Journal of the American Psychiatric Nurses Association
16(5) 288–298

DOI: 10.1177/1078390310384862
http://japna.sagepub.com
SAGE

Barriers and Motivating Factors in Reporting Incidents of Assault in Mental Health Care

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Abstract

BACKGROUND: There is a high incidence of assault against nursing staff in mental health care. Efforts to reduce the incidence of assault are hindered by the complexity and nature of the problem and by the fact that incidents of assault are underreported. **OBJECTIVE**: To identify factors influencing nurses to report staff assault by patients in an inpatient mental health care facility. **DESIGN**: The study used a modified nominal group technique in which nurses worked together to identify themes in decisions about reporting incidents of assault. The participants were nurses at two sites of a mental health care organization. **RESULTS**: Nurses used a complex decision-making process to decide whether an incident of assault was worth reporting. Safety culture, the design of the incident reporting system, and the effect on patients were important components of the decision-making process. **CONCLUSION**: Strategies that consider all levels of the organization's system should be used to improve reporting of assault incidents.

Keywords

mental health, assault, incident reporting, workplace violence

The number of reported incidents of physical and nonphysical violence because of aggressive patient behavior is high in health care (Gerberich et al., 2004; Hesketh et al., 2003; Lanza, Zeiss, & Rierdan, 2009), particularly in psychiatric settings (Fry, O'Riordan, Turner, & Mills, 2002; Gordon, Gordon, & Gardner, 1996; Lipscomb & Love, 1992; Molyneux et al., 2009). Nursing staff are the most frequent victims of assault (Gerberich et al., 2004; Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999) and suffer serious psychological consequences in the short and long term following assault (Ryan & Poster, 1989). Understanding the causes of assaults and developing measures to ensure the safety of staff is a high priority for health care organizations and depends on both sound theoretically motivated studies and high-quality data about incidents of assault that have already occurred. One source of information is formal incident reports, but reporting is usually voluntary and not all assaults are reported. Underreporting is a problem because it makes it difficult to assess accurately the frequency and causes of assault. Therefore, it is important to fully understand nurses' attitudes to formally reporting assault incidents and identify the factors that influence their reporting behavior.

In this article, we present the results of a qualitative study of mental health nurses' attitudes to reporting assaults.

Background

Efforts to reduce the incidence of assault against nursing staff are hindered by the complexity and nature of this form of violence. Assault may, or may not, be an intentional act, a distinction that is especially relevant for nurses working in a psychiatric health care facility who provide care for patients (Ferns & Chojnacka, 2005). Patient, staff, and environmental factors are associated with patient violence (M. Johnson, 2004). These factors include patient's diagnosis, past history of violence, whether the admission was voluntary or not, the staff members' level of experience and degree of satisfaction with the hospital, and the general level of agitation on the unit (M. Johnson, 2004). The interaction of patient, staff, and environmental factors is also likely to be important (Duxbury & Whittington, 2005; Meehan, McIntosh, & Bergen, 2006).

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Nurse management of aggression in acute psychiatric settings relies on accurate risk assessments and appropriate responsive behaviors by staff, including avoidance of risk-taking actions and coercive measures that could precipitate an incident (Abderhalden et al., 2008; J. Delaney, Cleary, Jordan, & Horsfall, 2001; K. R. Delaney & Johnson, 2006; Needham et al., 2004). The challenge of determining which situations present the most risk is complicated by the complexity and unpredictability of escalating aggressive behavior and the need to balance the patient's need for control and the nurse's need to control the situation (M. Johnson & Delaney, 2006).

Effective analysis of incident data is potentially one method of identifying the context surrounding an incident and of developing prevention strategies. A systems approach to the analysis of incident data involves identifying the latent organizational conditions that contributed to the assault so that interventions to reduce the risk can be implemented (Reason, 2004; Vincent, Taylor-Adams, & Stanhope, 1998). Significant underreporting of assault has been identified in mental health settings (Fry et al., 2002; Haller & Deluty, 1988; Kidd & Stark, 1992; Lion, Snyder, & Merrill, 1981; Lipscomb & Love, 1992; Molyneux et al., 2009), and this is surprising because staff might be expected to be motivated to report incidents of assault by concern for their own safety. The fact that many incidents are not reported means that it is difficult to gauge the full extent of the problem, resources cannot be focused on the areas of greatest need, and opportunities for learning how to reduce the risks are limited (Ferns & Chojnacka, 2005; Fry et al., 2002; Haller & Deluty, 1988; Kling, Yassi, Smailes, Lovato, & Koehoorn, 2009; Molyneux et al., 2009). A further major problem caused by underreporting is the absence of accurate data for staff who will provide clinical care to a patient in the future (Woods, Ashley, Kayto, & Heusdens, 2008).

