced staff support'. Howard & Hegarty (2003, p7) revealed that a common response to violence was the suppression of 'normal' emotional reactions and they found that staff described this as the most difficult aspect of dealing with violence. The suppressed emotions were anger and frustration, apathy, fear, upset tension and sadness (Howard and Hegarty, 2003).

The impact on staff who have experienced psychological trauma in their workplace has direct consequences for them, it also has a direct impact on the organisation who employs them. Developing an understanding of what staff need, when and how best to provide it is of importance for reviewing and developing services. For the individual, serious injury may mean not being able to work again because of the impact of the physical and psychological injury. For other patients on the ward it means the loss a member of staff with whom they have built a trusting relationship. Quality nursing staff are key to patient's recovery and to the organisation's ability to provide a therapeutic environment. The organisational recruitment and training of nursing staff make them a valuable asset and therefore it is important that nursing staff feel valued and supported.

Impact of being assaulted by a patient for staff

Workplace violence is a major cause of trauma for mental health staff working in secure units and contributes at multiple levels, leading to a range of effects: bio-physiological, cognitive, emotional and social effects (Greenwood & Rooney & Andrio 2012). Bio-physiological effects include anxiety and fear which are the most frequently reported. Fear may relate to the workplace or to patients, fear of permanent disability due to the assault or of becoming dependent on others (Hauck 1993, Lanza 1983). Cognitive and emotional feelings of shame and guilt are also commonly cited reactions to aggression reported in a majority of studies. Shame has been suggested to be a threat to the social self. Budden (2009) and Wilson et al (2006) suggest, unlike other emotions; 'shame damages the soul of the person, his or her most cherished and inner sense of identity and humanity' (p. 139). The experience of shame can include feelings

of a self-consciousness of having behaved in a disgraceful or dishonourable way and reflects their appraisal of self-worth. Wilson et al (2006) define posttraumatic shame as consisting of both acute and prolonged feelings and a secondary appraisal of the damaged social self. For example, loss of face, self-esteem, self-worth, feelings of alienation and the rupturing of social ties. Feelings of shame for nursing staff often focus on they should have managed the situation more effectively. Working daily with violent patient's staff may feel that they should have anticipated the assault and have let themselves or their team down by not acting more quickly. Budden (2009) goes further and suggests 'psychological traumas are, in a very profound way, about threats to the social self' (p1037). The author proposes that overwhelming threats can destroy relational bonds with the social world. For nurses the experience of a violent assault may run the risk of destroying the nurses' bond with the ward team and also the patient. However, trauma symptoms can be alleviated by psychological support or over time as described by NICE (2005) in a process of 'watchful waiting'.

Working in a secure setting with patients who are often violent and aggressive is said by many staff to promote an organisational culture where being assaulted is considered part of the job. The pressure to be seen to be coping can be a daily pressure for this group of nurses. The stigma associated with keeping thoughts and feelings to one self is not a new phenomenon. Goffman (1963, p3) defined stigma as 'an attribute that is deeply discrediting…turning a whole and usual person to a tainted and discounted one'. He further argues that once the stigma is noted by an observer the person can be under further due scrutiny, criticism and ridicule. This 'disciplinary gaze' can be internalized by the person leading them to self-doubt, shame and guilt (Schulze and Angermeyer, 2003, p301). In a more recent study of stigma and recovery of people

with a severe mental health problem Whitley and Campbell (2014) found that stigma and discrimination were not perceived as commonly experienced problems but were problems that the individual wanted to keep to themselves and they made a self-conscious decision to behave and look normal.

Psychological recovery

The trauma literature is well established. It includes studies that have described the impact of psychological trauma and the outcome of psychological interventions, such as psychological debriefing (Mitchell, 1983; McNally et al 2003); psychological growth following trauma (Calhoun & Tedeschi, 1999; Joseph, 2011; Lepore & Revenson, 2006; Wiess & Berger, 2010). There is, however, less research about the process of psychological recovery.

Indeed, the concept of psychological recovery reveals that people who have been traumatised may regain a semblance of normality, however the process by which this occurs has received 'surprisingly little attention'(Bonanna & Mancissi 2010, p77). Bonanno (2004) provides a definition of individual recovery as "a trajectory in which normal functioning temporarily gives way to threshold or subthreshold psychopathology (e.g., symptoms of depression or Posttraumatic Stress Disorder (PTSD) usually for a period of at least several months, and then gradually returns to pre-event levels. A 'full recovery may be relatively rapid, or may take as long as one or two years' (Bonanno, 2004, p. 20). Psychological recovery occurs over time when the signs and symptoms of trauma have a lesser impact. Bonanno (2008) suggests that psychological recovery is separate to resilience and that the two processes need to be seen separately. The author

contends that a limitation in the literature is that it does not consider the two processes separately and suggests that 'controversies about when and for whom clinical intervention might be appropriate' (Bonanno, 2008, p102) is problematic if recovery and resilience are not considered as distinct phenomena. Resilience to loss and trauma is the ability to maintain stable levels of psychological and physical functioning and is distinct in the absence of psychopathology to acts of violence, loss and life threatening events. Over time these symptoms subside; however, the traumatic event may have a lasting psychological impact in experiences of flashbacks, triggers and other psychological experiences associated with the original traumatic event and could impact their psychological recovery at times. In this study, recovery does not mean the complete freedom from traumatic symptoms, but is the ability to live in the present without being overwhelmed by thoughts and feelings of the past.

A different theory of psychological recovery is offered by Joseph. Joseph (2011) suggests that many individuals who survive serious traumatic events often experience various forms of resilience such as being 'transformed', where they develop a new sense of self. Joseph describes this change as post-traumatic growth. The theory of post-traumatic growth acknowledges individual differences and suggests that people respond and construct ways of dealing with traumatic incidents. For example, Joseph describes the impact of a storm wind on a tree; some trees weather the storm and are the same as before the storm hits. They do survive but they injuries adapt and grow around the scars. Individuals who survive serious traumatic incidents may grow following adversity. The trauma impacts their emotional wellbeing, their view of life, priorities and their behaviour which is reconfigured in a positive way. In this model, recovery is suggested to be through three common reconfigurations: personal change, such as

finding inner strength; philosophical changes such as a new found sense of what is really important in life; and relationship changes, for example valuing family and close friends and moving on from relationships with people who are not emotionally engaging. These changes are termed post-traumatic growth. In this study the author defines psychological recovery as the ability to live in the present without being overwhelmed by the thoughts and feelings of the past.

The psychological journey to recovery is sometimes difficult because of an individual's desire to return to how things were rather than how things are now. Evidence to support this is provided by Buckley and Dunn (2012) who found that following the July 7 2007 bombings in London many of those injured returned to work within relatively short time periods. It may be that individuals have a desire to return to work in order to normalise and attempt to reduce the impact of trauma. However, Buckley and Dunn (2012) revealed that some of those who return to work subsequently experience both psychological and health problems as well as changes to their interpersonal and social life at home and at work. This suggests that recovery is more complex and staff may need support at times of difficulties. Indeed sickness absence data from the secure hospital in this study mirrored a similar pattern of behaviour, where the majority of nursing staff returned to work on the wards as soon as they had recovered from their physical injuries within a 1-2 weeks' time period or less. However, later developed psychological problems related to the original assault. What at first seems to be 'highly adaptive responses to a trauma later become the very debilitating symptoms blighting an individual's life and preventing him or her from moving on' (Buckley & Dunn, 2012, p.363). This study provides insight and evidence of highly adaptive responses that can cause problems later for traumatised staff. There is an over

whelming desire for life to return to normal and going to work is part of that process. Nursing staff mostly return as soon as possible to work, but later present to the TRS experiencing further psychological difficulties related to the incident. This paper has given insight into the difficulties that staff experience when they want to return to work soon after a traumatic incident and identifies the difficulties they face.

The recovery of nursing staff who have been traumatised in the workplace is a developing area of concern for nurses working in secure hospitals. Providing care for violent and aggressive patients has a human cost. Currently there are no national data which record how many staff in secure hospitals return to work or how many leave because of their injury or because they can no longer cope with the levels of anxiety and stress caused by working with this patient group. NHS Protect only report data of how many assaults took place within NHS mental health services, private providers are not required to report the number of assaults. There are no data on the costs of these injuries to either the organisation or to the individual and to date no research on how they recover.

In summary, there have been a large number of studies investigating the nature and prevalence of aggression and violence toward healthcare staff Dack et al, (2013); Papadopoulus et al (2012) and Bowers et al (2011). This current study contributes to the literature by explaining the process of psychological recovery of nursing staff working in an inpatient secure mental health setting.

Aims

This research aims to understand the phenomenology of psychological recovery of HCAs who are assaulted by a patient working within a secure mental health setting. The study aims are important for two reasons, firstly to further develop our understanding of the recovery process experienced by injured HCAs and to develop trauma support which can provide support that best addresses what the staff need. Secondly to inform the organisational culture and management of the impact of these serious incidents and how an organisational response of support could be beneficial to the nursing staff and help them return to this difficult working environment and to the organization by reducing the turnover of staff and sick absence.

Study context

The research was conducted in a hospital run by a charity that has been established for 176 years and provides in-patient secure mental health care to patients who have severe mental health illnesses and who are aggressive and violent. The hospital where this study was conducted has a national reputation for caring for some of the most aggressive and violent mental health patients from England, Wales and the Republic of Ireland. The researcher was employed to set up the TRS in 2009

Method

This is a qualitative study employing semi-structured interviews to explore the experiences of unqualified nursing staff who have experienced psychological trauma following a serious violent assault by a patient whilst working in a secure in-patient mental health setting.

Participants were interviewed on two separate occasions. The first interview took place within five days of the assault occurring when they first accessed the service. At the first meeting participants were invited to an interview six months later in order to talk about the experience of their recovery. It was standard practice to offer all participants strategies to help coping and a referral for psychological treatment if needed. The eleven interviews in total were recorded at two interview dates 6 months apart. The second interviews were transcribed verbatim. The transcribed accounts were then anonymised and analysed using Interpretative Phenomenological Analysis (IPA). Other analytical approaches such as grounded theory and thematic analysis were considered and discussed in supervision. Grounded theory is concerned with a systematic analysis of the data leading to the development of a theoretical account of experience and was deemed not appropriate for the focus and sensitivity of the data in this study. Thematic analysis as suggested by Braun and Clarke (2012, p180) 'cannot provide any sense of the continuity and contradictions within individual accounts….also the 'voice' of an individual participants can get lost', and was not considered appropriate for this study.

'IPA's overriding concern is with exploring people's lived experiences and the meanings people attach to those experiences it is thus best suited to experience-type questions' Braun and Clarke (2012, p181) and was chosen as a best fit for the aims of this study. Smith et al give the example of a swimmer who is particularly aware of the swimming following major surgery. The everyday event assumes particular saliency in the light of these different circumstances. So too, in this study, the daily experience of providing care to challenging patients is disputed by an act of violence. The incident provides a lens to reflect on these everyday performances of care and become an 'experience' rather than merely an experience (Smith et al, 2009 p.2). Because the experience of and emotional response to violence is such a personal event, IPA is particularly suited to exploration and examination of participants' accounts because the double hermeneutic in which 'the researcher is trying to make sense of the participant trying to make sense of what is happening to them (Smith et al 2009 p.3). Therefore IPA was chosen as the best fit for the aims of this study as neither thematic analysis nor grounded theory considered this which was an important issue in this study.

Researcher's epistemological stance

The researcher is a HCPC registered Consultant counselling psychologist employed as Trauma Response Service Lead for a staff population of over 4,200 based on four hospital sites in England. With over twenty years' experience, the researcher has worked alongside traumatised healthcare staff with the aim of enhancing emotional wellbeing. As Thompson and Harper (2012) suggest, this clinical role has facilitated understanding of mental distress from the individualised perspective. This clinical experience has developed an ability to both focus and reflect on the meaning of an

experience for a participant. In this study, a critical realist social constructionist position was adopted. In this perspective, the researcher is not only aware of the importance of qualitative data, but of a need to go beyond the text in order to have a further layer of interpretation that considers the social context Harper and Thompson (2012). Such an approach sees the world, and what we know of it, being produced by constructs through language, representation and other social processes. The world is understood by how it is related to cultural, context and resulting from social interaction, rather than some inherent truth about the nature of reality Braun and Clarke (2012). Indeed, Smith et al (2009, p196) help to clarify by pointing out 'that IPA subscribes to social constructionism' which provides a detailed experiential account of the person's involvement in the context. By reflecting on the language of participants, the double hermeneutic process in IPA allowed the researcher to make sense of participants' experience. Interpretative phenomenology as an epistemological stance is concerned with the subjective experience of participants themselves, it pays attention to idiographic analysis, that is, the person in the context and it requires becoming familiar with participants' idioms and metaphors. The researcher brings a level of immersion in the participants' world and this is underpinned by a reflexive approach wherein underlying or a priori assumptions are engaged with or challenged. To come to an understanding whereby the participants' journey to recovery can be supported, attention to the meaning of a violent assault, for the person themselves, is crucial. Other analytical approaches such as grounded theory were considered and discussed in supervision.

Ethics

The research study was submitted to the University of Leicester ethics committee and approved in January 2014 (see appendix E) and the research sponsor for St Andrews Healthcare confirmed by letter giving approval for the research (see appendix F).

Participants

Inclusion and exclusion criteria**:** Criteria for inclusion in the study were unqualified nursing staff known as Healthcare Assistants (HCAs) who had been seriously assaulted at work by a patient/s as described on the Serious Untoward Incident (SUI) scale (see appendix G) and had accessed the trauma response service. Participants were included if they self-scored at or above a level 3 on the SUI form used by the charity for recording serious assaults on staff. Participants were excluded if they were traumatised because of non-physical assaults/trauma.

Participants were selected from the HCAs that accessed the Trauma Response service (TRS) following a serious assault by a patient on a secure mental health ward. Six HCA nursing staff were recruited to be interviewed, one participant withdrew from the research pathway for personal reasons and left the employment of the hospital.

The participants' names were changed to protect their identity. Two were men and three women. The two men were aged 34 and 55 and their ethnic background was one Black British and one British White male. The three female participants were one

Eastern European and two White British. The ages were 22, and two were both 47 years of age.

Procedure:

Recruitment: Participants were recruited from HCAs who had been seriously assaulted and who had contact with the TRS. Participants were asked if they would participate in the study by an administrator of the TRS. Those who agreed were given an information leaflet (see Appendix H) explaining the purpose of the research project and the nature of their involvement. Participants completed and signed a consent form (see Appendix I).

On contacting the administrator of the service for an appointment for support was asked if they would consent to participating in the research study. For those who consented, they became part of the research pathway as described above. The participants who did not agree to participate in the study were seen in the usual way within the TRS. The HCAs in the research pathway were able to withdraw from the study at any time and up to month after the second recorded session. Ten HCAs nursing staff were invited to join the research project and six participants were recruited.

Interview procedure

Each participant was asked to attend two interviews. The first interview enabled a factual account of the assault experienced by the participant and this was recorded and transcribed as a record of the case history. The participants were seen within five

working days of the serious assault for a first interview where they talked about the incident and how the assault had happened. This session was recorded and transcribed to form a record of the event for the researcher to use to help remind the researcher of the participant's experience when analysing the data from the second interviews. Six months later the participants were contacted by letter and second interviews were arranged. The second interview questions were one line prompts which were employed to help the interviewee to return to the subject of the serious assault. The questions were generated from discussions with the researcher's supervisor and experienced psychologist peers at work and from reading of pertinent literature (see appendix J). All the interviews took place at the main office of TRS. Interviews lasted on average 25 minutes and the researcher ensured the participants had access to further support if needed. The interviews were recorded and transcribed verbatim. One participant withdrew from the research pathway and eleven interviews of participants were conducted.

Recording of interviews

The interviews were recorded using a digital voice recorder. One participant withdrew from the research path way. The interviews were transcribed verbatim by the researcher. Interview transcripts were then collated for analysis.

Data analysis

The transcripts which were landscape formatted into numbered line grid with space in each merge to write first thoughts and comments. Analysis of the transcripts

was conducted employing the six stages of IPA as suggested by Smith, Flowers and Larkin, (2009). The first stage involved reading and rereading the transcripts whilst listening to the recordings of the interviews which enabled the researcher to engage with the discourse of the participant and became familiar with the participant's world. The second stage was initial noting of all interesting content and comments in the transcript were noted in the right hand side of the column for first impressions with the aim actively engaging with the participant's meaning. Thirdly, on subsequent readings the developments of emergent themes were recorded in the left hand column. This was to enable exploratory coding of repeated words and statements that may form clusters of meaning. The fourth stage was to search for connections across emergent themes. In the fifth stage this was repeated with all the participants' transcripts and allowed for new themes to develop, ensuring a commitment to the data at the idiographic level is maintained. The final and sixth stage involves noticing any patterns that may feature across the cases already analysed in step one to five, whilst retaining the themes that may be specific to individuals (Smith, Flowers & Larkin 2009).

Quality issues

In this study four 'characteristics of good qualitative research' were employed to evaluate quality (Yardley, 2000): Sensitivity to context; Commitment and rigour; Transparency and coherence; and Impact and importance.

Sensitivity to Context

Sensitivity to context was achieved in two ways: the researcher is employed by the organisation and spends time working on the wards and is attuned to the nature of the environment following guidelines by Smith et al (2009, pp56-78). Secondly, sensitivity to context underpinned the interviews through empathy, flexibility and understanding that the response to violence is individual. It is acknowledged that conducting the interviews in the workplace may have impacted on participants: in order to please the researcher they may have over-stated their recovery; the time scale of six months may not have been sufficient time. The researcher discussed with expert colleagues including her supervisor, the Chair of the Crisis, Disaster and Trauma section of the BPS and an experienced psychologist working in trauma about the use of brief interviews. The sessions were timed to allow attendance during a 12 hour shift which only allows half hour breaks from the ward area. All clinicians considered that a brief interview was appropriate because of the sensitive nature of the experience. All participants reported the interview did not cause them any distress. All participants were informed they could contact if needed and given the Staff Counselling service number. Confidentiality was made explicit to each participant and anonymity was assured at both meetings. The literature was reviewed further to reflect and contextualise the emergence of the themes.

