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# Caregivers facing violence in long-term care setting: A cross analysis of incident reports and caregivers speech

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## Abstract

**Background:** Workplace violence is frequent, especially in long-term care, but often unreported.

**Aims:** The aim of this study is to identify workers experiences and coping strategies when they face physical aggression from residents and assess the value of incident reports for violence follow-up.

**Methods:** This mixed method study is based on incident reports collected over 3 years from two different long-term care geriatric facilities in France and thematic analysis of 20 semi-structured interviews of nurses and nursing assistants.

**Results:** The reported frequencies of physical aggression among respondents range from none to daily aggression. Only 76 incident reports were submitted. Aggressions were under-reported by caregivers who often felt guilty for not having avoided them. Coping strategies included banalization and seeking support from colleagues. Incident reports can constitute a warning signal for the management team but are not a reliable tool for workplace violence follow-up.

**Conclusions:** Our study emphasizes the complexity of workplace violence prevention in long-lerm care settings. Proposals can be formulated to train and support caregivers, but a shift from a task-oriented organisation to a patient-centred approach seems necessary to reduce violence.

**Implications for Nursing Management:** Situations to be reported should be better defined, aggression reporting encouraged and judgmental attitudes toward reports discouraged.

KEYWORDS
coping, incident reporting, mixed study, physical aggression, workplace violence

## 1 | BACKGROUND

The World Health Organization (2002) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, against another person or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm." Violence in health care settings, especially against nursing staff, is a matter of concern in many countries (Babiarczyk et al., 2020; Enmarker et al., 2011; Estryn-Behar et al., 2008). Most affected sectors are psychiatric, geriatric and emergency departments (Babiarczyk et al., 2020; Spector et al., 2014). In France, a report by the "Network for surveillance of violence in the health care sector" (DGOS, 2021) shows that geriatric long-term care facilities (LTC) are the second largest source of reports of aggressive behaviours, after psychiatric care. Most victims are nursing assistants and registered nurses, and most aggressors are patients (70%). Nurses frequently do not report such aggressive behaviours because they consider it as part of their work and think it would be useless (Babiarczyk et al., 2020; Kvas & Seljak, 2014). Aggression can be defined as "a behavior that is intended to harm" (Allen & Anderson, 2017) and can take many forms. We will focus in this study on physical aggression.

Around 80% of people with dementia living in nursing homes experience at least one behavioural symptom of dementia, of which 32% are aggression as assessed by the Neuropsychiatric Inventory (Selbæk et al., 2013). Aggression is associated with male gender, poorer functional status and premorbid personality (Kolanowski et al., 2017). Caregiver attitudes may trigger aggressive behaviours, especially when resident's physical care is rapid or painful. On the other hand, a person-centred approach may reduce aggressive behaviours (Enmarker et al., 2011).

Exposure to aggression affects physical and mental health of health care workers (Jackson et al., 2002; Miranda et al., 2011). Workplace violence can have short-term repercussions, such as fear, anger, sadness, frustration, anxiety, irritability, apathy, feelings of guilt and helplessness (Lundström et al., 2007), but also long-term consequences, such as decreased job satisfaction and reduced quality of care provided to patients (Lanctôt & Guay, 2014), as well as increased staff turnover and absenteeism (Gerberich et al., 2004).

Qualitative studies are necessary to better understand how aggression is experienced by staff and why victims often prefer not to report it, but such studies are rare (Enmarker et al., 2011).

The aim of this mixed study is to understand how caregivers from two geriatric LTC experienced physical aggressions from residents, to identify their coping strategies and expectations. Such outcomes may shed light on consequences of incident reports in these facilities and allow to assess intensity to monitor workplace violence in LTC.

## 2 | METHODS

### 2.1 | Setting

Our study was conducted in two geriatric Long Term Care facilities of Rennes University Hospital. The nursing home contains three conventional units (1–3) for 94 residents (average age 85.2) (respectively, 31, 31 and 32 residents per unit) and a special care unit for people with dementia for 26 residents (average age = 86.4) with challenging behaviours. The Long Term Care Unit housed 120 patients (average age 82.7) with a poor health status who requested close medical monitoring. The care teams included 166 members composed of registered nurses, nursing assistants and hospital assistants.