Reluctance to report incidents has been identified as a problem for implementing a systems approach to safety in other health care settings. Surveys of health care practitioners in acute hospitals have found that nurses are more likely to report incidents than doctors and that there are various reasons for staff not reporting, including not knowing how to report incidents, time constraints, uncertainty about what to report, the expectation of blame or punishment, and a perception that reporting incidents does not result in improvements (Evans et al., 2006; Lawton & Parker, 2002; Schectman & Plews-Ogan, 2006; Vincent, Stanhope, & Crowley-Murphy, 1998). Incidents are more likely to be reported if they were witnessed by someone else and require immediate action (Evans et al., 2006) and if protocols were not followed and there was a bad outcome (Lawton & Parker, 2002).

Qualitative studies have deepened our understanding of why health care practitioners do not report incidents. In a qualitative case study, Waring (2005) interviewed hospital clinicians and found strong cultural beliefs in the inevitability and uncontrollability of error that militated against reporting incidents. Clinicians were also wary of participating in a reporting system that they perceived to be under the control of management, and they felt that reporting an incident would result in blame or punishment. Reporting by doctors would be likely to increase if they had control over the system and were assured that effective actions would be taken on the basis of reports (Waring, 2004).

Cultural differences between professions were also found to be important in explaining why nurses were more likely to report incidents than doctors. In a focus group study, Kingston, Evans, Smith, and Berry (2004) found that doctors' culture was more transparent and involved few directives, whereas nurses operated in a protocol-driven culture and felt fear of blame when reporting. Nurses reported that they used the incident-reporting system in an attempt to explain their actions and avoid blame.

It is unclear to what extent these findings generalize to mental health practitioners and to assault incidents specifically. Our knowledge of the attitudes and culture surrounding incident reporting in mental health care is limited. Ferns and Chojnacka (2005) suggested various reasons for underreporting, including badly designed incident-reporting systems, lack of belief that reporting will result in change, the frequency of violence, and fear of blame. Fry et al. (2002), in a survey of community mental health workers, found various reasons for staff not reporting assault, including believing that the incident did not warrant a report, that an assault would not be taken seriously, and that nothing useful would be achieved by reporting. A workplace culture that accepts that violence is part of the job was also identified (Fry et al., 2002).

Further in-depth exploration of mental health nurses' attitudes to reporting assaults and the culture surrounding assaults is required to deepen our understanding of how nurses decide whether or not to report an assault. Such data will help organizations to develop robust strategies for gathering information about assaults that will contribute to the development of countermeasures. The study reported here used qualitative methods to investigate the factors that affected whether mental health nurses reported an assault by a patient.

Aim

The aim of this study was to identify mental health nurses' attitudes to reporting assault in an inpatient mental health care facility. The study examined nurses' decision making about whether or not to report an incident of assault, and the objectives were to identify positive motivators to reporting as well as barriers. The study was conducted in

Table 1. Participants' Experience of Assault at Work During the Past 2 Years

Frequency	Experienced Assault	Observed Assault	Experienced Near Miss	Observed Near Miss
None	2	1	2	1
Rare	8	8	7	5
More than once a week	4	4	2	3
Too often to count	2	3	5	7
Total	16	16	16	16

one mental health care organization in Canada, but the goal was to increase knowledge about factors that influence reporting of incidents of assault in mental health care in general.

Method

Participants

The participants were 16 registered nurses, 4 males and 12 females, with inpatient nursing experience in mental health. There were 5 nurses in managerial positions and 11 working as frontline staff. There were three participants between 30 and 39 years of age, nine between 40 and 49 years and four between 50 and 59 years. The sample was representative of the age range in the organization where the mean age for nurses was 49 years at the time of the study. Fourteen participants had more than 10 years of experience in nursing and two participants had between 6 and 10 years of experience.