Commitment and Rigour

An established framework and method was provided by the guidelines for data collection and analysis employing an IPA approach (Smith et al 2009). Discussion at

regular supervision to ensure that the themes reflected the data was utilised by the researcher to ensure an IPA focus was maintained together with a reflexive diary to help map the emergent themes and ideas related to the participant's interviews. Quotations from participants that appear to encapsulate the themes were selected to illustrate the themes ensuring that themes provided a good fit with the data.

Transparency and Coherence

A clear account of the research process is provided. The data analysis is described in detail and the use of verbatim quotes supports the finding and helps the transparency and coherence of the analysis. All raw data interview transcripts were sent in password protected electronic document for the examiners in line with the University guidance for confidentiality.

Impact and Importance

The study is important and has implications for both clinical and research areas and contributes to further discussion and research of these sensitive issues which is examined in more detail in the discussion section.

Results

Table 1 shows the results of the stage six of the data analysis

Super-ordinate Themes	Corresponding Subordinate Themes
Putting on a front	• Pressure to be 'fine' • 'You're all right' • Not wanting to be a victim but having to prove why you are taking time off injured • 'You gotta beat this' • 'Get up get up you're fine' • 'Like being thrown in the lion's den'
Organisational relationship	• Is it ok not to cope here? • Manager's attitudes to injured staff • Betrayal by my team • Not valued • They should know my pain • Occupational Health unhelpful – not supportive
Recovery and moving on	• New me • Changed my partner • Only have people who are supportive around me • It's made me a stronger person • Family, partner and children more important than work • It's happen now (the assault) I will be OK

Following the initial analysis of recurrent themes (see Appendix J) and the coding and analysis of each participant's transcripts (see Appendix L), a higher level analysis led to the development of three superordinate themes which encompassed individual and shared themes of the experience of recovery from psychological trauma.

The subordinate themes inter linked and the pressure to be 'all right' and to return to work resulted in 'putting on a front' being the overarching theme (see Appendix M) for flow chart of interaction.

Exploration of the themes

Putting on a front

The first theme describes the participant's sense of not being understood by key others and of pretending to be different to the way they feel at work and having to 'put on a front', not being able to be as they feel which often is not alright. Participants said colleagues acknowledge the trauma they have experienced, but the participants often feel better able to cope with the after effects then their team and 'put on a front' to mask their true feelings. If colleagues minimize or ignore the trauma, their psychological responses and difficulties increased. Colleagues are perceived to minimise or ignore the trauma if they pressure them to be fine. Ruth describes being told she is fine but this is not congruent with how she feels. By saying that she is fine, colleagues then do not need to engage in the emotional labour of listening to the experience and she feels devalued. When returning to work four of the participants Ruth, Ann, Helen and Ben describe in different ways how they need to 'put on a front' and because they are not being understood. Not being understood linked to the theme 'organisational relationship' where again participants felt emotionally missed.

In a sub-theme, Ruth describes returning to work and the response she received from colleagues.

'*..... as like I was saying people kept saying "are you fine" and you just keep saying "I'm fine" but deep down you're not fine are you?[ ] I think it's disgusting the years I have worked at the hospital 15 years….yes, I didn't feel valued at all. I just said that*

this felt like I was just a number, you know. I am a loyal staff member and worked here for all them years and you know I am a respected person', (Ruth 35-57).

Ruth expresses this as a contradiction between real and expected emotions saying 'I'm fine', but 'deep down you're not fine'. The lack of acknowledgment of her feeling means she is not able to express her thoughts. Does she find it hard to say how she really feels and what is stopping her? The use of the term 'deep down' suggests it is a core of self that she is not fine. This may be linked to her not feeling valued …'*I was just a number'.* She may have a sense that she is depersonalised by the 'others'. After 15yrs service to the organisation her pain and distress are not being valued, they should know I am not fine. Ruth wants 'them' to know her pain and discomfort. They should not have to ask and if they do ask they should know. This she considered was as upsetting as being assaulted.

Ben expresses his experience of not being understood which comes to the fore when he took sickness absence. He describes having to 'justify' the reason he took time off work to occupational health, this was a sub-theme of 'putting on a front'.

'*Erm because it felt as though I was being victimised or vict, well I am a victim as such [ ] it felt as though I had to justify the reason why I was off even though it was through an injury[ ]it was a slap in the face basically and that was the icing on the cake, you know that really really sort of niggled me', (Ben 14-27).*

The process of explaining himself to the Occupational Health nurse makes him feel he is victimised. The issue of having to prove that he was injured is described as '*the icing on the cake'*. It is like the final insult. The contradiction between the two

metaphors *'slap in the face'* and '*icing on the cake'* is a reversal of common meaning. In this case, '*icing on the cake',* is used instead of a phase such as 'the last straw'. Icing on the cake means something that makes a good situation even better yet he means the opposite. The verbal response is perceived by him as a further physical assault: it is a 'Slap in the face'.

On her return to work, Ann is told by her manager to go back to the ward, but there is no discussion of potential support mechanisms for her or safety procedures. She is told 'you gotta beat' this (presumably, her fear); however, he minimises the grounds of her fear and suggest putting up a front.

'[ ] come on you gotta to beat this, just get in there and whatever so I went in there with em and there he was, he (the patient who assaulted her) was at the door. And they opened the bloody door, they knew what's happened, they opened the door and he (patient) went "Ann, Ann are you ok erm you know I miss you and all this lot." I was like this lump in my throat; it was awful I was a right mess when I got back', (Ann 290-305)

Ann then repeats 'I was like a massive lump in my throat', and again says 'Yeh, a massive lump in my, I couldn't swallow, nothing cos it had really stressed me out'. The repetition of lump in my throat as if Ann could not take any more. Ann realises that she can never go back to the ward because of the fear. Ann experiences the fear as a lump in her throat.

Helen has a similar experience. Colleagues say she should pick herself up and dust herself down and get on with things as normal.

'*Yer I think they were supportive but they were also quite firm I'd say sort of. Not trying to like, I don't know what word to use, erm I suppose like when a kid falls over and grazes their knees it's like 'get up get up you're fine' that sort of thing'[ ] and trying to sort of make me, make me feel better about it'. (Helen 313-329)*

Helen struggles to find the words to respond to whether the team were supportive. In fact she likens her experience to a parent talking to a child when they have fallen over. But she has not just grazed her knee. The repetition of get up suggests an authoritarian parent who dismisses what has happened. But she does not say this directly.

There seems to be an underlying message that the staff had recovered from their injury and they felt obliged to behave as if nothing had happened 'you're alright'. Does this suggest that if the returning injured nursing staff do not comply to this request it would have a negative impact upon the staff team and the ward because often things on the ward are not alright. Feeling the 'pressure to be fine', injured staff are emotionally missed by their colleagues which may compound feelings of being misunderstood and not valued. Being valued for who you are and the amount of time and care you have given to the patients and the organisation was described as important and part of their identity at work.

Ruth describes ‘pressure to be fine’ as like being ‘thrown in the lion’s den’:

‘*You know as I was, I did feel traumatised, I was awful, I felt awful, I felt like quite anxious, nervous when I came back to work and all they kept saying “aww your fine” it’s like being thrown in the lion’s den and their going ‘ha you just been thrown’ in that’s just happened that’s fine’[ ] Yeh it’s a nightmare at the moment an absolute nightmare …. the next couple of weeks I will be moving [ ] Erm cos I have actually been bitten erm a few days ago at work’.*

Ruth describes the lack of consideration and understanding between what she feels she needs and what the team thinks she might need. It is not the fear of seeing the patient but is more to do with patients in the environment that is the issue and just being thrown back in.

Ruth repeats ‘I was awful’ and ‘I felt awful’. In contrast her team say ‘aww your fine’. She then describes ‘it’s like being thrown in the lion’s den’. But Ruth is not fine, in fact she is bitten on her return by another patient. When she repeats ‘it’s a nightmare…an absolute nightmare’, there is a reality to this statement and the ward feeling like a lion’s den.

‘Putting on a front’ was the largest super-ordinate theme and the sub-themes were interlinked to ‘organisational relationship’ and ‘recovery and moving-on’.

Organisational relationship

In this theme some participants described how the team and organisational response had impacted them. They were shocked because they believed the relationship

and attachment they had with the organisation changed because they had been assaulted and all their hard work and caring was not taken account of in how they were dealt with. The participants experienced the response as hurtful and made them feel unvalued by the organisation or their team to whom they had felt a sense of loyalty. This theme compounded the need to 'put on a front' as a defence against the emotional pain.

Mo found he was alone with a patient who seriously assaulted him and none of the nursing team came to his aid. He was concussed and had to find his own way out of the ward to safety. He was been let down by the nursing team and he described this as the worst thing that happened.

'That's the bottom line of it' he has had enough. *'It'* being the impact of the experience had on Mo and how *'they didn't do anything in helping me at all'.* The bottom line is they let him down, not once but four times. He is not interested in *'what they say but they didn't really help me'.*

Mo cannot trust the nurses with whom he was working. He has to trust his own view to keep himself safe in this work. There is a sense of helplessness about the situation Mo found himself in a feeling of powerless and vulnerability. Mo talks about the situation and has to take a stand and not go back. Mo feels total betrayal by the nursing team; he has worked since on other wards and found them caring and supportive but feels very sad that the nurses worked in this way. The behaviours of the nursing team experienced by Mo is like the team mirroring an institutional view of psychological pathologies being played out in a gang, a gang that he is not part of.

Ruth had worked at the charity for 15 years and her role and the work she did was a proud part of sense of self, her work identity. But following her serious assault she did not get the debrief support she wanted, for her and her team to express their feelings and to have some time together. She did keep asking and couple weeks later a debrief session was arranged. She says:

Ruth: '*But it did actually help, but really this should have been sooner rather than later, its only because I had supervision with my deputy ward manager and I expressed how angry I was about it, and she knew I came to see you know I came to see you. There was no debrief the incident happened and it wasn't talked about again. I think it's disgusting the years I have worked, 15 years [ ] But that (the debrief) helped a lot.*

AG: *So it's about valuing, isn't it?*

Ruth: '*Yes, I didn't feel valued at all. I just said that this felt like I was just a number, you know. I am a loyal staff member and worked here for all them years and you know I am a respected person',* (Ruth 35 – 57).

The end result for Ruth is she feels she was just a number, a sense of being depersonalised by them (the organisation) they should have known her pain and discomfort she found their response as upsetting as being assaulted.

Ben had worked in the organisation for the last 20 years. He is concerned about the organisational relationships since this serious assault has occurred. The extract relates to the notion that some staff believe feel they are above the rest others and he

contrasts this with the concept of working in a team. For Ben being part of a team and having that relationship is important for himself and his safety but also for the care of the patients. Since the serious assault he feels the organisational relationship is different and he feels uncomfortable with how some staff and managers are.

'You get this, it's not paranoia but you do get a, you get err a feeling of the atmosphere and everybody gets that and it's not an unusual thing. You get this feeling of the atmosphere around you un are your sortta gonna be backed up for one thing, you know [ ] because a lot of people of got this idea of 'I am' and you're working in an environment where it's dangerous for one thing, you know you're not 'I am' you're working with people or who you're suppose to caring for plus your working with staff who's a team and you get these people walking around thinking you know 'I can do what I want'[ ] I'm really sort old school and that and team work is a big thing, approach is a big thing and I've seen some (laugh) really poor excuses'. Ben (61-105).

Ben describes these staff as 'I am'. This phrase suggests a strong sense of self (and self-importance) and is contrasted later with 'you're not I am'. The notion of self-importance is suggested in the phase 'I can do what I want'. This data extract contrasts the behaviours of some members of the staff team who believe they can do what they want with the reality of what happened to him where he had no control. It also contrasts the lone maverick worker with teamwork which might offer some protection against the dangerous environment. Teamwork is also associated with caring and looking after the patients and staff in the team. Having a close working relationship within the nursing team and trusting the staff, manager and the organisation to be there if things go wrong

it is what underpins the team being able to work in this difficult and sometimes dangerous environment.

Recovery and moving on

In this theme the participants described how the recovery process enabled personal growth and enabled some of them in the process of moving on.

Helen is very clear on how her life is moving on since she has recovered from the serious incident:

'I was really shocked it was the first time I had really sort of experienced something like that. So that was difficult for me. You know I knew the nature of the environment I work in and I know it's very challenging, un aggressive and violent but to have that happen to yourself it's just a really big thing. So now it's happened I feel like it's made me a stronger person in dealing with things again'.(Helen: 99-118)

Helen describes that it was a real shock when this violence happen to her. But she has a sense that it is like an initiation ceremony and now that it had to happen to her she is no longer emotionally vulnerable. Out of the adversity of the assault she has found a way of dealing with its impact in a positive way.

Helen experienced other life changes such as ending of a long-term relationship which she felt was unsupportive.

Erm home life I think at first I didn't really go out as much, probably became a bit withdrawn and I think I sort I said I have problems with my relationship as well [ ] I kinda dealt with that and that erm ended. That was a bit of a relief for me because he wasn't very supportive anyway [ ] and I thought to myself, I don't need people in my life who aren't gonna support me, I need people in my life that are going to support me, who are gonna understand [ ] but they can be there or you know just at the end of a phone call or at the end of a text or something like that'. (Helen 383 -410)

Part of the moving on process for Helen was she decided not to take threats too personally, she saw them not so much as an attack on her but rather that the patient was unwell. She suggests that the assaults are not premeditated but are in response to internal psychological issues the patient is trying to deal with.

Helen 'Yeh. I try to not let things like that, if someone threatens me and tugs me I try not to take that too personally because'.

AG 'But they still threaten you at times?'

Helen 'Yeh they can be, they can be really threatening but I can't be taking it too personally because [ ] they have their own issues' (Helen 85-92).

This theme is about not taking it too personally it is evident in how she now sees life as having two different identities:

'*In that aspect yeh I have, I don't take it too personally and I think that I have distinguished that I need to keep work separate from my personal life. You know I go to work I do my job, I can be caring erm but at the same time I need to be level headed I suppose [ ]and if they're gonna say something horrible to me, their gonna say something horrible to me [ ] I need to just deal with it, think to myself there in here for a reason and they're gonna say things to try and try and upset me, they're gonna try and intimate me, they're gonna try and do all those things but they probably don't mean it half the time and it's probably not a personal thing and it might be just that I've said 'no' and they don't like that', (Helen 373-390).*

Helen has found a way of making sense of her experience of being seriously assaulted and now that she is recovering she has found a way to move on with her life.

Helen 'So in that sense yeh. Erm home life I think at first I didn't really go out as much, probably became a bit withdrawn and I think I sort I said I have problems with my relationship as well.'

Helen describes how she now keeps her work and home life separate which gives her some control over my life back. She has a focus again and has decided to return to studying again at University.

Helen 'Yeh I am back at uni so that's great. I am seeing someone else now so that is really good, I am seeing my friends regularly and going out socialising [ ]Back in nurse training' Helen (432-435).

Not all the participants felt they had recovered and were moving on. Ann felt that the organisation had let her down and that this was impacting her ability to recover and move forward with her life.

Ann: So I've got all that as well going on. It's just that I've had no help, no help.

AG: So you feel let down?

Ann: Yeh I do feel let down by the place and by St Andrews. Very very let down, yeh I do. Ann (214-218).

The participants describe positive aspects following their recovery. Rather than an epiphany moment often described in positive psychological growth participants instead described a gradual positive experience which helped them to move forward with their life. It has been suggested that an accepted recovery trajectory for most people who experience a traumatic incident is one month (Joseph 2009). That is, they are not fully recovered but rather this is a starting point where symptoms are not so intense and most of the participants described an experience of returning to old ways of being.

Discussion of the results

The study aimed to understand the phenomenology of the process of psychological recovery of HCA's who had experienced an assault by a patient in their

care. The findings from this study have given insight into the experiences of the participants' journey of psychological recovery and their desire for life to return to some sense of normality. The participants' recovery included their personal struggle to go back to work whilst having to manage their emotions and regulate their thoughts about their colleagues: this was captured in the overarching theme 'putting on a front'. Issues of being understood and having an acknowledgement of the severity of the assault by their manager and wider team are illustrated in the theme 'organisation relationship'. What was striking was how participants reported struggling with these issues, in private at home. This is encapsulated in the third theme 'recovery and moving-on' wherein recovery did not end when they returned to work, rather it was just another chapter in their recovery process of negotiating and self-reassuring that they could indeed cope as nurses in a secure ward environment. The study found evidence that psychological recovery was not a separate process as suggested by Bonanno (2008), but rather resilience and recovery were intertwined; recovery was not on a linear trajectory, but an iterative process of moving back and forth as the participants faced different challenges along the recovery journey (see table 1, page 63).

Putting on a front

The overarching major theme from this study was 'putting a front on'; this theme illustrated that the participants felt a need to be 'all right' when returning to work with colleagues and managers even if they were not. This finding has been described in a previous study as 'the get over and get on with it, was reported by staff as a normal staff coping strategy' (Howard & Hegarty 2003, p17). In this study all participants reported they wanted to return to work and to have some normality in their life.