### 2.2 | Qualitative study

We conducted semi-structured interviews with nurses and nursing assistants working in LTCs.

The interview guide was elaborated on the base of a literature review on violence in LTC. The guide was centred on the narratives of one physical aggression involving a patient. It involved questions about context, precipitating factors, consequences for caregivers and residents, reports and perceived support. In addition, the guide contained more general questions about frequency of aggressions by

**TABLE 1** Main questions of interview guide

| Topic | Example of questions |
|---|---|
| Physical aggressions | Can you tell us about an episode of patient violence against you?<br>Did you file an incident report? Why or why not?<br>How often have you been physically aggressed by a patient in the last year? |
| Patients | What are the triggers for patient violence?<br>Which patients are most at risk?<br>What are the consequences for the patient? |
| Consequences | Have you ever had a work stoppage due to a violent episode?<br>Have you ever thought of changing job after such an episode? |
| Support | Do you feel supported by your colleagues? Your family? The institution?<br>Have you received psychological support? |
| Training and solutions | Have you ever participated in a training on patient violence?<br>Was that question addressed during your study?<br>Is there debriefings following violent episode?<br>According to you, what could help in reducing violence? |

residents, reason for reporting them or not and training programmes on management of aggressive behaviours. Main questions are detailed in Table 1.

Caregivers were recruited according to purposive sampling among voluntary staff. In order to maximize the diversity of experiences concerning aggressions, we selected responders according to relevant features, such as gender, age, years of experience, place of work (nursing home vs. LTC unit), job (nurses vs. nursing assistants) and working hours (morning/afternoon/night). Doing so, we did not seek representativeness but maximal variability of possible replies. Hospital assistants were not included, as they are theoretically not involved in direct patient care.

Interviews were conducted by an investigator (MB), resident in family medicine, for the purpose of her medical thesis. Interviews were recorded and fully transcribed anonymously by MB with consent of respondents. In order to understand the subjective meaning of experience, we conducted an inductive and deductive thematic analysis to search for themes emerging from the data, though careful reading (Fereday & Muir-Cochrane, 2006). The first step was data-driven. Emerging themes were identified by MB and then discussed with a second researcher (AC) and organized into categories. The second step was deductive, theory-driven, grounded on Lazarus and Folkman (1984) model of coping. These authors differentiate two types of coping: problem-centred and emotion-centred. More recently, a third strategy, seeking social support, was described (Bruchon-Schweitzer & Boujut, 2014; Cousson-Gélie et al., 1996). These three strategies were used as codes to describe coping experiences.

Inductive analysis was conducted after each interviews, and interviews were stopped after two interviews adding no new relevant element, defining data saturation. Results were then summarized and discussed between coauthors. First results were presented to quality managers, head nurses and leading physicians of the departments concerned, to enrich the comprehension of the data.

Data collection with real-time inductive analysis took 1 year, and further analysis including theory-driven interpretation, researchers discussion, cross analysis with incident reports and return to management team one more year.

### 2.3 | Incident reports

To report an incident, staff members can complete an online form, accessible from the intranet website. The same form can be used for all incident report, including patient fall, drug side effect and problem with other unit. They are automatically transferred to quality managers and the management team. For the purpose of the study, we collected all incident reports concerning physical aggression against staff by patients in the nursing home and LTC unit of the Rennes University Hospital during the 3 years preceding the interviews. We excluded incident reports directed toward staff members that involved families of patients and aggressive behaviours between residents not involving staff members. Incident reports indicated the staff members' name and job, place and time/date of the incident, patient's date of birth, description of the incident, measures that were undertaken and consequences for the staff members. Descriptive data are presented and cross-analysed with qualitative data in the following section.