Participants were invited to take part in the study through e-mail and poster distribution. The criteria for inclusion in the study included the following: registration with the College of Nursing of Ontario as a registered nurse, a minimum of 6 months employment as a registered nurse within the organization, a minimum of 450 working hours if part-time or unscheduled relief staff, and having witnessed or been involved in an assault or near assault by a patient while at work. In addition, they had to have English language ability sufficient to participate in the discussions. A screening interview either by phone or face-to-face interview was used to determine eligibility to participate. Participants completed a short, open-ended questionnaire about how many times in the past 2 years they had experienced an assault or near miss at work and how many times they had observed an assault or a near miss at work. Responses were then categorized and are shown in Table 1.

Study Design

Data were collected during a series of six nominal groups held in June 2007 at two sites of a mental health care facility, each with approximately 200 inpatient beds. A modified nominal group technique, first developed by Baumann et al. (2006), was used to explore nurses' decision making. The nominal group technique is a consensus development method that investigates the strength of a group's agreement about a specific issue. Participants generate ideas about a topic individually, work as a group to discuss and prioritize the ideas, and then rank their agreement with each idea. Analysis of the rankings determines the strength of the group consensus (Black, 2006). The modified nominal group technique used in this study involved the participants working together to generate ideas about the topic. It differed from the nominal group technique in that they did not rank their agreement with the ideas generated, the strength of consensus was not formally analyzed, and they conducted a preliminary thematic analysis of the ideas generated.

The question addressed in this study was what factors would influence nurses' decision to report an assault incident. The topic statement was carefully worded using the principles of appreciative inquiry (Hammond, 1996). The aim of appreciative inquiry is to avoid discussion of negative concepts or events, and it proceeds by appreciating the viewpoints and experiences of participants. We used this insight to avoid any judgmental connotations associated with not reporting incidents or following policy.

After the topic was presented to the participants, they worked together to discuss the concepts and generate responses. They then conducted a preliminary thematic analysis by grouping concepts that were similar and identifying their meaning. The role of the facilitator during this process was to ask for clarity and to direct the group through the stages of the process. In contrast, a focus group facilitator usually facilitates the group discussion using a prepared topic guide to ensure that all issues of interest to the researcher are discussed by the group. Ethical approval was obtained from the relevant research ethics committees, and participants completed informed consent prior to taking part in the study.

Procedure

Three nominal groups lasting 2 hours each were held at both sites with separate groups for managers and frontline staff. There were between two and four participants in each nominal group. An experienced group facilitator

acted as moderator and an observer (MLG) also attended to take field notes of the sessions. The field notes contained observations on the generation of data, group dynamics and the strength of group consensus.

The following definition of assault, provided by Wynne, Clarkin, Cox, and Griffith (1996), was used in the study:

> Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being, or health. (p. 44)

At the start of each group, participants were briefed about the aims of the study, the importance of confidentiality, and the procedure. The following topic was given to the participants at the start of the session:

> Think of a situation where you or a colleague, were assaulted, or nearly assaulted, and you knew that this incident had to be reported formally. What factors or conditions influenced your decision to report?

Working individually, participants generated ideas on the topic, noted these on cards, and took turns to post the cards on the wall. As the ideas were posted on the wall, the group discussed the issues and generated further ideas until they exhausted the topic. The participants then worked together to group cards containing similar ideas and to identify factors or themes that influence reporting behavior by naming them. The physical placement of cards created a visual representation and mapping of their preliminary thematic analysis. At the end of the group, participants completed a short questionnaire about the effectiveness of the process for discussing this topic. The group sessions were not audio recorded; recording is not usually employed in nominal group studies and was not required by the modified nominal group technique used in this study because participants themselves performed the preliminary thematic analysis (Baumann et al., 2006).

Data Analysis

The data generated by each group were expressed in different terms, even though they represented common ideas, and had to be translated into a final set of common themes using the detailed field notes. The first step of the analysis involved combining the preliminary themes generated by the participants and the field notes to create a rich picture of the views of each nominal group. A thematic analysis of these data was then conducted by identifying and coding themes (Pope, Ziebland, & Mays, 2006). A final set of themes was produced, which were then categorized according to whether or not they would influence staff to report a violent incident. For example, for the theme "Patient Illness and the Ability to Understand," participants said they would be less likely to report an incident if no change or improvement in the patient's condition was expected. Conversely, for the theme "Patient Care Focus," they said they would be more likely to report if they wanted to understand the cause of the behavior and ensure the patient received the appropriate treatment. During the analysis, great care was taken to preserve the meaning of the original data.