This adaptive behaviour may aid recovery and rebuild resilience. It could be a necessary defence to protect their inner fears and help to suppress their true feelings which enabled them to return to a ward that at times would be difficult and threatening. Indeed, 'psychological defence' and 'cognitive avoidance have been described by Brewin and Andrews (2000, p617) as deliberate avoidance which can become automatic and operate outside of awareness. The desire to be back at work was expressed by all and for work life to be as it was before the serious assault. However, the experience of being assaulted and traumatised changed their perception of how they felt about being at work and when they did return they all found it difficult. Part of this difficulty may be due to their normal trauma reaction following the serious assault; it is well known that symptoms of trauma after a serious incident include feelings of fear, shock, disbelief, numbness and feeling being alone. This is illustrated by Lee and James (2012), 'our lives are unpredictable and that we are not in control of our world', (page 5). It may be difficult to feel safe or trust others as Lee and James (2012) suggest that the traumatised can lose trust in themselves and their own judgments. The participants in this study had an extra challenge in they had to return to the environment in which they were assaulted and had to carry on working there. The way in which colleagues and managers reacted to them was often experienced as hurtful or uncaring. Not taking account of their distress, colleagues and managers they experienced as putting pressure on them. The stigma associated with being off work and injured was something that the participants did not talk directly about but was evident in the emerging theme 'putting on a front'.

The theme 'putting on a front' was linked to the theme 'organisational relationship' in the way the injured were communicated with and supported had a direct impact on their psychological wellbeing. These two themes had the most impact on the

participant's ability to recover and linked to the third theme of 'recovery and moving on'. The themes had an impact with the participant's family and partner who often questioned why they would want to work in a place which at times could be dangerous and violent. Having to defend wanting to return to work on the ward and having feelings of being stigmatised by your nursing team seems to have had a real impact upon the participants.

Indeed, as Whitley and Campbell (2014) found in a study of patients with a mental problem 'participants hardly talked about actual stigmatizing interactive encounters,' (page 6). In this study stigma was not something that was discussed openly but it emerged from the IPA analysis as an issue which had a negative impact. This internalised perception was similar to the individuals in the Whitley and Campbell study who were shamed and felt marginalized by the other residents because they had mental health problems, and residents around them had worries and concerns that they may expose the whole community to stigmatization. In other words if the staff team acknowledged the difficulties experienced by the assaulted participants the whole ward would also have that stigma and seen as not being able to deal with the impact of violence towards the staff team and carry on caring for the patients.

There may be an added dimension of the nursing teams finding it hard to express how they are feeling and that a culture develops where feelings are suppressed following a serious violent assault as suggested by Howard and Hegarty (2003). The suppression of 'normal' emotional reactions to the violence by individual staff and teams could be responsible for the development of a culture on the wards of carrying on and not engaging with the emotional response to colleagues. This notion of lack of

compassion by nursing staff to has been highlighted in the Francis Report (2013) with one of the 290 recommendations stating: that 'a robust methodology for understanding the culture of the ward should be used, such as the use of a cultural barometer', (Francis, 2013) p 13. Whilst current staff surveys provide insight into responses to their environment the Culture of Care Barometer is intended to offer an additional dimension by capturing the norms of group behaviour in the provision of care. It has been suggested that a 'key role is played by the ward sister (ward manager)…..in establishing an "enriched" environment for staff in which they feel valued and supported'. Clear and strong leadership enables nursing teams to sustain and engage with patients who are challenging and aggressive and helps contain staff team fears. This is in contrast to what participants described where there is a fear that by acknowledging their colleagues traumatised distress they too might find it hard to stay working on the wards that at times can be aggressive and violent. By not engaging too closely with injured staff returning to work they are creating a psychological safety net for themselves and the rest of the team. However, where ward managers (sisters) do keep in regular contact with the member of staff and disperse any myths and fears the staff members return to work on the ward and report feeling valued. However, there appears to be a resistance in some areas to change to this way of managing the dynamics on the ward by the nursing teams for fear of seeing things as they really are. Indeed, the secure ward environment is often unsafe and dangerous and challenging for the staff and patients.

Since this study was conducted, a new strategy for addressing some of these issues has been addressed via new national guidance Positive and Proactive Care: reducing the need for restrictive interventions, (Department of Health 2014). The guidance focuses on workforce development for commissioners and employers seeking

to minimise the use of restrictive practices in social care and health. It is one of a suite of guidance that has been written to support the introduction of 'Positive and Safe' ways of working. The guidance is directed at the use of seclusion and rapid drug sedation of patients who are violent and difficult to manage. These situations are often when serious violent assaults on staff occur. The debrief focuses upon what they did and the decisions they made and allows time for the staff to have their say. This national strategy will be monitored by NHS England and the CQC and could reinforce the development of more staff support following serious violent assaults. It is a way the organisation could have a process where the nursing and clinical staff involved develop ways of talking about these difficult issues and dismiss the idea often suggested by the participants in this study that talking about the impact could in some way destabilise the management of the ward. The reality is that by avoiding a discussion of fears and concerns the nursing staff currently has to suppress their emotions and suppressed emotions can then build into resentments with colleagues which can be detrimental to the team dynamics and the care of the patients.

Howard et al (2009) found that there was an increased burnout significantly correlated with increased perceived exposure to physical violence and reduced staff support. This notion has been described as the suppression of emotional responses which staff often described as the most difficult aspect of dealing with the violence (Howard & Hegarty 2003). In this study the perceived exposure to violence was ever present. What is not known is the impact of having to supress these fears and anxieties. The importance of having a structure that provides places of support where the staff can discuss these anxieties is paramount. The organisation now has a clinical supervision data base to ensure regular attendance and to help well-being of all ward based staff.

Organisational relationship

Findings suggest the theme 'organisation relationship' hindered the process of psychological recovery. Loyalty and a sense of worth as a trusted and hardworking employee was fractured by how the participants felt they were treated post-incident by their managers and the organisation with which they had previously had a strong bond. Participants were shocked and felt let down by the way the managers communicated with them and did not contact them whilst they were on sickness absence. They described this as being a secondary blow and as devastating as the original trauma. Expressing feelings of hurt and frustration; moreover, they were not kept informed about current issues regarding the incident and there was no real plan for their return to work. The process the participants described promoted the feelings of self-doubt and shame discussed earlier (Budden, 2008). None of the participants had on going contact with their managers post incident which further compounded their anxieties and concerns about returning to work. This is in contrast to the suggestion by (Black 2008, page 11) 'Early, regular and sensitive contact with employees during sickness absences can be a key factor in enabling an early return'. Black suggests that work promotes wellbeing and employers should work with the employees to facilitate return to work. It would seem that the participants' managers missed an opportunity to support injured staff to encourage a positive return into the workplace and to help re-establish a sense of belonging within the organisation culture.

Trust and feeling valued are important for all employees and it has been documented in the literature that employees develop attachments to team, leader and organisations. 'Trust in the workplace, in both leaders and co-workers, is almost by

definition an outcome of attachment styles', (Harms 2011, page 289). The traumatised participants in this study questioned the trust they thought they had in their manager and the organisation. They described feelings of betrayal being responsible for their own recovery.

Since feedback from this study the organisation has included in training of managers re 'returning to work' that all employees should be contacted on a regular weekly basis to discuss any issues or concerns.

Recovery and moving on

This theme focused upon the participant's experience of psychological recovery post incident. The 'recovery and moving on' theme did not stand alone, but rather was influenced by the themes 'putting on a front and the 'organisation relationship' as participants recovered from the traumatic incident. In this study the findings provided evidence that supported Joseph's theory of the process of the three stages of transformation that is, from being traumatised to experiencing psychological growth. Over time participants' described how making personal changes, developing a different philosophical view of their life and changing their priorities with regard to partners, family and friends enabled them to 'recovery and move-on' as described in the stages of psychological growth proposed by Joseph (2011). The author suggests transformation is a core part of the process of recovery and it is via three common reconfigurations following a traumatic event and are: personal changes, such as finding inner strength; philosophical changes such as a new found sense of what is really important in life; and relationship changes for example valuing family and close friends and not having

relationships that are not with people who are not emotionally engaging. In this study personal changes were reported by the five participants as 'positive change for me' and all five reported 'thinking about my needs' before those of others. All described philosophical changes of what was important in life; a hierarchy were work was seen as less important than that of a partner, children or family and a requirement the they were emotionally engaged and supportive. Joseph's theory is further supported by Helgeson, Reynolds and Tomich (2006) in a review 77 articles and conclude that 'experiencing intrusive thoughts about a stressor may be a signal that people are working through the implications of the stressor for their lives, these implications could lead to growth' (p. 810).

By contrast, the theory of psychological recovery suggested by Bonanna (2008) as a distinct trajectory to resilience was not found in this study. Rather recovery and resilience were described by the participants as interwoven. To work on a secure mental health ward you have to have high level of resilience which in its self is not a protector from experiencing a traumatic reaction from a violent assault. However, it may be that having a higher level of resilience could be a factor in the recovery process.

Social cognitive theory of posttraumatic recovery suggested by Benight and Bandura (2004) state 'people who believe they can surmount their traumatisation and take a hand in mending their lives', (p114) and can manage the impact of the trauma'. They purpose perceived coping self-efficacy as a mediator in the posttraumatic recovery which provides principles on how individuals are motivated to enable change and growth. In developing a way forward the participants found individual ways of moving on and recovering a life for themselves. This did not mean that the participants had

moved on completely from the impact of the assault. Rather that they were able to accommodate this impact and found ways of coping and living with it. As Brewin and Andrews (2000) suggested psychological defence and cognitive avoidance may help in the recovery process. The psychological process of being traumatised did intensify emotional reactions at times which were often difficult to manage. But by focusing on the future and returning to work and developing new ways of being this gave them a framework to re-establish their identity at home and within their workplace and themselves.

The three themes identified factors and provided insight into the participant's recovery such as the need to actively mask their emotional responses and pretend to feel differently to their feelings. The theme 'putting on a front' an overarching theme in this study may be a necessary defence to aid their recovery. Feelings of betrayal and disappointment by the lack of emotional engagement by their team linked directly to the 'organisational relationship' theme. Regular contact by a manager, having a planned return to work and having team based debriefing after the incident would all aid psychological recovery. A number of internal factors appeared to facilitate the process of recovery which included validating their emotional responses and forging new relationships. Findings from this study helped inform understanding of the phenomenological process of psychological recovery of HCA's following an assault by a patient which was the main aim of the study. The findings showed the role of ward team, their manager and their partner and family and the way they responded were key factors to their recovery and ability to move on in this study. All the participants did return to work. Their psychological recovery supported the author's definition as they were able to live in the present without being overwhelmed by thoughts and feelings of

the past. Four returned to working on the wards in a secure environment and one moved to work off the wards into a role which had limited patient contact.

Limitations

The participants in this study were unqualified nursing staff the results may potentially differ for other clinical staff and qualified nurses. HCAs receive limited training and have the most exposure to patient contact. The study did not assess any previous trauma related history and this could have impacted their reaction to the violent assault and their subsequent recovery.

This study was small, and this is usual for IPA studies. Care needs to be taken regarding the results however as a small study whilst informative, may lack generalizability.

Implications

This study provides an insight into the complex process of the HCAs psychological recovery after a serious violent assault. Firstly to work on a secure ward may require at times the HCAs and nursing staff have to suppress 'normal' emotional reactions not only to threats of violence and other patients behaviours that may be repetitive and part on a long stand psychopathology of the patients mental illness. On-going support via clinical supervision and a person-centred approach from managers and the organisation when staff are seriously assaulted is paramount. Insights and evidence from this study will be integrated in to training, support and procedures at all levels within the organisation. For example, preparation for all new starters and staff

changing wards of the types of violent situations nursing staff may find themselves. Building teamwork, learning from how good teams manage difficult violent situations so it is important to capture the skills they employ and transfer these to all teams. The charity is reviewing the procedures and training of the restraint, seclusion and rapid tranquilisation of patients to focus more on early defusing of situations in an attempt to reduce violent incidents. Awareness of these findings can also help the on-going development of support services for HCAs and nursing staff. Better prepared nursing staff will promote better care for the patients in their care. The nature of the work the charity engages in means the patients have been through other institutions and the charity placement is often seen as a last hope. It is to be noted that this work is recognised nationally as providing excellent care and therapeutic inventions by the nursing staff working on the wards.

Recommendations for future research

Further research is recommended to help further understand the experiences of HCAs and nursing staff and their recovery following a serious assault by a patient in secure care. By exploring the experience and emotional feelings of the recovering HCAs and to further track their recovery. The gaining of more insight for the organisation and nursing teams and staff to adopt a more holistic approach that takes account of the injured staff views. With as many as twenty five per cent of mental health nurses in public sector hospitals being subject to a violent incident resulting in a serious injury (Eisenstark et al, 2007) there is a need to take the management of these injuries seriously and to develop better ways of responding when members of staff need support.

Future research is proposed to develop a model of psychological recovery that is more inclusive of the principles of psychological wellbeing. Much research has focused upon outcome measures of the absence of signs and symptoms of psychological trauma and PTSD. It may be helpful to consider a measure of the outcome of psychological recovery that takes account of the psychobiological, cognitive, emotional and psychological support that formulates a model where recovery is more fully understood, a wellbeing model of psychological recovery.

Summary

This study has contributed to the understanding of the process of psychological recovery of the HCAs and their phenomenological journey of recovery, and their individual struggles to return to work. 'Putting on a front' was the main super ordinate over-arching theme and linked to themes 'Organisational relationship' and 'Recovery and moving on'. This interaction of the participants' accounts provides evidence of how the HCAs recovered and has helped to inform an understanding of the importance of supporting staff back to work.

The results of this study will be fed back to the organisational sponsor at executive director level and used to inform further training, policies and support developments within the charity for nursing staff that are seriously assaulted whilst working on the wards with patients.

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Appendix E

University of Leicester Ethics Review Sign Off Document

University of Leicester

To: Annette Greenwood

Subject: Ethical Application Ref: hf49-52ad

(Please quote this ref on all correspondence)

30/01/2013 15:03:28

Psychology

Project Title: **The process of psychological recovery of staff after serious violent assault by patients**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

- http://www2.le.ac.uk/institution/committees/research-ethics/code-of_practice

- http://www.le.ac.uk/safety/

The following is a record of correspondence notes from your application hf49-52ad. Please ensure that any proviso notes have been adhered to:-

Jan 30 2013 2:55PM Dear Todor,

This ethics application was discussed at the October 2012 ethics meeting, and approved pending minor amendments. I've corresponded extensively with Annette about this application over the phone and through email , and the amendments have now been satisfactorily made. She cannot access the online system, so I agreed to create this online application for her based on the application materials she sent me over email so that official approval could be given. I cannot approve my own application, so I've had to send it on to you. (I tried to have Joy complete the application so that I could then approve it, but it didn't work out.)

All the best,
Heather

--- END OF NOTES ---

Appendix F

St Andrew's HEALTHCARE

For the attention of Heather Flowe
University of Leicester

HUMAN RESOURCES

E: callen1@standrew.co.uk

T:01804 6[illegible]
F:01804 6[illegible]

30 November 2012

Dear Heather

RE: Doctorate - Annette Greenwood

I write to confirm that I Clare Allen, Director of Human Resources at St Andrew's Healthcare, give Gate Keeper approval for Annette Greenwood Counselling Psychologist/Trauma Response Service Manager. Annette is employed at St Andrew's Healthcare to undertake the research as submitted to the University of Leicester Ethic committee entitled: *'The process of psychological recovery of staff after serious violent assault by patients'*, as part of her Psychology Doctorate.

I give permission for her to have access to the staff who are seriously assaulted by patients and to interview them with their consent as described in the Research Plan submitted to the University of Leicester's ethic committee.

Annette Greenwood is funded by St Andrew's Healthcare and I am her sponsor for the Psychology Doctorate at the University of Leicester.