The research protocol has been approved for methodological and ethical aspects by the Family Medicine Department of Rennes University, according to university rules concerning medical thesis. In addition, the study has been examined and approved by Rennes University hospital ethical committee.

## 3 | RESULTS

### 3.1 | Caregivers' experiences of physical aggressions

The interviews ($n = 20$) lasted between 12 and 59 min. Mean age of interviewees was 43.4 years, and mean working experience in geriatrics was 10.3 years. Individual characteristics are presented in Table 2.

**TABLE 2** Characteristics of the study population ($n = 20$)

| Characteristics | Number of caregivers ($n = 20$) |
|---|---|
| Gender | |
| Female | 17 |
| Male | 3 |
| Age | |
| <30 years | 2 |
| 30 to 39 incl | 5 |
| 40 to 49 incl | 8 |
| ≥50 years | 5 |
| Experience in geriatrics | |
| <3 years | 4 |
| 3 to 5 incl | 2 |
| 6 to 9 incl | 2 |
| 10 to 14 incl | 8 |
| ≥15 years | 4 |
| Job | |
| Registered nurses | 6 |
| Nursing assistants | 14 |
| Place of work | |
| Nursing home | 6 |
| Alzheimers unit | 6 |
| Long-term care unit | 8 |
| Shift | |
| Day | 16 |
| Night | 4 |
| Additional training (university diploma in geriatric care) | 2 |

Most informants reported at least one episode of physical aggression over the last 12 months. Reported frequencies of physical aggression of respondents ranged from none at all to daily aggressions. The severity of aggressions was also subject to individual interpretation: "I no longer consider it as violence when patients try to hit or scratch us." *E4*. The deliberate nature of aggressive behaviours and cognitive status of aggressor conditioned how the act was interpreted. Aggressions deemed to be deliberate seemed to have a greater impact on caregivers.

Some caregivers considered themselves responsible for assaults because of their own behaviour or because they provided care that was too intrusive or hasty. Caregivers reported introspection when aggressive behaviours occurred, sometimes going as far as blaming themselves: "Did I do everything I had to do, maybe it was me […] who sent the wrong signal, did I perhaps make a mistake, […] an error? […] If someone hits me, perhaps it's because I did something wrong." *E2*. Caregivers felt guilty concerning these episodes, and their guilt increased when the patient self-injured as a result of the aggressive behaviour.

Caregivers questioned the responsibility of their institution in these violent incidents, referring to workload, lack of time devoted to residents, "obligations" such as bathing, activities lifestyle changes imposed by community living and residents' unease with the functioning of the unit. Informants described their job as physically arduous, with time constraints, in caring for increasingly dependent residents.

Some nursing assistants felt they had not accomplished their work if the resident had not been bathed, whether or not the resident consented. They argued that they washed the patient and attempted to divert any opposition he or she might express.

"I'm going to wash you anyway, I have to." "As we are on our own and we have objectives, we have to do it." *E7*.

Some staff members (a minority of respondents) reported feeling no latitude in decision-making and said that they were trapped by a task-oriented organisation.

About half of the caregivers from our sample reported having already been injured, with a declaration of an accident in the workplace or a sick leave following the assault. One even reported she had been off work because she feared an accident during her pregnancy.

Moreover, caregivers reported feeling "helpless," "powerless," "shocked," "scared," "weakened," "destabilized," "psychologically distressed" or "apprehensive" after having been physically aggressed.

> I have a difficult time when I'm kicked because I want to put the patient in a bed with vest restraints. I am not here to harm them, so I think we have to become hardened to it. *E9*

One caregiver was on sick leave because of burnout, which she attributed to difficulties of caring for some residents with aggressive behaviours.

Some caregivers thought about leaving their department because of aggressive behaviours, which adds to the workload and to a perceived lack of recognition and support. They reminisced their difficulty to cope with aggressive behaviours when they arrived in the geriatrics department or in the dementia unit.