A system framework for analyzing risk in medicine was then used to organize the themes according to the system hierarchy (Vincent, Taylor-Adams, et al., 1998). This framework was originally developed to broaden the analysis of adverse incidents by focusing not just on individual actions but also on the working conditions and the organizational context as factors that influence outcomes. The system levels of the framework are the institutional context (institutional rules and legislation), organizational and management factors, the work environment, team factors, individual staff factors, task factors, and patient characteristics. In this study we used the system framework to classify the themes that emerged from the data to reflect which part of the system influenced the reporting behavior that was described in each theme. For example, the theme "Reporting Policy" was classified as an influencing factor at the level of institutional rules and legislation, whereas "Peer Pressure" was classified as an influence at the team relationship level of the system. The aim was to identify organizational and environmental influences on reporting, thus broadening the focus to include a range of influences in addition to individual staff factors. We did not identify any factors at the task level so this does not appear in our results. Because sessions were not audio recorded the quotations in the results section are taken from the handwritten field notes.

Results

An overview of the results is shown in Table 2. The reasons nurses identified for reporting or nonreporting are shown, organized using the system-level descriptions. As can be seen from Table 2, factors associated with all levels of the organization's system were found to influence reporting behavior. In the following sections, we present findings related to institutional rules and legislation, organizational and management factors, the work environment, team relationships, individual attitudes, and patient factors.

Institutional Rules and Legislation

Nurses said that a clear legal obligation to report an assault would influence them to make a report. For example, they

Table 2. Nurses' Reasons for Reporting and Not Reporting Assault

System-Level Description	Reasons for Not Reporting	Reasons for Reporting
Institutional rules and legislation	Motivated to avoid a Workers' Safety Insurance Board claim	Legal obligation to report (e.g., forensic investigation) Possible hospital liability means there is a perceived need to justify and explain actions
Organizational and management—Safety culture	No expectation that the incident will be followed up No expectation of receiving feedback Distrustful of statistics Perceived pressure to minimize number of incidents Feeling not valued An expectation that they will be blamed for the incident An expectation that they will not be believed Cultural expectation that staff will tolerate risks Injury is considered minor	Perception that reporting will improve patient and staff safety Perceived need to justify actions Perception that the organization views prevention positively
Organizational and management—Policies	Not informed about policies	Aware of policies
Work environment—Staffing	Incident occurs at time of reduced staffing resources (night, weekend, inexperienced staff) No time for completing the paperwork at end of shift No assistance given with paperwork	Perception that reporting will result in increased staffing to ensure quality patient care
Work environment—Reporting process	Reporting process is not clear (what is reportable, who is responsible for reporting, who receives the reports) Reporting forms are not easily accessible Reporting forms not well designed	
Work environment—Support	No support given after the incident No possibility to leave the ward to seek medical attention (replacement staff)	Support given after incident Need for psychological closure
Team relationships	Team culture discourages reporting Coworker has acted wrongly	Team culture encourages reporting
Individual attitudes	Belief that reporting is optional Self-blame Embarrassment Victim is male	Feel obliged to follow policies
Patient factors	Patient is not liked by staff Belief that no improvement in patient behavior is possible Concern that reporting will have a negative effect on the patient Belief that patient is not capable of understanding his or her actions Patient aggressive behavior is chronic	Patient is liked by staff Belief that positive change in patient treatment will result Motivation to determine the root cause of patient's behavior Belief that patient is able to understand their actions

would be more likely to report if a patient had sustained bruising and there was concern about possible hospital liability. The legal requirement to complete thorough assessment documentation on the forensic unit was also cited as positively influencing reporting. A perceived need to justify actions such as requesting emergency assistance or restraining the patient would also encourage a nurse to report.

Organizational and Management—Safety Culture

Likelihood of follow-up. Nominal group participants said that perceived lack of feedback, lack of follow-up, and lack of action to prevent an incident recurring would influence nurses not to report. They used the phrase "why

bother," and the following comments are also descriptive of attitudes: "We've already written 10 reports on this patient and nothing has been done." "Apathy grows the longer you have been here with no communication, no changes, nothing happening." Conversely, nurses said that they may be influenced to report in order to ensure that the number of incidents is made known to managers and/or senior managers, so that risk can be understood and managed better. Participants also said that they may be motivated to report if they thought that the organization had a positive safety culture and that reporting would improve staff and patient safety.