If you need any further information please do not hesitate in contacting me

Yours sincerely

Clare Allen

Clare Allen
Director of Human Resources

Appendix G

CLASSIFICATION OF EVENTS

Level of severity table

St Andrew's HEALTHCARE

Examples are given to assist with grading and completing the event form. This is not an exhaustive list - any event not in this list must be graded comparatively. Information will be input into the event form database for St Andrew's use. The items in gold indicate safeguarding issues for patients:- safeguarding procedures may be required. If in doubt, please discuss with your ward manager /team manager

	Impact: / Nature or type of event:	LEVEL 1 - NO HARM **Potential to cause harm, damage or loss, with none resulting.** **Includes:** • **impact prevented** - e.g. attempted events, intervening actions prevented harm occurring • **impact not prevented** - e.g. event ran to completion but no harm caused	Level 2 - LOW **Minimal harm, damage or loss, i.e. may require first aid.** **Damage to an individual's or team's reputation; possible local media interest**	LEVEL 3 - MODERATE **Moderate harm i.e. requiring medical attention or precautionary visit to GP / general hospital (e.g. for stitches); non-emergency hospital admission that may be care planned.** **Moderate damage or loss.** **Damage to Service's reputation; possible local media interest**	LEVEL 4 - SEVERE **Severe or permanent injury or harm i.e. requires emergency medical treatment in A&E or hospitalisation which is unpredicted / not care planned. High level of damage or loss.** **Damage to Charity's reputation; local media**	LEVEL 5 - HIGHLY SERIOUS **Serious events resulting in life threatening harm or death, substantial service disruption, damage or loss.** **Damage to the Charity's reputation; national media coverage. Never events.**
AGRESSION & VIOLENCE	**Abuse/Aggression - Verbal** (Including sexist, homophobic, racist remarks or harassment, hate crimes)	Verbal abuse (e.g. SASBA level 2, MOAS level 2) which may be frequent or targeted - including inappropriate sexual remarks	Verbal abuse (e.g SASBA level 3, MOAS level 3) causing alarm, or distress	Verbal abuse with threat to damage or harm (e.g. MOAS level 3-4)	Verbal abuse with intent to harm or kill and individuals feel victimised (e.g. MOAS level 4)	Verbal abuse with capacity or credible threat to seriously harm or kill, indivdual(s) are in serious / immediate danger.
	Abuse/Aggression - Physical (e.g. shoving, pinching, slapping, punching, biting, objects thrown; includes hate crimes)	Attempted assault but no contact; minor physical aggression which may be frequent or targeted (e.g. MOAS level 2).	Assault causing minimal injury or harm (e.g. MOAS level 3)	Assault causing moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission (e.g. MOAS level 3-4)	Assault resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment (e.g. MOAS level 4)	Assault resulting in life threatening injury, harm or death. Homicide (including attempted).
	Abuse - Sexual (including harassment & hate crimes)	*See verbal*	Inappropriate sexual behaviour (e.g. SASBA level 3)	Uninvited physical contact (e.g. SASBA level 3-4)	Sexual assault, abuse or harassment (including allegations of), sexual contact (e.g. SASBA level 4)	Serious penetrative sexual assault or rape (including allegations of).
	Hostage Taking and Organised Disturbance • includes riots (if 12 persons or more), violent disorder, rooftop protests, barricades, concerted indiscipline, gaining entry	Planned/attempted but prevented	Does not involve violence and is easily defused by staff. Minimal impact on ward	Involves barricading, any violence is low level. Moderate impact on ward	Resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment. High level damage. Ward/area suspended or severely disrupted. Emergency Service intervention.	Resulting in life threatening injury, harm or death, significant damage. Service suspended or major disruption. Emergency Service intervention.
	Weapons • includes making and use • includes conventional, made and adapted	Weapon (or potential weapon) found outside of / before entering ward or secure area.	Unsecured tools and similar itemswith potential for use as weapons found in a secure area, e.g.maintenance or kitchen items	Deliberate fashioning of a weapon. Weapon found in secure area.	Use of a weapon. Injury, harm or damage resulting from use of a weapon.	Use of a weapon resulting in life threatening injury, harm or death, or substantial damage. Firearm found/involved
ENVIRONMENT	**Environmental Failure** • includes buildings • includes fixtures and fittings • includes exposure to hazardous substances	Minimal cost to charity or no harm caused	Low cost or loss to charity or resulting in minimal injury or harm	Moderate cost to charity or resulting in moderate injury or harm requiring medical attention, hospital investigations or assessments. Localised service disruption	High cost to charity, resulting in severe or permanent injury, harm or major disruption	Significant cost to charity, resulting in life threatening injury, harm or death, or significant service disruption
	Fire	Attempted fire setting, accidental fire prevented with no resulting harm or damage	Fire resulting in minimal injury or harm, or little damage	Fire resulting in moderate injury or harm requiring medical attention, hospital investigations or assessments, moderate damage	Fire resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment. Severe damage	Fire resulting in life threatening injury, harm or death, significant damage or service disruption
	Property Damage • includes accidental and intentional	Attempts to damage property but prevented or damage limited	Minor damage to items of Charity or personal property	Damage which requires maintenance but the area is made safe and can continue to be used	Damage which results in severe service disruption (e.g. to a room or area)	Damage which results in significant service disruption (e.g. to a ward)
HEALTH	**Infection Control** • includes needle stick injury, Outbreaks			Exposure to a source of infection causing illness requiring medical attention	Exposure to a source of infection causing illness, e.g. outbreak of a notifiable infection., isolation. Needle stick injury. Pressure ulcer of grade 3 or above	Death where primary cause may be related to healthcare associated infectious disease
	Medication • includes errors • includes loss/theft	Incorrect medication prescribed / dispensed, but not administered.	Error in prescribing, administration or omission of medication with few or minimal adverse effects	Error in prescribing, administration or omission of medication with effect on patient, requiring medical attention	Error in administration of medication requiring **emergency** offsite medical attention. Event involves a controlled drug.	Resulting in life threatening injury, harm or death
	Physical Health • includes injury sustained during restraint • includes accidents and falls	No injury or harm / minimal loss	Minimal injury or harm	Moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission	Severe or permanent injury, harm requiring **emergency** offsite medical treatment.	Resulting in life threatening injury, harm or death
	Self-harm and Suicide	Threats to self-harm or self harm with injury prevented (e.g. ligature tied but removed)	Self-harm with minimal injury or harm	Self harm with moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission	Self-harm with severe or permanent injury, harm requiring emergency **offsite** medical treatment.	Resulting in life threatening injury, harm or death
	Substance Use / Misuse • includes alcohol, legal and illegal drugs and substances • includes possession and supply	Suspected possession or supply of alcohol, drugs or substances, but no evidence. Items found outside of / before entering ward or secure area	Evidence of alcohol, **legal** drug or substance consumption, possession or supply on ward or within secure area.	Moderate harm arising from use of alcohol, **legal** drugs or substances.	Severe or permanent harm requiring emergency offsite medical treatment arising from use of alcohol, drugs or substances. Evidence of **illegal** drug use, possession or supply.	Use of alcohol, drugs or substances resulting in life threatening injury, harm or death
SECURITY	**Absent without leave** (AWOL) or **Missing** • includes escape from secure area, abscond from escorts	Attempt to leave/abscond/escape **(informal and detained** patients)	**Informal** patient missing but returns soon after	**Informal** patient missing but not deemed violent / suicidal /	High risk **informal** patient is missing. **Detained** patient is AWOL	High risk or high profile **detained** patient is AWOL. Escape from a medium secure unit
	Confidentiality Breach and Data Loss • includes unauthorised disclosure and business sensitive information	Minimal breach with harm limited, e.g. document found on photocopier, encrypted data stick located	Minimal breach with up to 20 people affected, or risk assessed as low, e.g. loss of records	Moderate breach with up to 100 people affected or risk assessed as high, e.g. loss of person identifiable data	Severe breach with more than 100 people affected, information of particular sensitivity or sensitive information as defined by Data	Highly serious breach with potential loss of privacy, adverse effects on individuals or a negative impact on the Charity; potential for ID theft
	Loss and Theft	Very low cost or loss to charity	Cost or loss to charity £2,000 - £10,000.	Cost or loss to charity £10,000 - £250,000. Reported loss of a patient's money, i.e. suspected theft (whilst in patient's control)	Cost or loss to charity £250,000 - £1m. Loss of a patient's money / suspected theft (whilst in SAH control)	Cost or loss to charity >£1m.
	Security Compromise or Breach • includes items found on search • includes loss of keys	Contraband (including illegal) item(s) found outside of / before entering ward or secure area. Perimeter breach not resulting in escape, e.g. security door or perimeter gate open, keys found	Low risk contraband item(s) **(legal only)** found on ward or secure area.	High risk contraband item(s) **(legal only)** found on ward or secure area; Damage to secure perimeter; Key loss or compromise, loss of electronic ID	**Illegal** item found; secure keys lost or compromised	Serious breach of secure perimeter, e.g. keys compromised resulting in changes to locks in a secure area
	Other	Enter level of classification according to severity				

Appendix H

Doctorate research study:
'*The process of recovery of staff after a serious assault by patient(s)*'

INVITATION

You are invited to participant in the above research study. The first session will be recorded and you will be asked to sign a consent form.

You will then be invited to attend a follow up interview in three months' time to discuss your recovery from a serious assault.

The interview will be arranged for you and will again be recorded.

The recorded interview will be transcribed with all identifying data removed ensuring complete anonymity.

All data will be stored in a locked metal filing cabinet and all recordings will be destroyed upon completion of transcription.

You will be contacted via letter giving two weeks' notice prior to the date your interview will be scheduled for.

You can withdraw from the study without having to give a reason up to 1 month after the first interview date.

The completed thesis will be submitted as part of a Doctorate of Psychology at the University of Leicester.

Interviews - all identifying information removed.

You will be asked to sign a consent form.

Thank you for taking the time to read this information.

Contact details:

Annette Greenwood
Trauma Service Manager
01604 616149
agreenwood@standrew.co.uk

Dissertation supervisor:

Dr Stephen Melluish
Clinical psychology Department
University of Leicester
Regents Road
Leicester
sjm36@le.ac.uk

Appendix I

St Andrew's HEALTHCARE

Clarification of Informed Consent

- I fully understand that the interview is to be recorded and transcribed for analysis.
- I have been advised that all identifying personal information will be removed and the recording will be destroyed upon completion of the research study ensuring complete anonymity.
- I fully understand findings from the analysis will be referred to in a written thesis for a Doctorate in Psychology at the University of Leicester.
- I have been advised the thesis may be published within an academic journal to promote learning and understanding of how staff recover from serious assaults at work.
- I fully understand findings will also be used to review and develop services for staff within St Andrews Healthcare.
- I fully understand that I can withdraw from the study without having to give a reason up to 1 month after the interview date.

I confirm that all of the above has been explained to me clearly by Annette Greenwood and that I fully understand the process of the research study into the process of recovery of staff after a serious assault by patient(s).

I hereby consent to participate in this interview and to a second interview three months later regarding a serious assault.

Print Name: _____

Signature: _____

Date: _____

Contact details:

Annette Greenwood
Trauma Service Manager
01604 616149
agreenwood@standrew.co.uk

Dissertation supervisor:

Dr Stephen Melluish
Clinical psychology Department
University of Leicester
Regents Road
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07791777336
sjm36@le.ac.uk

Appendix J

Research Study

Interview questions and prompts:

- How has your recovery been and how are you since I last saw you?
- Could you describe anything that was helpful for your recovery?
- Was there anything that was not helpful after the incident that made things more difficult for you?
- Is there anything that would have been helpful to aid your recovery?
- How long did you have off before returning to work?
- Did you return to the area where the incident took place and what was it like going back?
- Have you been working with the patient that assaulted you and how has that been?
- Overall, has anything in your life changed at home or at work since the incident?
- How would you describe you wellbeing now?
- Is there anything else you would like to add?

Research questions were developed within my supervision session. Questions were then discuss with experience peer clinical psychologist at work and refined with the research aims.

Appendix K Initial Analysis – IPA Recurrent Themes

Initial Analysis – Experience and expression of recovery process for assaulted staff						
Sub themes	**Helen**	**Mo**	**Ben**	**Ann**	**Ruth**	**% theme presenting**
Super ordinate Theme Emotional understanding						
Trauma mediated by whether understood	**	*	**	*	**	100%
Want to be how I was before	*	x More about teams behaviour	*	*	*	80%
Experience of not being understood	*	****	****	****	****	100%
Being let down	*	*	x more about how I am treated	*	*	80%
Loyal but not valued	*	*	*	*	*	100%
Lack of recognition of injury	*	*	x	*	*	80%
Absence of managers support	*	x	*	*	*	80%
Emotionally missed by my team	*	*	x	*	*	80%
Change of focus in my life	**	*	*	**	*	100%
Thinking about my needs first	*	*	*	*	*	100%
Positive change for me	*	*	*	x	*	80%
It is just a job	x	x	*	x	x	20%

Key
X subthemes does not occur
*Theme occurs in this participants account
**Increase in asterisks indicates that theme occurs strongly in this participants account

Appendix L

IPA Coding

Emergent Themes - Ben	Original data	Exploratory comments
	14-27 *Ben:* Erm because it felt as though I was being victimised or vict, well I am a victim as such and please I not. AG: You were a victim when the patient hit you. *Ben:* Yeh. AG: So. *Ben:* That's right yeh, and it felt as though I had to justify the reason why I was off even though it was through an injury but nobody could prove it. So it was a very grey area. AG: Right. *Ben:* Un it was a slap in the face basically and that was the icing on the cake, you know that really really sort of niggled me. Erm.	*Descriptive comment* Although Ben is a victim of an assault he does not want to use the term to describe himself. Even though he is the victim the manager is not recognising him as such because he had to justify why he had time off work sick. *Linguistic comment* Repetition of the word victim suggests his discomfort with the term. The contradiction between the two metaphors 'slap in the face', and 'icing on the cake', is a reversal of common meaning. In this case, 'icing on the cake', is used instead of a phase such as 'the last straw'. Icing on the cake means something that makes a good situation even better yet he means the opposite. 'Slap in the face', may suggest that after 20 years of working in the organisation, he is not believed when he has an injury. *Conceptual comment* This suggests that a difficulty in conceptualising oneself as a victim could mean that he does not do this readily. The response to him taking time off was not empathic; rather it was treated as needing 'proof' and is a grey area.

	49-52 *Ben:* And there's a lot of ripples and some of emm all had different inputs of information of what goes on, n so you're thinking, erm it's very sort of like treading on egg shells.	*Descriptive comments* The ripples refer to the amount of talk about the incident/violence. Some emm relates to other staff including managers and RIDDOR assessors who had different points of views about violent incidents in general. Because of people's different views (about what happened?) he feels like he can't get it right. *Linguistic comments* 'there's lots of ripples', my understanding is that he is likening himself to a pebble thrown into a pond causing ripples. My feeling is that rather than ripples going outwards they are instead coming in towards him. Is he the stone that is thrown into the pond to cause the ripples or the incident that occurred? And then the ripples seem to become people with differing views. 'treading on egg shell' The metaphor highlights the discrepancy between the violence that has been done to him and the expectations about how <u>he</u> must behave now which is to be non-confrontational. *Conceptual comments* There is a distancing going on where people respond not to the specific incident. It is almost as if they might be managerlist in their responses to him.

	84-91 *Ben:* Because a lot of people of got this idea of 'I am' and you're working in an environment where it's dangerous for one thing, you know you're not 'I am' you're working with people or who you're suppose to caring for plus your working with staff who's a team and you get these people walking around thinking you know 'I can do what I want'. 102-105 *Ben:* I'm really sort old school and that and team work is a big thing, approach is a big thing and I've seen some (laugh) really poor excuses.	*Descriptive comments* The extract relates to the notion that some staff have that they are above the rest as a worker and he contrasts this with the concept of working in a team. *Linguistic comments* 'I am'. This phrase suggests a strong sense of self (and self-importance) and is contrasted later with 'you're not I am'. The notion of self-importance is suggested in the phase 'I can do what I want'. *Conceptual comments* This data extract contrasts the behaviours of some members of the staff team who believe they can do what they want with the reality of what happened to him where he had no control. It also contrasts the lone maverick worker with teamwork which might offer some protection against the dangerous environment. Teamwork is also associated with caring and looking after the patients and staff in the team.

IPA Coding

Emergent Themes - Ruth	Original data	Exploratory comments
	35-57 Ruth: Yeh, yes I was. It was really good for the whole team. Cos people knew, as like I was saying people kept saying "are you fine" and you just keep saying "I'm fine" but deep down you're not fine are you? AG: No. Ruth: But it did actually help, but really is should have been sooner rather than later, its only because I had supervision with my deputy ward manager and I expressed how angry I was about it, and she knew I came to see you know I came to see you. There was no debrief the incident happened and it wasn't talked about again. I think it's disgusting the years I have worked at St Andrews, 15 years. AG: Yeh. Ruth: But that helped a lot. AG: So it's about valuing, isn't it? Ruth: Yes, I didn't feel valued at all. I just said that this felt like I was just a number, you know. I am a loyal staff member and worked here for all them years and you know I am a respected person.	*Descriptive comment* Ruth finds the belated debrief useful, a way of being heard. She feels pressured by people (manager and team) to be 'fine'. But she does not feel fine. She thinks 'it is disgusting – it's wasn't talked about', and she does not feel valued. *Linguistic comment* Ruth expresses a contradiction in saying 'I'm fine', but 'deep down you're not fine'. Does she find it hard to say how she really feels and what is stopping her? The use of the term 'deep down' suggests it is a core of self that she is not fine. This may be linked to her not feeling valued ….I was just a number. A sense that she is depersonalised by them. After 15yrs service to the organisation her pain and distress are not being valued, they should know I am not fine. *Conceptual comment* Ruth wants 'them' to know her pain and discomfort. They should not have to ask and if they do ask they should know. This is as upsetting as being assaulted.

	125-166 Ruth: The incident happened on the Sunday, I was officially off on Monday and Tuesday as my days off, I was on training on the Wednesday and they actually rang me up at the Braye centre saying "are you coming back to work to finish your end of your shift because you're only on a course 9-5". So I got quite upset about that, then I came back to work on the Thursday and they just asked if I was fine and the service user that attacked me was still on the ward. AG: Humm. Ruth: In a different area, like an extra care area. AG: Yeh. Ruth: And they said "oh don't worry we won't put you round there with her" but it wasn't when I had my debrief, it wasn't about seeing the service user it was about being back on that ward environment and how I felt at the time. AG: Yes. Ruth: You know as I was, I did feel traumatised, I was awful, I felt awful, I felt like quite anxious, nervous when I came back to work and all they kept saying "aww your fine" it's like being thrown in the lion's den and their going 'ha you just been thrown' in that's just happened that fine.	*Descriptive comments* Ruth is unhappy about the way she has been treated on returning to the ward. Lack of consideration and understanding between what she needs and what the manager and team think she might need. It is not seeing the patient but more to do with patients in the environment that is the issue and just being thrown back in. *Linguistic comments* Ruth repeats 'I was awful' and 'I felt awful'. In contrast 'they' her team say 'aww your fine'. She then describes 'it's like being thrown in the lion's den'. But Ruth is not fine, in fact she is bitten on her return by another patient. When she repeats 'it's a nightmare…an absolute nightmare', there is a reality to this statement and the ward feeling like a lion's den. *Conceptual comments* Does this mean the nightmare has come true? She went into the lion's den and has got bitten.