## 3.2 | Caregivers' coping strategies

### 3.2.1 | Problem-focused coping

Caregivers sought information or advice to help them cope with violence, such as identification of residents and at-risk situations, information on the persons' life and preferences, and triggers of aggressive behaviours. Such data were judged useful to adapt their professional approach.

Informants said they tried to analyse aggressive behaviours to prevent and manage future episodes and to improve cares. In addition, they reported having used de-escalation techniques (relaxation methods, additional explanations of the care provided, massage and soft speaking) and distraction to cope with aggressive behaviours of residents.

Over half (11/20) of the caregivers from our sample followed a training programme on management of aggressive patients. However, most of them claimed that the training was not adapted, *especially* for people with dementia, because they considered that "you cannot reason with people [with dementia]" *E10*.

### 3.2.2 | Emotion-focused coping

Caregivers used different strategies to attenuate their emotions. Sometimes, they downplayed aggressive behaviours by considering them as part of their job or minimized the episodes and their consequences, "Because when someone just hits with their hands, it's not serious," (E10), or even showed fatalism, "You have to take a lot of distance from all of this, because we would not wash the residents in the morning," E16. One caregiver said that it was necessary to "harden oneself" and to "prepare psychologically to be hit." E9.

All caregivers sought excuses for residents' aggressive behaviours and to ascribe significance to it: "They cannot find their words and cannot express their feelings, so it has to come out one way or another" (E10). They emphasized that residents had no conscious desire to harm: "It's not his fault," E9, or "She did not do it deliberately," E3. They saw in this act a way of communicating: to express fear, anxiety, physical or psychological distress or annoyance, thereby suggesting that residents were not responsible for their behaviours. Others referred to their own responsibility for occurrence of aggressive behaviours, as described earlier with self-accusation mechanisms.

### 3.2.3 | Seeking social support

Almost all caregivers said they felt supported by their colleagues and reported helping one another when coping with an agitated person (providing care together and handing over to another professional).

They also stressed the importance of talking and sharing information and experiences. Despite such peer support, some staff members felt judged by their colleagues.

> You'll be considered as a bad caregiver. Judgmental attitudes between caregivers are common, and you can quickly be labeled as good or bad in situations like that. *E5*

Half of caregivers felt that the management team did not pay enough attention and reported lack of recognition or feeling guilty.

> Whether or not you feel bad or suffer from assaults, you must keep quiet and do the job. *E19*

> I sometimes even have the impression that … if we are victim of violence, they'll try to make us understand that we did not manage the situation properly. *E10*

### 3.3 | Caregivers' expectations

Caregivers emphasized the role of peer communication, especially concerning patients' personality or habits and triggers of aggressive behaviours.

> We need sufficient time […] to talk about patients, in particular those who regularly cause us problems, and we do not have that time. *E12*

Institutional meetings failed to meet the needs of caregivers. They sought recognition and support from colleagues and management team.

> We'd like nurses or managers to listen to us a bit more. *E11*

Caregivers expected informational support to come from training or debriefing, with special attention to newcomers.

> I think we need training […] training would help them see things differently. *E7*

Finally, material support is understood as workplace organisation (increased living space and individual bedrooms), occupational activities, increased number of caregivers to enhance availability and the recruitment of professionals interested in geriatrics.

### 3.4 | Incident reports

Only 76 incident reports concerning aggressions were registered during the 3 years prior the study and were retrospectively analysed. More than half of these reports came from the dementia unit (44, i.e., 57.9%), followed by 18 (23.7%) from the LCT unit, and 6, 1, and 7, respectively, from units 1–3 of the nursing home. Perpetrators of aggressions were more often men. These incident reports concerned 42 different patients, 15 of whom were responsible for more than one aggressive episode. Type and site of assaults are described in Table 3.

Aggressive behaviours mainly occurred in private spaces such as bedrooms or bathrooms. Aggressive behaviours were more likely to occur during hands on body care (washing/bathing and diaper changes), during bedtime, mealtimes and interpositions between patients.

One-hundred and eight aggressive acts were reported among the 76 incident reports (Table 2). Scratching was rarely reported (two reports), and only in association with other gestures, as was spitting. Two cases of biting alone were reported.