Injury tolerance. A perceived high level of tolerance to staff being assaulted and injured was noted by all of the nominal groups. They described the hospital culture as accepting that psychiatric staff should expect certain risks and said that some nurses may have been told on hiring to expect to get hurt. Nursing injuries were noted as less likely to be reported than patient injuries. Participants also said that nurses tended to minimize the seriousness and impact of personal injury. They described this as a kind of desensitization and a reason for nonreporting. There were limits to their tolerance, however, and they said that a physical injury involving cuts, abrasions, drawing of blood, injury to the genitals or legs, and multiple assaults by a single client were identified as factors that would motivate a nurse to report.

Blame. Participants said that if nurses believed they would be blamed, or retribution was expected from colleagues, supervisors, or physicians, they would be less likely to report. Examples included feeling that their job security was threatened, and this was particularly felt by part-time and unscheduled relief staff who expressed concern about not gaining extra shifts or doing well on performance appraisals. Nurses also said that they sometimes blamed themselves when they were assaulted, and this meant they would be less likely to report assault. However, they said that reporting an incident could also be seen as a way to avoid blame because it enabled staff to explain and justify their actions and to ensure that the facts were reported correctly. Furthermore, if witnesses were present, staff said they wanted to make sure that accurate details of an event were recorded.

Organizational and Management—Policies

The organization's policy on reporting states that if there is a threat of assault, or an actual assault against a staff member by a patient, the incident must be reported on an employee incident report form**.** Nominal group participants said that if hospital policies were not known, nurses would be less likely to report, and conversely, they would be more likely to report if the policies were known.

Work Environment—Staffing

Nurses said that workload and staffing issues combine to create an impact on reporting and described the following scenarios. Completing incident reports and other paperwork such as police reports, patient action reports, and transfer to hospital forms if a patient has been injured requires time and means there is less time for patient care activities. In a crisis situation, nurses said that they may not remember to complete the incident report but may report an incident when the crisis situation is resolved and the unit is stable. They also stated that unscheduled relief staff or agency staff members who are unfamiliar with the incident-reporting system may require assistance with making an incident report, and this would also increase workload. They said that an incident occurring on a weekend when there is fewer staff, and less experienced staff, would result in a nurse being less likely to report an incident. However, if reporting was viewed as potentially resulting in more appropriate staffing, both in number of staff and their experience levels, nurses said that they would be more motivated to report.

Work Environment—Reporting Process

All six nominal groups identified problems with the reporting system that would negatively influence the reporting of incidents. There were many responses about the lack of understanding of the reporting system. Specific problems included confusion about what is reportable, not knowing who is responsible for completing a report, not knowing who will receive copies of the reports, and concern about what happens to information in the reports. The incident reporting forms were not easily accessible and were perceived to be unclear and repetitive.

Participants described challenges associated with the timing of incidents, particularly if they occurred at the end of a shift when there was no time for paperwork. If a nurse was able and willing to stay overtime to complete the paperwork, a manager's approval would be required, and it may not be possible to contact the manager. Participants said they were not aware of guidance from the organization about how to handle these concerns within the existing process. Additionally, the perception that managers thought there were too many incidents of assault was identified as a reason for staff deciding not to report.

Work Environment—Support

Assisting a victim to gain psychological closure was described as a positive outcome of reporting by the nurses. Nurses said that providing support for completing the incident form and ensuring that extra staff would be provided

if the nurse had to leave to receive medical treatment is important. One participant commented that "The hospital does not make it possible or easy to do what should be done." Postincident debriefing was also described as important.

Team Relationships

Participants said that if a coworker has done something wrong, peer pressure and/or team relationships can influence reporting in either direction. They said that staff could protect a colleague by covering up the details of an incident and that the unit culture could encourage or discourage reporting.