	AG: Is that what the wards like a bit sometimes a lion's den? Ruth: Yeh it's a nightmare at the moment an absolute nightmare and I have actually asked for a transfer to another ward and hopefully in the next couple of weeks I will be moving. AG: Right. Ruth: Erm cos I have actually been bitten erm a few days ago at work. AG: Right so. Ruth: Again. AG: Another assault? Ruth: Yeh, not just me, other members of staff as well. It's very, very unsettled at the moment. AG: And that's quite hard isn't it? Ruth: Yeh very unsettled. I am anxious about going back to work tomorrow.	
	248-256 Ruth: Yeh yeh my confidence has defiantly recovered, yeh its fine, yeh. You just get on with it you know AG: Yeh. Ruth: I think that's what people see me as and they were quite shocked when they knew I was coming to see you think 'oh god I thought you were alright' and stuff like that, but I might look alright from the outside but inside you don't feel alright do you, it's just.	*Descriptive comment* *Linguistic comments*

IPA Coding

Emergent Theme - Ann	Original data	Exploratory comments
	290-305 Ann: They said he isn't so I went in and "Ja" who was I was with said come on you gotta to beat this, just get in there and whatever so I went in there with em and there he was, he was at the door. And they opened the bloody door, they knew what's happened, they opened the door and he went "Ann, Ann are you ok erm you know I miss you and all this lot." I was like this lump in my throat; it was awful I was a right mess when I got back. AG: When you say 'like this' what do you mean, like shaking? Ann: Yeh shaky, yeh sorry. AG: It's alright. Ann: Yeh, a massive lump in my, I couldn't swallow, nothing cos it had really stressed me out.	*Descriptive comment* Ann did not feel supported by her manager when is had to visit the ward. She has found the incident very difficult and she has moved jobs because of the impact of the incident. *Linguistic comment* Ann talks's about her manager but he say's 'you gotta beat this, just get in there (where the patient is)'. But Ann then repeats 'I was like a massive lump in my throat', and again says 'Yeh, a massive lump in my, I couldn't swallow, nothing cos it had really stressed me out'. The repetition of lump in my throat as if Ann could not take any more. *Conceptual comment* Ann realises that she can never go back to the ward because of the fear. She is fearful of the patients and does not trust the advice of her manager.

IPA Coding

Emergent Themes - Mo	Original data	Exploratory comments
	134-154 Mo: So I haven't seen I haven't seen him in anywhere in long time. He won't bother me even if I see him because he is just a patient. You know I got to to move on. AG Yeh. Mo: You know. AG So it's not the patient it's where you were working that was the issue for you? Mo: I think ee the patient because they are mentally unwell we have to consider that is, as that's why they're here. AG Umm, umm.. Mo: In hospital but I think what I was worried, what I was struggling with the staff they didn't give me support at time. AG Umm. Mo: So I really had a hard time to pick myself up and, and recovery and what. AG Yeh. Mo: Cos I didn't get any support for this time from the ward that was the main concern.	*Descriptive comment* Mo says he has not seen the patient (who attacked him). But even if he did see him, he would not be distressed because he is a patient. He would see being bothered by him as not moving on. It is almost as if he is saying that one expects a patient to be violent. *Linguistic comment* 'but I think what I was worried, what I was struggling with'. Repeats his sentence and struggling replaces worrying, it become more severe. Emphasises his difficulty in the word really. Pick myself up – in contrast to his expectation of support from staff – which would mean they would help him back on his feet. The repetition of the word 'and' perhaps signals his lack of familiarity with the word recovery or conveys his sense that he hasn't recovered. *Conceptual comment* Mo feels let down and wants them to question their nursing practice…he is a student nurse and he cannot understand why they behave like this towards him.

	183-196 Mo: They didn't do anything in help me at all. They didn't put it on the letter; they are not really specifying that they did help me. AG: Umm. Mo: They can say that what they had say but they didn't really help me at all. AG No. Mo: That's the bottom line of it. The manager had to go back to them and then when I was with J the manager send an email that day apology for certain things that they should have done. AG Yes. Mo: Which they didn't do it, but they didn't specify more what was it. AG: Umm. Mo: Umm. AG: Ok. Mo: That was it yeh.	*Descriptive comments* Mo has been let down by the nursing team and that is the worst thing that happen, being let down by your nursing team. *Linguistic comments* 'That's the bottom line of it' he has had enough. 'It' being the impact on Mo and how 'they didn't do anything in help me at all'. The bottom line is they let him down, not once but four times. he is not interested in 'what they say but they didn't really help me'. *Conceptual comments* Mo cannot trust these nurses. He has to trust his own view to keep himself safe in this work. There is a sense of helplessness about the situation Mo found himself in. Mo talks about the situation and has to take a stand and not go back. He has lost his trust in that team of staff.

	201-215 AG: Ok. So overall do you think that your life has changed at home or at work? Mo: In what ways. AG: In any way since this happened? Mo: Well erm once your injured you got to find a way to to come out. My reflection is that I felt that it is not that good for me to go back that's why I, I have to go. AG: So you made that choice for yourself. Mo: Yes.so I said I don't think, I cannot justify what why other nurses did that, why they done that more than four times and I've been injured there's so to me it affected me. AG: Umm. Mo: So much.	*Descriptive comment* Mo cannot stay working on that ward. He has reflected and decided to go, move away. He is going to put himself first. *Linguistic comment* '…once your injured you got to find a way out', in the same way he did on that night whist concussed. And he says 'I cannot justify what why other nurses did that, why they done that more than four times and I've been injured….it affected me'. No more being put in a position to be injured. *Conceptual comment* Mo talks about his experience in terms of the help he did not receive. He is going to look after himself because he cannot trust that staff team to do it. He is very sad that nurses work in this way, it is not like this in his training or on other wards.

	238-252 Mo: Yes, I think I lost my brother in South Africa. AG: I am very sorry to hear that. Mo: Yes so he was really brutally beaten and I lost my aunt as well. AG: Umm, right, what happened to your aunt? Mo: Well my aunt was here in Northampton but she really been having like have a chronic illness and like you know these physical conditions, like I say to her she was (cardiac) arrested. But think when my brother died it really affected me because I was in the stage of writing my exams and you know things were just up and up and up. AG: Umm. Mo: Up and up on to the fence.	*Descriptive comment* Mo has had two bereavements in his family since the incident. His brother has been beaten to death in South Africa. Mo has had his life threaten at work and been badly beaten. He is sad at the loss of his brother who has died from a beating. *Linguistic comment* 'things were just up and up and up'…. 'Up and up on the fence', everything bad is coming together at once and the 'problems are going up and up'. Usually when sitting on the fence you do not want to make a decision but it is not clear he means sitting on the fence might mean a place of safety or a place of imprisonment. Does he mean on top of the fence and looking down or on the fence trying to get away? *Conceptual comment* Mo is dealing not just with his own issue of being unsupported but also two significant bereavements – a sudden death and a brutal murder.

IPA Coding

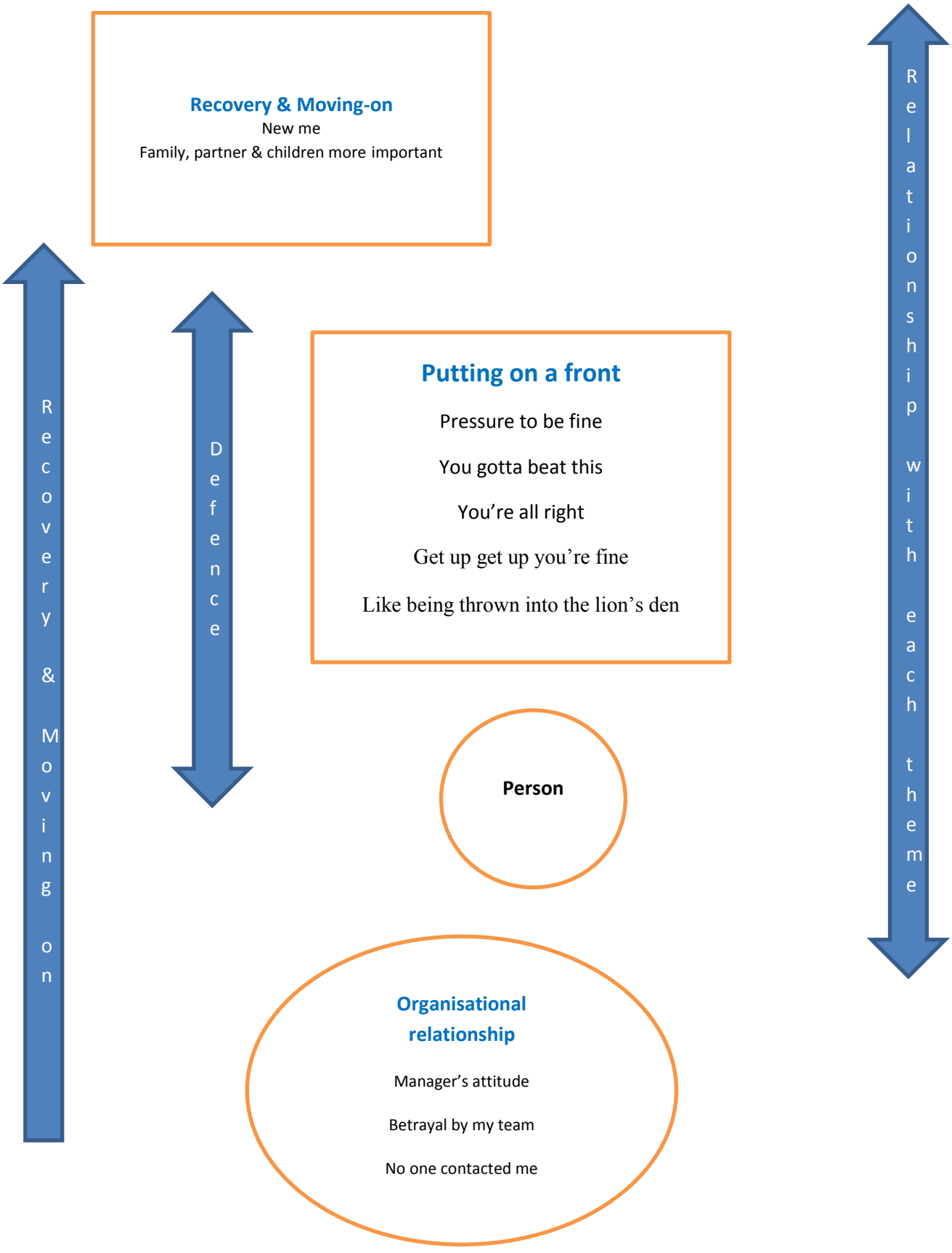
Emergent Themes - Helen	Original data	Exploratory comments
	99-118 AG: Or maybe you was just so shocked. Helen: I was really shocked it was the first time I had really sort of experienced something like that. So that was difficult for me. You know I knew the nature of the environment I work in and I know it's very challenging, un aggressive and violent but to have that happen to yourself it's just a really big thing. So now it's happened I feel like it's made me a stronger person in dealing with things again.	*Descriptive comment* Although Helen was aware of the challenges in the work she does, it was still a 'shock' when the serious violence happen to her. *Linguistic comment* Helen talks about the violence as 'that' twice – this may be a distancing mechanism 'sort of' in some way. Repetition of really to invoke the sense this had happen to her. The contrast between what she knows and what she experiences. *Conceptual comment* Initiation – ceremony – she has now had it happen to her and she is no longer emotionally vulnerable. This could be a benefit finding and part of her psychological growth – 'it's made me stronger person'.

	235-259 Helen: It was four days off, but it happened on the Monday and I didn't go back till the following Wednesday so it was just over a week away from the ward really. AG: It's nothing is it? Helen: No, but the Doctor did say to me 'you need to go back to me as soon as possible otherwise you not going to want to go back at all' so. AG: Do you think that true? Helen: Yeh, think if I didn't go back I would have been more anxious. The longer away, you know from the ward you're constantly thinking oh now I need to go back, I've been away for so long. I am glad I went back when I did. AG: So your anxiety had gone up. Helen: Yeh. AG: Yeh. Helen: Yeh. I mean it was difficult anyway and I did feel anxious. Erm sort because of the gal being there and also because I was quite physically affected. I thought what if something happens again now! Like no necessarily me being involved in restraint but what's to say one of em could come up and punch me and make things worse.	*Descriptive comments* The doctor said you need to go back to work as soon as possible because delaying the return could compound how she feels and if she does not go back straight away she will not ever want to back. She took the doctor's advice and returned to work in just over a week. *Linguistic comments* She says she was glad she went back to work when she did. The use of the words longer and long emphasise that she feels that a week is a long time to be away from work. It does not seem to matter whether she is off sick or at work; she uses the word anxious to describe her emotional state. Repetition of the word anxious. *Conceptual comments* On returning to work, the person who attacked her is still in her environment. She talks about the potential of further violence. She conveys a sense of threat or danger.

	262-268 Helen: So that was quite difficult having those sort of thought in my head, but I am glad I did go back then. Cos then it was then it helped me deal with it a lot quicker. AG Humm. Helen: Rather than waiting three or four weeks and then going back and having all that time off thinking and thinking about things.	*Descriptive comments* Wanting to deal with the impact of the serious assault 'quicker'. Not wanting to deal with that impact. *Linguistic comments* Here Helen talks about 'all that time thinking and thinking about things (what has happen and how she feels)'. It is too painful to dwell on what happen, better not to think. *Conceptual comments* Is there a fear within thinking that might make the serious assault real? If she allows herself to process these thought how will she be? Will she lose her nerve, her ability to word in this dangerous place?
	313-329 AG: So they were supportive in some ways? Helen: Yer I think they were supportive but they were also quite firm I'd say sort of. Not trying to like, I don't know what word to use, erm I suppose like when a kid falls over and grazes their knees it's like 'get up get up you're fine' that sort of thing. AG: Cajole you? Helen: Yeh trying to make it a bigger of a deal than than it is. AG: Umm. Helen: And trying to sort of make me, make me feel better about it but not trying to upset me too much by going 'oh yeh you know' that sort of thing. AG: Umm. Helen: If that makes sense.	*Descriptive comments* Helen is not sure, she thinks 'they' (staff) are supportive. But she is not sure because she is treated like a child. They are supportive but quite firm. Move on and do not focus on what has happen (the assault). *Ling*uis*tic comment* Helen struggles to find the words to respond to whether the team were supportive. In fact she likens her experience to a parent talking to a child when they have fallen over. She says get up get up you're fine'. But she has not just grazed her knee. The petition of get up suggests an authoritarian parent who dismisses what has happened. But she does not say this directly. *Conceptual comment* The staff response is that she should pick herself up and dust herself down and get on with things as normal which

	AG: Yeh. Helen: Does that make sense? AG: Yeh, Yeh that makes sense. Helen: (Laughs)	emotionally missed her.

Appendix M
Interaction of sub themes in Putting up a front



Part 3

Reflective Critique

Reflective critique of the work

Identifying the focus of the research project

The research project developed from a need to have a better understanding of the recovery process experienced by staff who access the Trauma Response Service (TRS) in order to inform its future development. The current service builds on my experience of providing psychological trauma response services for healthcare workers over 25 years. Some of this experience was gained in the NHS working on high profile and traumatic experiences at work. However, in those cases, for example a member of staff murdered a patient or a clinical intervention was performed on the wrong patient it was unlikely to occur again in the same department. For the last 6 years in my current role I have been developing a service for a charity that provides secure mental health for patients who have a history of violent and aggressive behaviours. Thus new learning was needed to understand the impact of trauma on staff where the recurrence of a similar incident to themselves or a close colleague is highly probable. The main challenge has been that staff who have been seriously assaulted, will following a short period of recovery, have to return to the place where the traumatic incident occurred. The return may prompt a physiological response or trigger psychological anxieties and thus the service should take account of these factors.

Using an approach derived from Gibbs' (1968) model of critical reflection, the research project allowed me to explore new ideas for developing the service. Part of the research plan included discussing these issues with the nursing staff accessing the TRS and those responsible for managing patient services. The model proposed by Gibbs outlines four stages of the reflective process: description, feelings, evaluation and

conclusions which inform the fifth stage of action. The project provided the focus to discuss psychological recovery with colleagues who are known experts and to facilitate this I became a member of the executive committee of the British Psychological Society (BPS) section for Crisis, Disaster and Trauma I discussed some of these issues with members of the committee. Although I had previously been a committee member of a national related organisation the process of being engaged in doctorate study enable one to see how the work I did and the research project focussed how it fits in the broader national provision of trauma services at work. My intention is to present my work at the BPS Annual conference in Nottingham next year. I felt that in order to understand the recovery process my research project would need to focus upon the lived experience of trauma to aid the development of a service that best reflected their needs. Formulating the research plan has been the most interesting part of the doctorate.

Choosing a methodology

I am aware that before undertaking this research I had developed my own ideas derived from practice about how nursing staff might experience their psychological recovery. After discussions with other experienced researchers, clinicians and my supervisor we decided that qualitative methodology, Interpretative Phenomenology Analysis (IPA) would be my approach because of its sensitivity to the experience of the participants. I felt it was important to hear what injured nursing staff had to say regarding their experience of recovery.

The value of IPA was that it offered the opportunity to analyse the particular instances of participant experiences and gain further insight into the process of their

psychological recovery following a serious assault by a patient. I had feelings of excitement and anxiety because I wanted to ensure that I could do justice to each of the participant's unique experiences. To help locate myself in the methodology was to understand how different theorists approached IPA namely Smith et al (2009) and Clarke and Braun (2012) which helped establish an understanding and by using an internet resource site http://www.ipa.bbk.ac.uk/ which gave a good background and point of reference throughout the research project.

I found these resources very accessible and helpful for checking the progress of the analysis. They advise a strategy of immersive reading. By adopting this approach of reading and reflecting on participants narratives I was able to pay closer attention to their meanings. For example, one participant described the reaction from his manager '*as icing on the cake*'. By subverting the common meaning of this cliché, he was able to convey the contrast between his expectation of a positive response and the reality of the manager's dismissal of the serious assault he experienced. I went through the stages of the process many times finding reassurance that I was on the right track. Having time to reflect and walk away and rethink allow me to immerse myself within the process. Attending regular supervision sessions I was able to openly discuss concerns and issues as they arose and discuss possible ways forward were an important part of my learning. My supervisor suggested taking time to analyse the data and I was given one week of study leave by my organisational sponsor so that I could immerse myself in the transcripts and emerging themes.