Reported consequences for caregiver were physical injuries for 16 incident reports, pain for 12 of them and psychological distress for 6 of them (fear, anxiety, burnout and fainting). The six caregivers who reported psychological distress were all in the LCT unit and did not report any other consequences.

Over 3-year period, 46 different caregivers submitted incident reports, and 14 submitted between 2 and 13 incident reports. Two caregivers submitted numerous incident reports (13 for one of them and 10 for the other). Most incident reports were submitted by nursing assistants on their own or with other personnel.

### 3.5 | Cross analysis of incident reports and qualitative data

Seven interviewed caregivers submitted from 1 to 10 of the registered incident reports. Nursing assistants submitted more incident reports than NRs, perhaps because they provide care requiring closer contact with patients. Caregivers working in the dementia unit submitted more incident reports. However, only one caregiver from the dementia unit estimated that the frequency of aggressions was several times a week, and none of them reported daily aggressions. One female caregiver explained that her incident reports corresponded to her early years working in the dementia unit and were due to the difficulties she had adapting.

The caregivers of unit 2 submitted very few incident reports, yet the patients they took care of did not differ from those from the other units. On the contrary, it turns out that there was an underestimation of aggressive events in this unit. Feedback from the management team indicated that caregivers of unit 2 were younger and that turnover was greater than in other units. Therefore, caregivers from this unit may have been less familiar with incident reporting procedures. Thus, the number of incident reports submitted by each unit does not seem to be correlated with frequency of aggressions.

We found various reasons why caregivers may refrain from proceeding to incident reports, such as perceived lack of utility

**TABLE 3** Assaults by type and site

| Type of aggression/unit | Unit 1 | Unit 2 | Unit 3 | Alzheimers unit | LTC unit | Total | Percentage |
|---|---|---|---|---|---|---|---|
| Blows, slaps | 4 | 1 | 4 | 29 | 10 | 48 | 44.4% |
| Grabbing/pinching | 1 | 0 | 2 | 14 | 5 | 22 | 20.4% |
| Use of physical items | 2 | 0 | 2 | 4 | 3 | 11 | 10.2% |
| Threatening gestures | 1 | 0 | 1 | 4 | 5 | 11 | 10.2% |
| Biting | 1 | 0 | 1 | 3 | 2 | 7 | 6.5% |
| Spitting | 0 | 0 | 0 | 6 | 1 | 7 | 6.5% |
| Scratching | 0 | 0 | 0 | 2 | 0 | 2 | 1.8% |
| Total | 9 | 1 | 10 | 62 | 26 | 108 | 100% |