Individual Attitudes

Nurses said that personal attitudes may affect reporting if an individual thinks that reporting is optional or sees reporting as "taking on a battle." The attitude that the personal effort to report is not worth it, because of the minimal expectation of a positive outcome, was expressed. Other perceptions included the view that a nurse may blame himself or herself for not having proper control of the environment, or be embarrassed that an incident has occurred. If an employee feels that completing the incident report takes staff away from patient care, he or she may decide not to report. Nurses said that staff apathy or a sense of resignation can result in not reporting. There is a tendency not to report assault if the victim is male.

Patient Factors

Nurses' attitudes and beliefs about their patients were also identified as factors influencing their reporting behavior. Nurses said that they were less likely to report if they were concerned that reporting would have a negative effect on the patient. For example, if they were concerned that a patient would suffer negative side effects associated with a medication change prescribed following a reported incident, they would be less likely to report. Conversely, reporting an incident was also seen as a way to achieve a desired review of medication, potentially resulting in improved patient behavior.

If a patient was seen as not responsible for his or her actions or not competent to understand his or her actions because of a medical condition, or if there was little potential for improvement in the patient's condition, reporting was less likely. However, if a nurse believed that a patient was able to understand his or her actions or was injured, submission of an incident report was more likely. Whether or not a patient was liked by staff was felt to influence both reporting and nonreporting.

Discussion

The findings of this study of mental health nurses accord with the existing literature showing that underreporting of assault incidents is a significant problem in health care generally (Cullen et al., 1995; Edmondson, 2004; Lawton & Parker, 2002; Stanhope, Crowley-Murphy, Vincent, & O'Connor, 1999). The study provided valuable data from a mental health facility in Canada, augmenting evidence of underreporting from other countries. Nurses in this organization weighed the risks and benefits of reporting assault based on their experience and beliefs. Their decision making regarding formal reporting of assault episodes is based on a complex array of multilevel factors. Although the organization had a policy in place requiring incidents to be reported, some nurses felt that the perceived negative consequences of reporting outweighed any obligation to report.

The results of this study highlight the crucial role of safety culture in establishing an effective incident-reporting system. Cultural influences that discourage reporting were found to operate at all levels of the organization, including management, in the organization of the work environment, at the team level and at the individual level. Based on the in-depth discussions in the nominal groups, the lack of follow up after an incident, the cultural normalization of assault and the fear of blame are strong barriers to reporting.

Team leadership and culture is particularly important in creating a safe environment for staff and patients (Firth-Cozens, 2001; Leonard, Graham, & Bonacum, 2004). Any interventions to change the organizational culture should emphasize the development of a supportive team culture in which assault is not normalized and effective preventative measures are developed based on knowledge of previous incidents, early identification of risk, and collaborative approaches to developing strategies to reduce risk.

The importance of cultural factors in improving safety and encouraging reporting has been identified in relation to health care in acute settings (Barach & Small, 2000; Gaba, 2000; Lawton & Parker, 2002; Vincent, Stanhope, et al., 1998; Waring, 2005), but culture in mental health care has received less attention. This study contributes to our knowledge of the cultural factors that affect reporting specifically in mental health care. The results are also in accord with studies of other industry sectors showing that high underreporting of injuries is associated with a poor safety climate (Probst, Brubaker, & Barsotti, 2008), and they confirm the importance of ensuring that the focus of research is broadened to include organizational system factors as well as individual factors.

Problems were reported with the design and usability of the incident-reporting system, including inaccessible

and badly designed forms, unclear policies, and a work schedule that did not provide protected time to allow a staff member to complete the required documentation. Many previous studies have also found that these factors discourage reporting (Holden & Karsh, 2007; C. W. Johnson, 2003; Vincent, Stanhope, et al., 1998), and there are a number of excellent reviews that identify how to design an incident-reporting system to avoid these problems (see, e.g., Holden & Karsh, 2007; C. W. Johnson, 2003).

A key finding from this study was that patient factors were very important in deciding whether or not to report assault. Nurses were influenced by the patients' ability to understand their actions and by their confidence about whether a change in treatment would mitigate the behavior. They were also concerned about the impact of a report on the patient, either positively or negatively. Responsibility for the assault was seen as lying with the patient, and nurses weighed up whether the patient was able to change and control his or her behavior and the potential for this to be achieved by a treatment change. These were key factors in deciding whether to report. There was little discussion of the role of interactive and environmental factors in motivating an assault. Current approaches to understanding assault in health care emphasize the context surrounding the incident and the interaction of multiple causal factors (Lanza et al., 2009). Understanding the many contextual factors surrounding assault is crucial to lessen any implied or perceived blaming of staff or patients. These findings highlight the need to ensure that assaults are reported so that staff can learn more about the context and precursors of assault.