This was the best and most exciting part of the research process. Themes emerged for the transcripts and I was surprised and delighted with the findings. I have

found that since completing the research project I am now listening differently to service users and often reflect on what they have said in a different way. My clinical training taught me to listen and formulate and now I spend more time thinking about what has been said so that my responses are more finely attuned to their individual needs, experiences and context. This has informed my clinical practice and service development.

The distinctiveness of IPA as a methodological approach

The rationale for the choice of IPA methodology was driven by the need for a deeper understanding of individual and shared experiences of nursing staff recovery after a serious violent assault by a patient within a secure hospital setting.

IPA is concerned with understanding the lived experience and how the participant is able to make sense of their experiences. Its main concern is with meanings, the meaning of the experiences of the participants. This was important and why it was the approach I chose because IPA is phenomenological and explores an individual's personal perception or account of an event as opposed to attempting to produce an objective record of the event itself. I wanted to understand the experience of psychological recovery from the participant's experience. There is an acknowledgement in IPA that whilst getting close to the participant's personal world, the researcher's own experience and their preconceived ideas will be part of the participant's world through a process of interpretative activity.

I found IPA interesting because it 'involves a dual interpretation process, referred to as a 'double hermeneutic', (Braun & Clark 2013; p181).

Participants

The service provided access to participants who had experienced serious violent assault at work and were recruited from nursing staff who contacted the service following a serious assault by a patient. The participants who volunteered all wanted to pass on their experiences and hoped this would be of benefit to others who might have the same experience and to enable organisational understanding of the complex challenges they faced whilst working on the wards. The participants were concerned their absence from work had an impact on the other patients on the ward who may miss them. Many described having good working relationships which had taken time to develop trust. Not all the patients on the wards were violent and they often missed injured staff and the consistency of nursing care needed to support the group of patients.

The greatest challenge was not in recruiting participants but in the follow-up so that an assessment of their recovery could be made six months after the initial session. One participant was lost to the study because she was unable to return to the work environment.

Participants attended a single session which was recorded where they were able to describe their experience of being assaulted. Following this session they were contacted via letter to attend an interview 6 months later where their psychological recovery was the focus of the interviews. The interviews were recorded and transcribed

verbatim. This gave me a very different role listening to the nursing staff and remembering not to go into clinical mode and staying in the role of the researcher listening to their experience and using gentle prompts if needed.

Research setting

St Andrews Healthcare is a charity that has a national reputation of caring for some of the most vulnerable patients with complex mental health, neurological and learning disability who many have aggressive and violent challenging behaviours within a low and medium secure setting. The patients are mostly funded by the NHS England or Ministry of Justice and the charity has provided patient care for over 176 years. The charity is committed to developing wellbeing for both patient and staff wellbeing. The research setting was chosen because as before my appointment there was little recognition that violent assaults on staff were an issue. However, as the TRS has developed it became important to review and assess the needs of the nursing staff and the development of the service. As sponsor of this research project they have supported my studies from executive director level to the nursing staff who have provided support and encouragement.

Ethics and research governance

My sponsor gave written permission for the study to be conducted at my place of work and I applied for ethical approval from the University. The process of the University application helped me to focus on the research project and to consider all aspects of the research study. I had written a plan for the research project and I found

this a useful tool in enabling the attention to detail needed for the ethics submission. Consideration had to be given from the start to the consistency of documents, how much to probe and the line between researcher and clinician from the first time the participants contacted the service through their journey and how and where data would be kept safely. The whole process took longer than I had planned and incurred an electronic problem which with the support of the chair of the ethics committee was soon solved. The ethical application process allowed me time to reflect and ensure that every aspect of the study was considered and the participant's data and their experience were protected.

Interviewing

I work daily with traumatised staff but in the role of a researcher I was conscious not to prompt too much and allow each participant the space to disclose their experience. I think it is a sometimes difficult the role of both clinician and researcher and at times I felt unsure but on listening to the interview later reflected on the amount of different information I was presented with. The interviews were the starting point of the research project and I found them to be very different to the clinical interactions I normally have with traumatised nursing staff. It was an interesting journey which made me feel both anxious and excited at the same time.

Transcribing the data

Transcribing the interviews into an IPA format was an opportunity to hear for the first time the recordings of the participant interviews. This process took longer than

I had thought because of the need to check and double check what each person was saying. One participant had a strong African accent and it took a number of hours to transcribe. The process allowed me to be more in touch with the linguistic style of the participant as I endeavoured to transcribe verbatim. This part of the research project benefitted from forward planning. I began the process by clarifying what style the transcriptions should be presented in. This ensured the management of the transcription and provided the necessary line counting for the analysis part of the research. Again more hours were needed to rewrite and re do sections ready for the next stage of the IPA analysis. Time I learnt that could not be rushed; you cannot push the river but have to let it flow. I kept this notion in my mind throughout the process and for the rest of the doctorate. This was in stark contrast to my day job of leading a busy TRS.

Process of the IPA thematic analysis

This has been a really enjoyable part of the research project. I took the advice from my yearly review panel and booked a week's study leave so that I could focus and immerse myself in the transcripts and recordings. I also took time to explore the theory of IPA analysis to reinforce my understanding of the process. This took more time than I had imagined but it did was worth the hard work because I was more able to understand the six steps of analysis as suggested by (Smith et al 2009) and started to fully understand how the process unfolds. Supervision sessions were also important and from struggling at first to understand the IPA process I felt delighted when after a number of weeks work I had my emergent themes which then developed and moved from the participants experience and now included my own. Together with my supervisor we discussed the IPA analysis and suggested ideas and concepts, the more

thoroughly you review and return to the transcripts the more you find. The analysis was an on-going process which benefitted by revisiting many times.

What I have learnt about psychological recovery

I have been surprised at the wealth of information related to psychological recovery and the difficult journey the recovering nursing staff experienced. I was impressed how the IPA analysis draws out the individual experiences and themes and allowed for the emergent themes to be clustered as sub-ordinate themes. The results suggest that injured nursing staff were stable and on the way to recovery but underneath they feel a pressure from colleagues to be alright. Some of the pressure results in the staff feeling stigmatised and tainted. This was not spoken about openly but became apparent following the IPA analysis. The pressure they felt was real, if they are not feeling stable and have anxieties and concerns it could undermined the whole ward, because some of the other staff could be left wondering if this type of work is safe. On returning to work, the way colleagues and managers spoke to them had a massive impact on how they recovered and their ability to return to work. The notion of putting on a front was also linked to feelings of being stigmatised. By being injured and traumatised they were in some way different, like 'bad apples' marked and stood out because of their experience.

A secure mental health ward is sometimes a hostile environment and it is not possible to prevent all the violence and assaults that occur but it is possible to change and influence how the injured staff are spoken to and supported. The research also highlights that members of staff felt let down and betrayed when managers did not

contact them whilst on sick leave. They described themselves as loyal to the organisation that then let them down by scrutinising the amount of time they had off because of the incident. However, despite feelings of stigma and betrayal there was clear evidence of psychological recovery and the participants gave examples of how their lives had moved on and examples of psychological growth. I reflected that they are other factors such as job satisfaction and enjoying caring for patients was a factor in why the staff returned to the wards.

The literature review

This part of the portfolio was a real challenge for me. My last degree an MPhil (Sc) in the 1990's was completed before electronic searches via the internet were possible. I made a positive commitment to spend time learning how to use the search engines and attended sessions at the University library. I arranged some individual advice sessions and it took some time to fully understand the process of the literature review. I felt at times that the task was beyond my understanding. But with good supervision and persistence I started to see what the process involved and this enabled me to focus on the papers I needed and helped my understanding of my subject area.

The service evaluation

The service evaluation was an opportunity to gain an important insight into how the service was received by the service user's. It was a chance to explore the experience they had and to identify any areas for development and improvement. I wrote up the evaluation as the last part of my project and this help me to use a more systematic and

critical approach to the writing of this report. What has been interesting whilst working through the service data is how many nursing staff accessed the service in the last 6 years. Over 1,400 individual staff have been seen, most of whom are still working on the wards with the patients in addition to work on wards and leading debriefing sessions.

The survey questionnaire revealed the service users high levels of satisfaction when using the service. At the start of the analysis the first hurdle to negotiate was the SPSS database was in need of software update. With support from the University IT department I was able to solve this problem and with the support of a psychologist colleague I soon was able to use this database software. The analysis of the IES-R trauma scale was helpful in that it showed that staff did recover over time (6 months). It was important because it identified they had experienced high levels of a trauma reaction in the first days post incident. This finding will be used to inform training of senior nurses and leaders in the organisation to raise their awareness to their colleagues needs. This is the first evaluation and will now be repeated biyearly to evaluate the service and how best to support injured nursing staff. Another important finding from the evaluation identified a gap in the sickness absence reporting which in future will enable the hospital to record and monitor sickness absence from patient injury and trauma separately to all other categories such as illness and non-work related injuries and physical conditions. The organisation will be able to assess costs and identify patterns across the hospital to assess the real cost of the injuries and to develop ways of supporting and helping the injured staff. It is acknowledged that the impact of the commissioning organisation had an impact on the limitation of this evaluation.

The Trauma Response Service is unique and in 2013 this was recognised with a nomination for a national award for service quality and excellence (Nursing Times Awards 2013) and was short listed to the last five out of hundreds of entries for this award. The service is now seen by other organisation as an example of best practice in supporting traumatised staff in a secure setting. The acknowledgement at a national level has been well received by the nursing staff and management within the charity.

Concluding comments

I have enjoyed the opportunity to investigate the complex process of psychological recovery following a serious violent assault at work to nursing staff. Working on my doctorate has given me the skills needed to assess the complex issues that nursing staff negotiates when recovering and returning to work on the wards. At times the process of doing the doctorate has been challenging, but each challenge has brought about new learning and knowledge and a sense of achievement. I have learnt a number of new skills and methods which have developed my understanding and enabled me to look critically at my service and to further my insight of the service users I see. Having learnt these new skills I can in any future research and evaluation of my service ensure it is more systematic and I will be able to provide evidence and outcomes of the service I provide. My supervision sessions and reviews have been invaluable and besides developing my knowledge base, I have grown in my understanding of how to investigate and research in a systematic manner. I have been encouraged by other psychologists within the charity who have given me support and encouragement throughout the process.

Through the whole process I have been dealing clinically with individuals providing a service with calls and emails from the injured nurses on the wards, the work continues and more is to be done to further understand how best to make changes to provide a safer and more compensate place for the nurse to work.

The completion of this doctorate is of great importance to me at a personal level and has enabled me to take time to look and reflect at a deeper level the complex psychological experience of recovery from a serious assault. It also has relevance for the development the current service and implications for organisational development and the retention of nursing staff. It has enabled knowledge -sharing for the growing field of secure mental health in both in the UK and Europe and has been a truly valuable experience. Next year I have two papers excepted at National conferences to further share my findings and to encourage research and debate.

References

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Part 4

Service Evaluation

An evaluation of the Trauma Response Service based within a secure Mental Health hospital for nursing staff seriously assaulted at work

Executive summary:

This evaluation provided insight in to the level of satisfaction, effectiveness and responsiveness of the Trauma Response service (TRS). Participant data revealed the circumstances in which staff were most vulnerable to assault. The results showed that there was a high level of satisfaction in the service provided and the level of responsiveness when contacting the service. Confidentiality experienced by service users was high.

Service users were seen within five working days of the first contact to the service and this is within recommended timescale. The level of trauma impact as measured by the Impact of Events Scale Revised (IES-R) scale scored high on the first appointment while at six months the score was below the caseness score which suggests recovery from the trauma of being assaulted. Analysis of the data revealed that staff were more commonly (45%) assaulted in the first year (45%) of employment. Assaulted staff who were seen within five working days recovered over a six month period with (58.82%) experiencing no further problems suggesting the Trauma Response Service is effective at supporting staff.

Recommendations arising from the findings will be implemented into current practice for example: changes will be made to induction for all clinical staff. Preliminary training it is suggested will include preparation for working in a secure environment with a focus on managing relational security and through 'Learning through Work', an on-going course for all new unqualified nurses during the first six months of employment. Qualified nurses will have access to an experienced nurse mentor from their starting date and can attend the nurse group established to support new starters within the charity. The sickness absence policy will require senior managers to make regular contact with staff while absent due to an assault and guidelines are included in the leadership training for all senior manager regarding operational responses to traumatic incidents.

This evaluation study has provided valuable evidence for the further development of the TRS and core policies, procedures and training within the organisation. This work will continue with a bi yearly evaluation to further ensure and provide evidence for the continuing development of the service and to increase understanding of the experiences of seriously assaulted staff working on secure wards.

1.0 Introduction

1.1 Provision of secure in-patient mental health provision of care: the national situation

Secure mental health provides care for patients with complex mental health problems some of whom can display high levels of aggressive and violent behaviour. Such settings are shown to have beneficial outcomes for patients including lower re-conviction rates following hospital discharge (Coid et al 2007); however, some patients threaten or are violent towards nursing staff in secure settings. Indeed the Nursing in Secure Environments scoping study (UKCC, 1999) found that patients' mental problems and offending patterns place an intense demand on nurses. In addition, staff must maintain empathic relationships with them to support patients' recovery and wellbeing whilst also considering risk management including the prevention and management of violence and aggression to themselves and other patients in their care. This is conceptualised as a role complexity because nurses are required to work with patients who may invoke abjection or fear in them (Mason, 2002; Jacobs et al 2009).

Successive policy initiatives driven by the Emery Report, (1961), Butler Report (1975), Glancy Report (Home Office & Department of Health 1974), Reed Report (1992) and more recently the Bradley Report (2009) have led to the growth of in-patient beds within secure mental health hospitals which has now become a specialist field in its own right. It is estimated that there are currently more than 20,000 beds (on designated secure or locked wards) (Sugarman & Dickson, 2015). Unlike prison, from where the nursing role is solely to contain or manage behaviour, staff in secure settings

can be vulnerable to unpredictable and violent behaviour in the more open environment of the locked ward.

1.2 Impact of violence and aggression towards nursing staff

Violent and aggressive incidents are the third largest cause of injuries reported under the Reporting of Injuries, Disease and Dangerous Occurrences Regulation 2013 (HSE 2013) known as a (RIDDOR) within the health and social care sector. Indeed NHS Protect reported an 8.7% rise in reported incidents from 63,199 in 2012/13 to 68,683 in 2013/14 physical assaults against staff in England NHS Protect (2013/2014). Types of injuries include being punched and kicked, broken noses, arms and legs and the patients threaten to kill or harm staff and their families and children. Some patients may have a forensic history of physical harm and abuse. The knowledge of their social and violent histories can mean verbal threats are very intimidating for the staff. The psychological impact of being violently assaulted can result in staff being traumatised as well as physically injured. They may have signs and symptoms of a traumatic reaction such as fear, anxiety about returning to work, hyper-arousal, sleep problems and problems with concentration and become withdrawn.

Evidence of serious assaults on nursing staff has shown that 71% (43,699) of incidents occur in mental health services, which include community, acute and secure settings (NHS Protect, 2013). The environment of the medium and low secure ward means that members of staff have to go through security airlocks and leave all personal belongings including mobile phones and keys. Whilst on the 12 hour shift they cannot discuss personal details that patients could use against them or details of where they

live. The working environment can be intense and at times the staff will be on high alert employing their relational security to deescalate or respond to a violent attack.

1.3 Background on psychological support for nurses

Since the late 1990s there has been increasing recognition that work can be good for mental health Black (2008) and that supporting healthcare staff is important. Indeed, NHSE (1998) suggests that all NHS staff in England should have access to psychological support services. Building on these principles there has been a growth in services to support healthcare and staff nursing. At the same time initiatives were supported by the Royal College of Nursing (RCN) which commissioned guidance for NHS Trusts in England and Wales outlining how staff support services should be formulated (Greenwood, 2000). Within the NHS, the provision of psychological support for nurses has largely taken the form of staff counselling for work-related stress and personal problems such as depression and anxiety, relationship difficulties, bereavement or similar concerns. A number of studies have recommended that staff in secure services should be provided with effective support structures (Kirby and Pollock, 1995; Coffey and Colman, 2001; Mason, 2002).

1.4 Developing a psychological model of support

The Trauma Response Service (TRS) was developed in 2009 by the author who has twenty years' experience of developing psychological support services for traumatised staff within the NHS. A review of the levels of staff support currently available was undertaken and found that this did not include support for staff assaulted

and traumatised by patients. Following a scoping exercise the TRS was developed to provide a responsive and effective service which offered a support session within 4-5 working days of the traumatic event

It was important to develop a model of support which took account of the context of the hospital setting as described and which reflected the needs of the staff and organisation that was responsive and effective at providing support to the traumatised staff.

The development of the ASSIST model, which is not a treatment for Post-Traumatic Stress Disorder (PTSD), but is a psychological first aid intervention was in response for a service for traumatised nurses following serious assault or threat at work. It provides a responsive, accessible and structured support which promotes psychological well-being. It builds on an individual's natural ability to recover from a traumatic incident and employs 'watchful waiting' as suggested by NICE (2005); (Greenwood et al 2012; Greenwood, 2015). In this brief psychological model, individuals are seen for one or two sessions. The sessions are structured to provide information about the impact of trauma, strategies for coping with the signs and symptoms of trauma, strategies to help cope with the impact and signs and symptoms of trauma and it takes account of the individual's natural resilience and ability for psychological recovery. It also includes sign posting to further support if needed. Service users access the service by self or a manager's referral. At the first session the Impact Events Scale-Revised 22 item (IES-R) scale is given to assess the level of trauma experienced (see Appendix J). The session is structured to provide the individual with an understanding of the impact of psychological trauma and information

on the signs and symptoms of possible normal reactions to the trauma following a serious assault. A discussion on how to cope with the impact of traumatic emotions and sign posting on how to access further support via the 24 hour helpline is provided.

The service database records demographic details and a description of the incident. The assaults are recorded on a central Datix database for Serious Untoward Incident (SUI) and the Classification of Events matrix was used to score on a scale 3-5 within the Aggression and Violence section by ward staff reporting the SUI (see SUI Classification of Events matrix Appendix K).