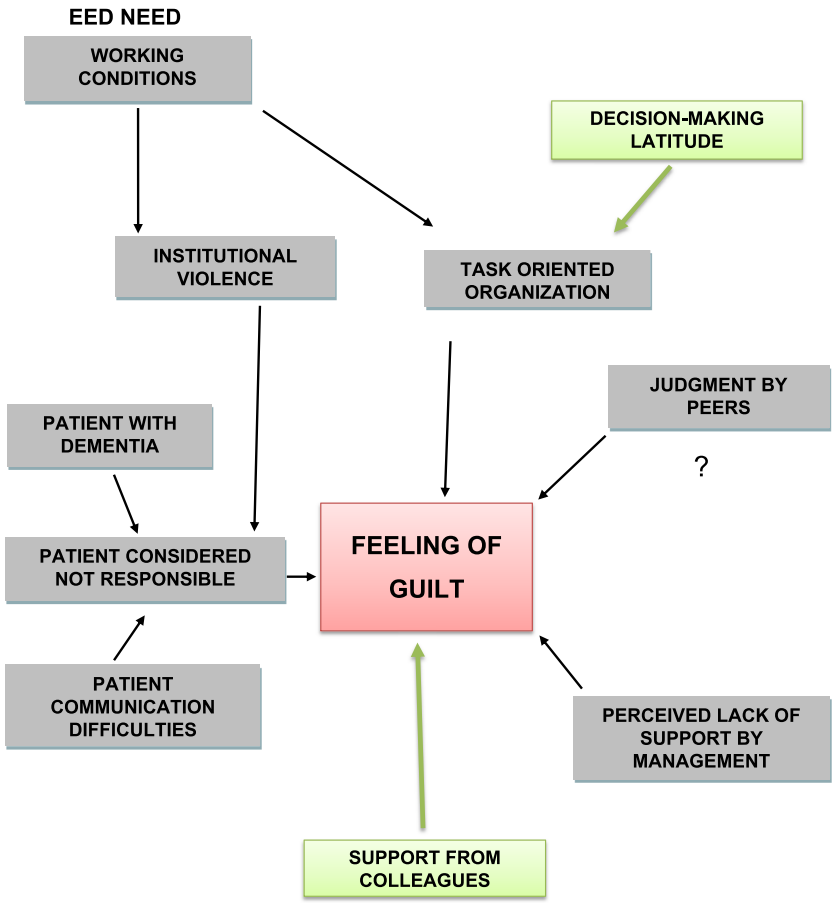


**FIGURE 1** Schematic representation of the data from the semi-structured interviews concerning the mechanism of feeling of guilt (black arrows indicate positive actions and green/thick arrows negative actions)

(no administrative response and no additional drug prescribed to the resident) and fear of a negative reaction from supervisory personnel:

> I've already heard of colleagues being criticized for filing incident reports. *E4*

> I was rebuked the first time I submitted an IR, [...] a manager told me "aren't you sick of writing incident reports? [...] what is it you are always complaining about and filing incident reports for everything and anything." *E12*

We observe that psychological distress can trigger the submission of incident reports, which may serve as a warning signal regarding the caregiver's psychological state. One caregiver filed two incident reports about "fainting" and "burnout" shortly before going on sick leave. Yet feeling guilty could discourage submission of incident reports. Figure 1 shows the different factors that lead to such a feeling.

Caregivers sometimes used incident reports as a communication channel, to call attention to a recurring situation or to an increased workload caused by challenging behaviours of a resident.

## 4 | DISCUSSION

The number of incident reports per unit was not correlated with the number or impact of violent incidents. Yet filing IR forms seems to be an indicator of caregiver's psychological state, related to difficulties such as caring for a patient or job dissatisfaction, and thus constitute a warning signal for management.

We found that incidents were under-reported because of various obstacles referred to by caregivers and also found in other studies (Gerberich et al., 2004; Kvas & Seljak, 2014; Zeller et al., 2009). Guilt appears as a key factor in our qualitative study, whereas it seems less frequent in questionnaire surveys (Babiarczyk et al., 2020; Kvas & Seljak, 2014). One explanation could be the difficulty for caregivers to identify and express such a feeling in a questionnaire survey.

Our study also suggests that coping strategies involving emotions lead caregivers to minimize violence and consequently not to report it. Beyond caregiver's banalization, limited public awareness of such incidents constitutes an additional barrier to preventing actions (Brophy et al., 2019).

In our study, caregivers suggested that workload was a probable cause of residents' aggressive behaviours. Lack of time available to provide proper care leads to the feeling of rushing things with the patients, which may generate aggressiveness on their part (Morgan et al., 2008). Isaksson et al. (2009) has confirmed the association between caregivers workload and prevalence of aggressive behaviours. In our study, deleterious working conditions were sometimes the main reason for reporting aggressions. Given that incident reports alert on serious problems experienced by caregivers who are expecting solutions, they may be frowned upon by the middle management.

Caregivers often referred to the involuntary nature of aggressions of patients arguing that they were not responsible for their acts. Judging aggressive behaviours as involuntary enables caregivers to remain empathetic toward patients (Holst & Skär, 2017).