Underreporting of assault incidents limits opportunities to learn, and the results of this study suggest actions that could be taken by organizations to increase reporting. Organizations could improve compliance with reporting of assault if the culture supports nurses in being confident of appropriate and timely follow-up and not fearful of inappropriate blame. Organizations should not accept staff injuries and should convey an attitude that all injuries will be treated seriously and investigated. Support to staff following an incident is important: both psychologically and by providing the resources that will allow them time to complete an incident report and receive care for their injury. Education about policies and a well-designed incident-reporting system may enhance reporting behavior.

Staff concern about the impact of reporting on patients could be supported with timely review of care plans after every incident or near miss so that potential treatment modifications that may have a positive impact on behavior can be discussed. Appropriate flagging of patients with a history of aggressive behavior will assist clinical staff to be more aware of potential risks and perhaps encourage reporting of a near miss. Interventions to develop skills in risk assessment and management are also important. These skills might assist staff to be more aware of the range of potential risks and determinants of aggressive behavior. This could weaken the link between nonreporting and perceptions that patients cannot understand their actions and that improvement is not likely even with treatment change. Incident reporting is one source of information about assaults and, because of underreporting, it should not be the only source. In addition to these recommendations, there remains a need to use complementary methods to learn about the problem of violent assault in health care to understand the causes and reduce their frequency (see, e.g., Lanza et al., 2009).

Conclusions

This in-depth study of mental health nurses' attitudes to reporting incidents of assault found that their decisions about reporting assaults through the formal incident-reporting system were determined by many factors. The study identified many factors at all levels of the system that affect whether nurses report incidents of assault. Many of these factors are amenable to modification by organizations wishing to create a more open culture and increase reporting. A strength of the study was the use of the modified nominal group technique. This method was well received by the participants and appeared to be successful in engaging them in discussion of a sensitive problem. The strong group interactions observed during the nominal groups were important in generating rich and nuanced data.

The main limitation of this study was the relatively low participant numbers, which means that the results should be interpreted with caution. Relatively small samples are common in studies using the nominal group technique and modifications of it in health care (e.g., Aspinal, Hughes, Dunckley, & Addington-Hall, 2006; Levine et al., 2006; Tuffrey-Wijne, Bernal, Butler, Hollins, & Curfs, 2007). In relation to the nominal group technique, Delbecq, Van de Ven, and Gustafson (1975) state that 10 to 15 participants should be sufficient if they have a homogeneous background, and Ludwig (1997) noted that most studies are based on a sample of 15 to 20 participants. Although the total number of participants in this study was in this range, the number of participants in each group in this study was much lower than this, and we acknowledge that this is an important limitation of the study. The groups comprised 2 to 4 nurses, and this could have limited the group interaction and therefore the range

of factors they identified. The method differed from standard nominal group processes in that a measure of group consensus was not an outcome, and so the size of the groups might not be as important as in other nominal group studies. Future studies could use the same method to study the attitudes of other professionals who provide direct patient care, such as doctors and allied health professionals, who are also the victims of assaults in the workplace.

In conclusion, this study used a novel modified nominal group technique to investigate mental health nurses' decision making about whether or not to report incidents of assault. The results showed that there are many factors at all levels of the system that influence their decision making, including the organizational context, management behavior, and the work environment. The culture surrounding assault was a strong factor in deterring nurses from reporting. Other factors influencing nurses' reporting included concern about the effect of reporting on patients and beliefs about the causes of assault. Efforts to improve rates of reporting should take into account the range of factors identified in this study. Underreporting of assault incidents means that additional methods should be used to identify risk mitigation strategies and reduce the number of assaults in mental health care.

Authors' Note

The views and opinions expressed in this article are those of the authors and do not necessarily reflect those of the Royal Ottawa Health Care Group.

Acknowledgments

We wish to thank the staff who participated in the study.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research and/or authorship of this article:

Janet Anderson's work at NIHR King's Patient Safety and Service Quality Research Centre is funded by the National Institute for Health Research. This report presents independent research commissioned by the UK National Institute for Health Research. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the UK National Institute for Health Research or the UK Department of Health.

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