1.5 Background of the types of incidents and injuries referred to the TRS

This hospital employs over 4,000 staff of which 80% work in clinical areas and has report high level of assaults (1471 per year reported in 2014 via the hospital central Datix data base) because of the complex needs of the patient group. In some areas these happen on a daily basis and many assaults on the staff are unreported for a number of reasons. This is evident in the difference between the number of reported incidents via the Datix database the recording of assaults within the RIO data base for patient case notes on a separate electronic system. All serious assaults on staff were where they attended Accident and Emergency units or have more than three days sickness absence should be recorded on a Datix database.

Listed below are the most frequent methods of assault and causes of injury over the last three years, see Table 1.

Table 1. Showing method of assault on staff as recorded in Datix

Punched	Kicked	Scratched	Bitten	Grabbed
29%	19%	9%	7%	7%

These violent assaults include head and eye injuries, ripped scalps, broken noses and limbs and other physical harms, a few cause permanent physical disability and can have implications for future working in this area of nursing. Some of the staff who accessed the service had witnessed their colleague being violently assaulted and were traumatised by this experience. Secondary trauma has been described (Figley, 1995) and in nurses (Beck, 2011) suggests nurses need to be educated about their vulnerability and to become aware of the signs and symptoms of secondary traumatic stress.

In this evaluation staff injuries were recorded as an assault or as the psychological impact of an assault to a colleague or patient.

1.6 Need for an evaluation of the service

The rationale for the evaluation focused upon the access, responsiveness and the effectiveness of the service. In particular were staff seen within 4-5 working days and receive an appropriate response. Effectiveness in this evaluation was linked to how effective the response was by the service.

This service evaluation was conducted within a secure mental health hospital which provides low and medium secure care to patients. The hospital is an independent charity and a provider of care funded under contract by NHS England and the Ministry of Justice (MOJ). The hospital provides care in accordance to NHS standards and procedures and is regularly inspected by the Care Quality Commission (CQC).

In 2009, following a pilot study to assess how best to support nursing staff who were violently assaulted and traumatised the author was appointed as the service

manager to lead, design and develop a service of psychological support. The hospital provides secure in-patient mental healthcare for over 900 patients on four sites within England with a range of services for adolescents, adult female and male patients within low and medium secure levels of care for a range of mental disorders, neurological problems and learning disabilities. The patients' difficulties included serious levels of aggression and violent behaviour which is directed towards both staff and other patients.

In this evaluation the aims were commissioned by the Director of Nursing. The evaluation sought to understand the access, effectiveness and responsiveness of the service for staff following a violent assault and to profile the demographic population accessing the service to inform further developments. A key service feature for the nursing staff was confidentiality and access. It is acknowledged that the focus of aims restricted the scope of this service evaluation.

Aims

The aim of this evaluation was to assess service user satisfaction with the access, effectiveness and responsiveness of the service:

1. To analyse of the demographic profile of the service users to help further developments of the service
2. Establish if the service was responsive to the needs of the staff for support following a serious assault at work by a patient
3. To assess the confidentiality experienced by the service users
4. To assess how quickly service users were given the first appointment

5. To profile the level of trauma experienced by the service users via the Impact of Events Scale Revised (IES-R) scale of trauma and at 6 months follow up to assess psychological recovery

2.0 Method

2.1 Sample

The participants were one hundred staff who accessed the TRS within a six month period and were recorded on the TRS SPSS data base and who had been either experienced a serious violent assault or witnessed a colleague who was seriously assaulted. The assaults were recorded as between 3-4 of the Serious Untoward Incident (SUI) matrix (see Appendix M). All participants were informed about the confidentiality at the first session and asked if they would give verbal consent to a follow up questionnaire being posted to their home address 6 months later; any staff who requested not to be contact were recorded in their case notes (See Appendix N). In this evaluation none of the staff refused consent. They were also informed that they had the right to withdraw at any time and not complete the postal questionnaire.

2.2 Measures

2.3 Demographic data

Demographic data for the participants included the start date of employment, age, gender, ethnicity, job role, date of assault, whether the person was distressed and stayed at work, distressed and went on sickness absence, type of assault and injury and whether the person had lost consciousness.

2.4 Impact of Events Scale Revised (IES-R) 22 item scale

Impact of Events Scale Revised (IES-R) Weiss (1997) has 22 items (see Appendix O). It has three subscales that measure subjective stress, avoidance, intrusion and hyper-arousal. It is a validated measure of the impact of traumatic signs and symptoms associated with post traumatic reactions; it is not a measure of PTSD. The IES-R 22 item trauma scale was completed by all participants at the first session and distributed for completion with the service questionnaire. The questionnaire has 22 questions which is measured on a Likert scale from 0 (not at all) to 4 (extremely) to indicate how frequently the measure has been true during the past seven days. The total score, which ranges from 0 to 88, provides a measure of the severity of the trauma reaction. The cut off score for caseness for high levels of trauma signs and symptoms was 33 and above as suggested by IAPT Data Handbook (2011, p 22 & 28) were indicators of high levels of psychological distress following a traumatic event and signs and symptoms of PTS at the time of completion.

2.5 Trauma Response Service survey questionnaire

The Trauma Response service questionnaire (see Appendix P) was developed from six half hour focus group meetings with senior nurse managers and nursing staff. The Director of Nursing led the focus group sessions. From the focus group the Director of Nursing formulated seven questions that reflected the findings of the focus groups were: helpfulness of the session, level of experience confidentiality, understanding of your feelings better, responsiveness of appointment, help in preparation for working in a clinical area, recommending service to a colleague (Family Friendly test) and did you

have sufficient sessions. These seven questions relate to the access response, were staff able to be seen within 4-5 working days and was the service responsive, did the service provide access when closed and give clear signposting for other forms of support. Effectiveness in this evaluation was linked to how effective the response was by the service. These were scored on a 1-5 Likert scale with 1 = strongly disagree to 5 = strongly agree. Questions 8 and 9 have a yes and no answer which is scored yes=1 and no =2. Question 9 if answered yes asks for a brief description of the problem relating to the trauma experienced. Question 10 asked for any other comments or feedback.

3.0 Procedures

One hundred members of staff were the participants of the evaluation study and had accessed the service in the six month period of the evaluation study between October 2012 and March 2013. All the participants were given the Impact of Events Scale Revised (IES-R) questionnaire at the first session. At the end of the first session they were asked if they would consent to being contacted in the future to complete a questionnaire for feedback about their experience of the service. All participants agreed by verbal consent to receiving a service questionnaire. Six months after the first session a questionnaire pack and letter (see Appendix Q) explaining the purpose of the evaluation were posted out to the service user's home address and included in the pack was a pre-paid postal envelope for returning the questionnaire. The questionnaires were numbered to identify the service users.

3.1 Ethical considerations

All participants were informed about the confidentiality at the first session and asked if they would give verbal consent regarding the service evaluation and to a follow up questionnaire being posted to their home address 6 months later; any staff who requested not to be contact were to be recorded in their case notes (see Appendix N). In this evaluation no staff refused consent. They were also informed that they had the right to withdraw at any time. Questionnaires were posted with a self-addressed envelope and there was no further contact to prompt a response. For the returned questionnaires all identifying information was removed and all completed questionnaires were kept in a locked filing cabinet within the TRS offices. The service data base is held on a secure drive within the hospital server which is encrypted and protected by the hospital IT security in line with NHS governance. Following analysis all identifying information was removed before reporting the results.

4.0 Results

Thirty four questionnaires were returned giving a return rate of 34%. This included an overview of the demographic profile of service users, details of the findings of the service questionnaire regarding information on responsiveness and effectiveness of the service. Feedback regarding confidentiality which had a high means scores of 4.7 overall. The service was seen as helpful and learning was transferable to understanding the process of trauma. Analysis of the IES-R scale scores were significant $p < .001$.

4.1 Analysis of the demographic profile of the service users to help further` developments of the service

Seventy one per cent described themselves as White, 19 as Black, 4 Asian and 1 Mixed and 5 were not described see Table 2.

Table 2. Demographic detail of the participants survey n=100

Gender	Male	Female
	29	71
Age (yrs)	20 → 62	mean = 38.38

Role	Senior Staff Nurse	1
	Occupational Therapist	2
	Healthcare Assistant	44
	Physiotherapist	1
	Social Worker	2
	Administration/Clerical/Reception Staff	1
	Senior Nurse Manager	14
	Staff Nurse	12
	Deputy Service / Ward Manager	8
	Bank Healthcare Assistant	5
	Ward Manager	2
	Gym Instructor	1
	Rehabilitation Assistant	5
	Any other role	2

Ethnicity	Asian	Black	Mixed	Other Ethnic Groups	White
	4	19	1	5	71

Type of Trauma	Assaulted	Psychological	Group Debrief
	56 (12 lost consciousness)	28	16

An analysis of the service data base showed 71% were female and 29% were male staff in this sample. The highest score (95%) of assaults by a patient were in the ward area, 56% were unqualified and 39% were qualified nurses (see Table 3).

Table 3. Showing assaults by patients on nurses (n=100)		
Unqualified nurses = 56%	Qualified nurses = 39%	Total assaults on nurses = 95%

Table 4: shows the time from job role from start date to assault, with first twelve months being the highest score. All the staff assaulted by a patient worked clinically in the ward environment. These findings have informed changes to the induction process for all new starters who will be working on the wards with patients.

Table 4. Shows time in role to date of assault					
Time in role to assault	Less than 12 months	13 - 24 months	25 - 36 months	37 - 48 months	More than 49 months
Number of staff assaulted	45	17	7	2	26

4.2 Establish if the service was responsive to the needs of the staff

Results of the service questionnaire showed participants experienced high satisfaction and found the service was effective. The results showed in Table 5 are the level of satisfaction and effectiveness of the service.

Table 5. Showing mean service questionnaire scores (n = 34)							
Question	1	2	3	4	5	6	7
Mean	4.79	4.85	4.5	4.62	4.35	4.85	4.35
Total Mean Score = 5							

Participants accessing the Employee Assistance Programme (EAP) for support following an assault were low 8.3%. Most participants 58.82% reported no further problems experienced related to the trauma and 38.24% did experience problems.

4.3 Summary of the feedback question 9.

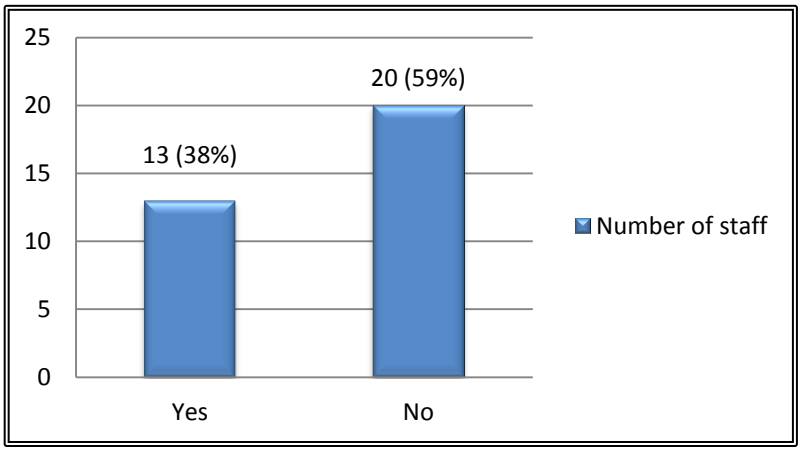

Figure1. Showing the number of staff who did and did not have problems

4.4 Summary of comments

Twenty five participants made comments which have been summarised into four board categories. The service was seen as 'timely and responsive' to incidents of assaults, prompt and accessible, recommended by colleague and told others it was helpful. Staff said they would have left job and not returned to work. Staff felt listened to, just being

there was enough, easy to talk to and trusted AG. And lastly helped process their feelings, normalised the trauma and helped with their coping strategies. The summary feedback suggests the staff were satisfied with the service and found it effective and helpful with dealing with the impact of trauma.

4.5 Evaluation of the IES-R scale

Analysis of the IES-R was calculated as stated by Weiss (1997) the total mean scores for the 22 items was calculated. A cut off score of 33 for caseness was employed.

The thirty four IES-R trauma mean scores were calculated with a total mean score of 68 for the first IES-R scale and a mean score of 16.6 for the scale after 6 months. The total mean score of 68 was above the caseness score for symptoms of PTS and the second total means score 16.6 was lower than the cut off level as suggested by (IAPT, 2011) suggesting that the participants recovered over the 6 month period. The means scores of the first session and the second follow-up IES-R scores and mean were compared to assess levels of change. Table 6 shows IES-R mean and standard deviation scores.

Table 6. Showing IES-R mean scores and standard deviations for Time 1 (first session) and Time 2 (6 months later) (n = 34)

IES-R scores	Time 1	Time 2
Impact Scale	68.15 (17.12)	16.6 (7.45)

A paired two tailed t test on the Time 1 (first session) and Time 2 (six months later) total mean scores. There was a statistically significant decrease in IES-R scores from Time 1 (m = 68.15, SD = 17.12) to Time 2 (m = 16.71, SD = 7.45) t (33) = 16.19, $p < .001$ (two-tailed). The mean decrease in score was 51.44 with a 95% confidence interval ranging from 44.97 to 57.90.

The eta squared statistic (.89) indicated a large effect size.

5.0 Discussion

The aim of this evaluation was to assess service user satisfaction with the access, effectiveness and responsiveness of the service.

5.1 Analysis of the demographic profile of the service users to help further developments of the service

Analysis of the demographic profile identified some important findings regarding access to the service. In particular, the date of starting work at the hospital and the time of the violent assault showed that most participants (45%) were assaulted in the first twelve months of employment suggesting that staff are most vulnerable when they first commence employment. The location of the violent assault revealed the ward area was the place most assaults (95%) occurred to nursing staff. Care and attention to how new starters are informed will be reviewed via analysis of further Datix report of assaults on staff and correlating this with their start date. Additionally, annual training now includes the 'See, Think, Act', guide to relational security which has been rolled out to all ward

areas to provide ward staff with guidance on how to 'Keep everyone safe', (Department of Health, 2010).

Two thirds of the victims were female; gender balance on difficult and violent wards is now discussed at regular meetings with the Lead Nurses for each specialist pathway. Analysis of the workforce data base showed a ratio of 68% female to 32% male of qualified nurses and 58% female to 42% of unqualified nursing staff. Many wards already ensure a mix of male and female members of staff to help ensure safety, with one ward recruiting more male staff. Further analysis of the on-going violent incidents is needed to gain further insight into this finding; indeed the new database provides time of day and day of the week to help access the risks to staff and patients.

5.2Establish if the service was responsive to the needs of the staff for support

The staff were seen within 4-5 working days and they reported it was effective and responsive and that the service provide access when closed and give clear signposting for other forms of support.

The service users reported that access was within the time frame they were seen promptly with a mean score of 4.62 out of 5 and were satisfied with the response. Most referrals were via self or by the manager via emails or calls to the service. To ensure calls are dealt with during annual leave a back-up service for appointments and support is provided via the EAP contract with experienced counsellors who are used to supporting traumatised staff. This has been a useful addition to the service and ensures

the wards which are staffed 24 hours every day of the year have support when they request it. Many staff using the service reported it was helpful to have information about the impact of trauma following an assault at the first session. Following this finding a leaflet has been developed so that service users can take it away after the session and can show it to their significant other. Information regarding the impact of trauma seems to help traumatised staff take back a sense of control and to enable a discussion with partners and family about the difficulties they are experiencing.

Early intervention for traumatised individuals is suggested as good practice by NICE. (2015) review of CG26: Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. The members of staff reported feeling valued by the organisation for providing a responsive service and that it was effective in providing support. To help increase levels of responsiveness a selection of the electronic form asks has the 'Trauma service manager been informed', by ticking yes on the electronic Datix form an alert is sent automatically to the Trauma Service manager and an appointment is arranged. This system and an organisational policy outlining how managers should respond to staff involved in violent and traumatic incidents has meant that getting support following a serious violent assault is common practice and has helped to take away some of the stigma experienced of having to ask for support. Regular feedback to senior management team and hospital directors has had a positive impact in ensuring organisational learning. Leaders need to understand the difficulties experienced by their members of staff working with patients who on a daily basis manage challenging behaviours such as violence and aggression.

5.3 Confidentiality experienced the service users

Trust in the confidentiality of any psychological service is paramount. The nursing staff were cautious regarding the confidentiality of the service from the start and concerned that if they talked about finding things difficult or not coping they would be seen as weak and unable to do their job. Unlike the Occupational Health service that has to record the presenting issues on an employee's personal record, all information regarding staff attending the service is confidential. All identifying information is removed for the quarterly reports about service uptake up which is fed back to the senior management team and directors of the hospitals. Participants reported a high degree of trust regarding confidentiality with a mean score of 4.85 out 5 which has led to the continuing success of the service. A culture of acceptance of aggression was evident with staff reporting 'it's part of the job to be punched' or 'it happens anyway' was evident on some wards which had developed over a number of years. Page (2014, p6.) suggests 'the notion of stigma carries with it the implication that there is something inherently discreditable about the person who is stigmatised'. The service has now been established six years and the take up each year is over 400 staff assessing the service. There is still some stigma attached to being assaulted by a patient and more work and training is needed to help deconstruct this phenomenon which is often linked to feelings of shame and quilt.

5.4 To assess how quickly service users were given the first appointment

The service questionnaire showed that service users did feel the response and access was quick and most were seen within 3-4 working days for their first appointment with

a mean score of (4.62). A quick response enabled the recovery process by giving them information to reassure at this often difficult time. Participants reported there were enough sessions which supported the ASSIST model (Greenwood et al, 2012, p97) which offers early invention of 1-2 sessions of psychological first aid to the traumatised staff.