Magnavita (2014) has reported a significant association between physical aggression and poor social support. Morgan et al. (2008) noted that caregivers needed reassurance regarding the quality of their work and wanted their feelings to be acknowledged and validated. Vandecasteele et al. (2017) discuss the positive impact of communication between colleagues thanks to emotional support, which allows unburdening and "recovery" in the aftermath of aggressive situations. Workshops devoted to analysis of professional practices could be used to address problems situations reported by caregivers, without them feeling judged, and thereby improve provision of care (Lagadec, 2009).

Architectural design of care units also plays an important part in preventing aggressive behaviours by residents. Prevalence of challenging behaviours is often associated with unit size, spatial layout and homelike character. Units with over 30 residents, for example, reported an increase in the agitation and aggressiveness of residents (Chaudhury et al., 2017).

Several studies have pointed out that person-centred care is the best strategy in preventing and dealing with aggressiveness (Holst & Skär, 2017).

French heath authorities define good care practices as a way of being, acting and communicating that is mindful of the other person, responsive to her needs and demands, respectful of her choices and refusals and remaining vigilant of risks of mistreatment. Interviewed caregivers reported that they adopt such attitudes toward patients and know how to deal with aggressive behaviours. Adding training on good care practices may not be useful. On the contrary, caregiver may feel trapped between a task-oriented organisation of work that leaves little space for the unexpected and the injunction to slow down movements to provide person-centred care (Loffeier, 2015).

### 4.1 | Strength and limitations

To ensure the validity of our research, we strove to apply rigours criteria as presented by Forero et al. (2018), that is, credibility, dependability, confirmability and transferability. Credibility is provided by MB long-term commitment to the study, as she conducted the interviews, transcribed them, proposed categories and wrote the first draft of the article. We improved results dependability by systematic coding and iterative discussion between researchers. Recruiting voluntary caregivers could have constituted a bias, as they may have felt more concerned by workplace violence, although some informants did not report any aggressive behaviours. Cross analysis of two sources of data, incident report and interviews and return to management team allow triangulations that enhance confirmability of our results. Transferability is limited as our study was conducted in two French facilities only. Our results are certainly influenced by the quality improvement and managerial culture, in those facilities or more broadly in France. However, our findings are consistent with those of previous studies in other settings, thus strengthening their external validity.

## 5 | CONCLUSIONS

Our study confirms that incident reports are not a reliable tool for the follow-up of workplace violence, as they reflect neither the number of aggressions nor their impact on the health care workers. The number of incident reports is modulated by the banalization of such acts by caregivers and their psychological state. However, incident reports could serve as a warning signal for the management team. Caregivers do not share a common definition of aggressive behaviours, thus suggesting that situations to be reported in incident reports should be better defined. Incident reporting should be encouraged and judgmental attitudes avoided. Usefulness of incident reports needs to be clearly explained to caregivers.

Our study shows that guilt felt by caregivers was underpinned by their feeling that the patient was not responsible for his acts and by recommendations regarding good care practices. Guilt could be reduced if caregivers felt they had non-judgmental and tangible support from their colleagues and management team.

However, the question of aggressive behaviours of patients is part of a wider problem involving organisational and situational factors. It would be utopic to prone prevention of aggressive behaviours without considering the conditions in which they arise.

### 5.1 | Implications for nursing management

Incident reports can constitute a warning signal for management teams but are not a reliable tool for the follow-up of workplace violence.

Caregivers experiencing aggressions often feel guilt. They need non-judgmental support from their colleagues and managers.

Caregivers should be informed of what needs to be reported and on the purpose of incident reports.

Our study highlights the need of an organisational shift from a task-oriented organisation to a person-centred approach.

## CONFLICT OF INTEREST

The authors declare no conflict of interest in the present study.

## ETHICS STATEMENT

The research protocol has been approved by the Family Medicine Department of Rennes University for methodological and ethical aspect and has followed the institutional university process for medical thesis. It has also been validated by Rennes University Hospital Ethical Committee.

## DATA AVAILABILITY STATEMENT

Verbatim cannot be on open access for confidentiality reason. They could be transmitted by the corresponding author on justified request.

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