5.6 To profile the level of trauma experienced by the service users via the Impact of Events Scale Revised (IES-R) scale.

Levels of reported trauma following the violent assault were high and above the suggested (IAPT 2011) cut off caseness score of 33. It is to be noted these scores were 3-4 days post incident injury. There may be another compounding factor for the level of trauma experienced maybe high because many staff described feeling they might die or be killed during the assault. This level of fear and hopelessness may be related to the knowledge that some of the patients have previously seriously harmed or killed family members or staff. However, the post IES-R scores six months post incident there was a statistically significant decrease with a $p < .001$ suggesting that reported trauma had declined from the violent assault did occur.

Overall, the IES-R scale inferred that staff had recovered from the violent assault, however the scale measures the level of stress reaction and does not give any further information as to the individual's psychological wellbeing. Many of the staff still work as nurses on the wards and have returned to place where they were assaulted. This is in contrast to individuals who get seriously assaulted in public areas who often avoid the place of the incident. The members of staff returning to the ward and the place where

they were assaulted reported feeling anxious particularly when the Personal alarms (PITS) sound which staff wear at all times and are pulled if they are threatened or attacked. The stimulus response to the alarm was fear and panic. Overcoming this normal reaction to stay safe and not panic can be a challenge; however most do remain at work on the wards. More research is needed to understand how the members of staff accommodate this emotional fear and distress whilst still being able to work in the ward environment often with the patient who has assaulted them. Yoder (2010) suggests 'the most common theme in work-related coping strategies was a change in personal engagement with the patient or the situation' (p 192). In some cases where a patient is targeting a member of staff, either the patient or the member of staff will be moved. This can bring other problems; staff teams work very closely together and feel safe with a team they know. Going to a new ward means establishing with a new team and a new group of patients, hence many staff choose to stay on the ward were they were assaulted if it is assessed as being safe via risk assessments to do so.

Participants in the service evaluation reported that they did understand their feelings better following the session which was effective and the session helped them prepare for working in a clinical area. High confidence in the service was expressed by participants reporting they would recommend the service to a colleague as accessible, responsive and effective.

5.7 Limitations

There may have been a bias in the sample in that those who found ease of access and had a good and responsive experience completed the questionnaires. Regarding effectiveness the IES-R was designed to be completed seven days following a traumatic event, in this evaluation it was employed twice after seven days and six months later. However, the scale has been adapted by IAPT and that method was used in this evaluation. Further research is needed to establish the validity of this scale for post trauma measures. The inclusion of a general health questionnaire may have given a more holistic view of the service user's wellbeing at the first session and the follow up questionnaire which would improve the measure of effectiveness.

The service questionnaire was developed from focus groups to assess responsiveness and service user experience and accessibility. It is acknowledged that this was a first evaluation of a new service and further evaluations would need to develop a more robust tool that included questions to further assess the level of access, responsiveness and the effectiveness of the service and for these to be formulated in a more systematic approach. It is acknowledge that the Director of Nursing may have had a bias in choosing the questions, future evaluations will need to have a more robust selection of questions criteria.

6.0 Conclusions

The findings from this evaluation have provided evidence of a high level of satisfaction with the service access, responsiveness and the effectiveness in supporting the traumatised staff. It has had an impact on the policies and training within the

organisation as well as within the TRS which is now located as a core service within the organisational culture. It has shown the TRS service is confidential and responsive and offers timely appointments for the needs of members of staff. The results showed that staff do recover from being traumatised by the violent assault and most continue working on the wards with patients at the hospital. The data collected from the service evaluation has already been fed back to the senior management team and has given helpful information to promote a safer and more informed place for staff to work. Supporting the traumatised nursing staff and enabling their return to the ward ensures continuity and consistency of the nursing teams which has a direct impact on the quality of care for patients. Results showed staff felt the service principles were 'Friend and Family friendly', as described by NHS England (2014) and they would recommend it to colleagues who they describe as their family at work. The service questionnaire did provide a written feedback section as suggested as good practice in the Friend and Family friendly document NHS England (2014). However, more work is needed to further understand the complex process of psychological recovery of staff following a serious violent assault by a patient and new research projects are being considered regarding the reduction of stigma and to further understand the long term impact of the assaults regarding head injuries. To help further the research in these areas the appointment of a placement of trainee doctorate clinical or counselling psychologist is being considered.

And lastly, it is acknowledged that the dedication of the staff nursing within the hospital who are sometimes caring for very challenging and violent patients has to be highly commended and be supported by a service that is professional and responsive to their needs.

The service was nominated and shortlisted in 2013 for the national Nursing Times Awards for excellent and quality service for the wellbeing of nursing staff.

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Appendix N

CLASSIFICATION OF EVENTS

Level of severity table

St Andrew's HEALTHCARE

Examples are given to assist with grading and completing the event form. This is not an exhaustive list - any event not in this list must be graded comparatively. Information will be input into the event form database for St Andrew's use. The items in gold indicate safeguarding issues for patients:- safeguarding procedures may be required. If in doubt, please discuss with your ward manager /team manager

	Impact: / Nature or type of event:	LEVEL 1 - NO HARM **Potential to cause harm, damage or loss, with none resulting. Includes:** • **impact prevented** - e.g. attempted events, intervening actions prevented harm occurring • **impact not prevented** - e.g. event ran to completion but no harm caused	Level 2 - LOW **Minimal harm, damage or loss, i.e. may require first aid.** **Damage to an individual's or team's reputation; possible local media interest**	LEVEL 3 - MODERATE **Moderate harm i.e. requiring medical attention or precautionary visit to GP / general hospital (e.g. for stitches); non-emergency hospital admission that may be care planned. Moderate damage or loss. Damage to Service's reputation; possible local media interest**	LEVEL 4 - SEVERE **Severe or permanent injury or harm i.e. requires emergency medical treatment in A&E or hospitalisation which is unpredicted / not care planned. High level of damage or loss. Damage to Charity's reputation; local media**	LEVEL 5 - HIGHLY SERIOUS **Serious events resulting in life threatening harm or death, substantial service disruption, damage or loss. Damage to the Charity's reputation; national media coverage. Never events.**
AGRESSION & VIOLENCE	**Abuse/Aggression - Verbal** (Including sexist, homophobic, racist remarks or harassment, hate crimes)	Verbal abuse (e.g. SASBA level 2, MOAS level 2) which may be frequent or targeted - including inappropriate sexual remarks	Verbal abuse (e.g SASBA level 3, MOAS level 3) causing alarm, or distress	Verbal abuse with threat to damage or harm (e.g. MOAS level 3-4)	Verbal abuse with intent to harm or kill and individuals feel victimised (e.g. MOAS level 4)	Verbal abuse with capacity or credible threat to seriously harm or kill, indivdual(s) are in serious / immediate danger.
	Abuse/Aggression - Physical (e.g. shoving, pinching, slapping, punching, biting, objects thrown; includes hate crimes)	Attempted assault but no contact; minor physical aggression which may be frequent or targeted (e.g. MOAS level 2).	Assault causing minimal injury or harm (e.g. MOAS level 3)	Assault causing moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission (e.g. MOAS level 3-4)	Assault resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment (e.g. MOAS level 4)	Assault resulting in life threatening injury, harm or death. Homicide (including attempted).
	Abuse - Sexual (including harassment & hate crimes)	*See verbal*	Inappropriate sexual behaviour (e.g. SASBA level 3)	Uninvited physical contact (e.g. SASBA level 3-4)	Sexual assault, abuse or harassment (including allegations of), sexual contact (e.g. SASBA level 4)	Serious penetrative sexual assault or rape (including allegations of).
	Hostage Taking and Organised Disturbance • includes riots (if 12 persons or more), violent disorder, rooftop protests, barricades, concerted indiscipline, gaining entry	Planned/attempted but prevented	Does not involve violence and is easily defused by staff. Minimal impact on ward	Involves barricading, any violence is low level. Moderate impact on ward	Resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment. High level damage. Ward/area suspended or severely disrupted. Emergency Service intervention.	Resulting in life threatening injury, harm or death, significant damage. Service suspended or major disruption. Emergency Service intervention.
	Weapons • includes making and use • includes conventional, made and adapted	Weapon (or potential weapon) found outside of / before entering ward or secure area.	Unsecured tools and similar itemswith potential for use as weapons found in a secure area, e.g.maintenance or kitchen items	Deliberate fashioning of a weapon. Weapon found in secure area.	Use of a weapon. Injury, harm or damage resulting from use of a weapon.	Use of a weapon resulting in life threatening injury, harm or death, or substantial damage. Firearm found/involved
ENVIRONMENT	**Environmental Failure** • includes buildings • includes fixtures and fittings • includes exposure to hazardous substances	Minimal cost to charity or no harm caused	Low cost or loss to charity or resulting in minimal injury or harm	Moderate cost to charity or resulting in moderate injury or harm requiring medical attention, hospital investigations or assessments. Localised service disruption	High cost to charity, resulting in severe or permanent injury, harm or major disruption	Significant cost to charity, resulting in life threatening injury, harm or death, or significant service disruption
	Fire	Attempted fire setting, accidental fire prevented with no resulting harm or damage	Fire resulting in minimal injury or harm, or little damage	Fire resulting in moderate injury or harm requiring medical attention, hospital investigations or assessments, moderate damage	Fire resulting in severe or permanent injury, harm requiring **emergency** offsite medical treatment. Severe damage	Fire resulting in life threatening injury, harm or death, significant damage or service disruption
	Property Damage • includes accidental and intentional	Attempts to damage property but prevented or damage limited	Minor damage to items of Charity or personal property	Damage which requires maintenance but the area is made safe and can continue to be used	Damage which results in severe service disruption (e.g. to a room or area)	Damage which results in significant service disruption (e.g. to a ward)
HEALTH	**Infection Control** • includes needle stick injury, outbreaks			Exposure to a source of infection causing illness requiring medical attention	Exposure to a source of infection causing illness, e.g. outbreak of a notifiable infection., isolation. Needle stick injury. Pressure ulcer of grade 3 or above	Death where primary cause may be related to healthcare associated infectious disease
	Medication • includes errors • includes loss/theft	Incorrect medication prescribed / dispensed, but not administered.	Error in prescribing, administration or omission of medication with few or minimal adverse effects	Error in prescribing, administration or omission of medication with effect on patient, requiring medical attention	Error in administration of medication requiring **emergency** offsite medical attention. Event involves a controlled drug.	Resulting in life threatening injury, harm or death
	Physical Health • includes injury sustained during restraint • includes accidents and falls	No injury or harm / minimal loss	Minimal injury or harm	Moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission	Severe or permanent injury, harm requiring **emergency** offsite medical treatment.	Resulting in life threatening injury, harm or death
	Self-harm and Suicide	Threats to self-harm or self harm with injury prevented (e.g. ligature tied but removed)	Self-harm with minimal injury or harm	Self harm with moderate injury or harm requiring medical attention, hospital investigations or assessments including care planned admission	Self-harm with severe or permanent injury, harm requiring emergency **offsite** medical treatment.	Resulting in life threatening injury, harm or death
	Substance Use / Misuse • includes alcohol, legal and illegal drugs and substances • includes possession and supply	Suspected possession or supply of alcohol, drugs or substances, but no evidence. Items found outside of / before entering ward or secure area	Evidence of alcohol, **legal** drug or substance consumption, possession or supply on ward or within secure area.	Moderate harm arising from use of alcohol, **legal** drugs or substances.	Severe or permanent harm requiring emergency offsite medical treatment arising from use of alcohol, drugs or substances. Evidence of **illegal** drug use, possession or supply.	Use of alcohol, drugs or substances resulting in life threatening injury, harm or death
SECURITY	**Absent without leave** (AWOL) or **Missing** • includes escape from secure area, abscond from escorts	Attempt to leave/abscond/escape **(informal and detained** patients)	**Informal** patient missing but returns soon after	**Informal** patient missing but not deemed violent / suicidal /	High risk **informal** patient is missing. **Detained** patient is AWOL	High risk or high profile **detained** patient is AWOL. Escape from a medium secure unit
	Confidentiality Breach and Data Loss • includes unauthorised disclosure and business sensitive information	Minimal breach with harm limited, e.g. document found on photocopier, encrypted data stick located	Minimal breach with up to 20 people affected, or risk assessed as low, e.g. loss of records	Moderate breach with up to 100 people affected or risk assessed as high, e.g. loss of person identifiable data	Severe breach with more than 100 people affected, information of particular sensitivity or sensitive information as defined by Data	Highly serious breach with potential loss of privacy, adverse effects on individuals or a negative impact on the Charity; potential for ID theft
	Loss and Theft	Very low cost or loss to charity	Cost or loss to charity £2,000 - £10,000.	Cost or loss to charity £10,000 - £250,000. Reported loss of a patient's money, i.e. suspected theft (whilst in patient's control)	Cost or loss to charity £250,000 - £1m. Loss of a patient's money / suspected theft (whilst in SAH control)	Cost or loss to charity >£1m.
	Security Compromise or Breach • includes items found on search • includes loss of keys	Contraband (including illegal) item(s) found outside of / before entering ward or secure area. Perimeter breach not resulting in escape, e.g. security door or perimeter gate open, keys found	Low risk contraband item(s) **(legal only)** found on ward or secure area.	High risk contraband item(s) (**legal only**) found on ward or secure area; Damage to secure perimeter; Key loss or compromise, loss of electronic ID	**Illegal** item found; secure keys lost or compromised	Serious breach of secure perimeter, e.g. keys compromised resulting in changes to locks in a secure area
	Other	Enter level of classification according to severity				

Appendix O

Service Evaluation
Staff Trauma Support Services
CONFIDENTIAL
Staff Contact Details

REF NO:

Participant consented: **YES/NO**

Follow up contact: **YES / NO** **When:** _____

Refer to Atos: **YES / NO** _____ **Drive:** **YES / NO**

Have you used service before: **Trauma** ☐ **Help EAP/Atos** ☐

GP Letter: **YES / NO**

GP's Name:

_____

Surgery Address:

_____

_____

Date of Event:

_____

Risk Assessment Procedure followed: **YES / NO / NOT APPLICABLE**

If "No" – give reason:

_____

_____

Suspended from duty: **YES / NO (Authorised leave)**

Referral: (please circle) **Self / Manager / OH-Medigold / Police Liaison / Lead Nurse / PMAV Lead/ Health & Safety / HR Business Partner /**
Hospital Director / Datix report

Date of first session: **1:1**_____ **Phone:**_____
Email:_____

Appendix P

18

STUDY ID # _____

IMPACT OF EVENT SCALE-REVISED

Instructions: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you *during the past 7 days* with respect to the disaster. How much were you distressed or bothered by these difficulties?

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Any reminder brought back feelings about it.	0	1	2	3	4
2	I had trouble staying asleep.	0	1	2	3	4
3	Other things kept making me think about it.	0	1	2	3	4
4	I felt irritable and angry.	0	1	2	3	4
5	I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6	I thought about it when I didn't mean to.	0	1	2	3	4
7	I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8	I stayed away from reminders about it.	0	1	2	3	4
9	Pictures about it popped into my mind.	0	1	2	3	4
10	I was jumpy and easily startled.	0	1	2	3	4
11	I tried not to think about it.	0	1	2	3	4
12	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13	My feelings about it were kind of numb.	0	1	2	3	4
14	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15	I had trouble falling asleep.	0	1	2	3	4
16	I had waves of strong feelings about it.	0	1	2	3	4
17	I tried to remove it from my memory.	0	1	2	3	4
18	I had trouble concentrating.	0	1	2	3	4
19	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20	I had dreams about it.	0	1	2	3	4
21	I felt watchful and on guard.	0	1	2	3	4
22	I tried not to talk about it.	0	1	2	3	4

Appendix Q

St Andrew's HEALTHCARE

Trauma Response Service Questionnaire

In order to evaluate effectiveness and ensure that it fulfils the needs of future participants, please consider the following statements and circle the number corresponding best to how you feel about each statement.

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Dis-agree
1	Did you find attending a session with the Trauma Manager helpful?	5	4	3	2	1
2	Did you feel it was confidential?	5	4	3	2	1
3	Did you understand your feeling's better?	5	4	3	2	1
4	Did you see the Trauma Manager quickly?	5	4	3	2	1
5	Has the session helped your preparation for working in clinical areas?	5	4	3	2	1
6	Would you recommend the service to a colleague?	5	4	3	2	1
7	Did you feel you had adequate sessions(s)?	5	4	3	2	1
8	Have you accessed the St Andrew's Wellbeing Service (ATOS)? If 'Yes', did you find it helpful?	YES YES			NO NO	
9	Have you experienced any problems relating to the trauma since your sessions? If 'Yes', please give a brief description:	YES			NO	

10 **Please add any comments or suggestions to assist with future development. Constructive criticism is welcome:**

Please feel free to keep a photocopy of this questionnaire should you require to.

Appendix U

St Andrew's HEALTHCARE

Healthcare Governance Directorate

E: agreenwood@standrew.co.uk

T: 01604 616149
F:

Our ref: AG/KG
Your ref:

Date: 010

STRICTLY CONFIDENTIAL

Dear

I am writing to thank you for using the St Andrews Hospital Trauma Response Service.

I have developed a simple feedback information questionnaire to assist me with any future developments of the Trauma Response Service and to access service user experience. I am writing to you in the hope that you could possibly take a few moments out of your day to complete and return the questionnaire for me.

The questionnaire itself is completely anonymous; however you may write your name on it if you choose to. I have also enclosed a freepost envelope for your convenience.

Your thoughts and impression of the Trauma Response Service are of great importance to me. Thank you once again for taking the time to return the questionnaire to me if you have done so.

May I also take this opportunity to relay, that should you require any further support or advice; please do not hesitate in contacting me directly on the above number.

Kind regards,

Annette Greenwood MSc; MPhil(Sc);AFBPsS
Counselling Psychologist
Trauma Service Manager
Clinical Risk Management