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Executive summary

This report presents the findings from forty telephone interviews, which formed the third stage of a project for Skills for Care on violence and abuse against social care and support staff. The interviews were carried out throughout March and early April 2013 with a wide range of employers and workforce leads across the public and independent sector working with individuals with differing needs. The overall project looked at: the trends and current prevalence of violence against social care and support staff, and the support available to tackle violence against social care and support staff; and what current guidance and monitoring procedures are employers using to respond to and record violence against social care and support staff.

Experience of incidents of violence and abuse

The experience of incidents varies greatly across organisations from none to frequent incidents. People working with people with learning disabilities or dementia are most likely to experience violence and abuse. There are particular concerns about lone workers and more research is needed with personal assistants. The impact on staff varies depending partly on the severity of the problem and partly on the organisational response. The impact may vary from a brief time out, to a decision to leave employment or the relatively rare need for a visit to hospital. Supportive management; effective training in prevention and responding to violence and abuse; clear policies and procedures – all have a part to play in enabling staff to feel able to report an incident, cope with one when it occurs, and reducing the likelihood of future problems.

Staff and organisational response

There was concern among some interviewees that staff were reluctant to report incidents of violence or abuse against them. Sometimes this was because it was seen as ‘part of the job’, and also that it is unavoidable when working with individuals with particular needs. Under-reporting may also be due to lack of awareness of procedures or fear that the employer will not support staff.

Overall, staff are encouraged to report and record incidents of violence or abuse, however, the methods of recording and the type of incident varies. Supervision and debrief are the most common support mechanisms available to staff. The availability of counseling services varies. Team meetings and peer support are considered particularly important for lone workers. Records are widely used to identify trigger factors and to inform risk assessment, risk management and care plans.
Learning and development materials
There are many different approaches among organisations to learning and development on preventing and responding to violence and abuse, and a wide range of in-house and externally sourced training courses, used across all sectors. Most interviewees supported the idea of a nationally agreed approach to supporting and training social care and support staff in managing violence, although it would need to be specific to individuals groups e.g. people with learning disabilities etc.

Monitoring
Methods of monitoring included hard copy and electronic recording. The frequency of reviews varied from weekly to annual reviews, and could result in further training and policy development. At the local level, reviews may lead to the involvement of other agencies, reallocation of staff, and requests for more suitable placements for individuals. Reporting of more serious incidents to the Health and Safety Executive under RIDDOR\(^1\) was widely mentioned. A national recording and monitoring system was considered useful by most interviewees although with caveats that it would need to be purposeful, and not be too time-consuming.

Facilitators and Barriers
Three key factors were identified which enabled an effective response to violence and abuse against social care and support staff: supportive management, clear procedures and guidance, and training. While interviewees tended to refer to ‘training’, they were often talking about a wide variety of learning and development activities. Openness was also mentioned as important to encourage reporting.

Obstacles to an effective response include the issue being regarded as ‘part of the job’ by many staff, and a lack of clarity about what constitutes violence or abuse. Interviewees acknowledged the usefulness of sharing good practice and provided a range of suggestions for effective dissemination.

In conclusion, violence and abuse against social care support staff is an important and complex issue. There is a worry among some that the use of these terms connotes blame and responsibility which is not appropriate to people who may lack mental capacity and insight into the consequences of their actions. Interviewees often mentioned that staff perceived violence and abuse as an unavoidable aspect of working with individuals with particular needs, and therefore not susceptible to change. However, there are good indications that open and supportive organisational cultures,

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\(^1\) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
effective training for staff and managers, and clear and consistent approaches can prevent and reduce the incidence of violence and abuse against social care and support staff.
1. Introduction

This report presents the results of the third stage of a project on violence against social care and support staff, commissioned by Skills for Care on behalf of the Department of Health. The interviews follow an evidence review of the prevalence of violence against social care and support staff, and an online survey of employers and workforce leads across the public and independent sectors. The overall project looked at the:

- Trends and current prevalence of violence against social care and support staff,
- Support available to tackle violence against social care and support staff; and
- Current guidance and monitoring procedures employers are using to respond to, and record, violence against social care and support staff.

The interviews aimed to obtain further understanding of:

- Employers’ views on the scale and impact of violence and abuse on social care and support staff.
- Current internal support for staff and organisation in responding to violence (both physical and verbal).
- Employers’ views on potential reporting systems.
- How current materials are used or not used in different situations.
- How existing materials could be enhanced to promote the use of existing materials.
- Barriers and facilitators of good practice which support the response to violence against social care and support staff.
- How to share and improve current practice.

1.1 Methodology

From the on-line survey of managers and workforce health and safety leads on the Skills for Care database, a sample was compiled of those respondents willing to take part in a telephone interview. An introductory email was sent to all potential interviewees explaining the purpose and background of the interviews in March 2013. In addition, contacts provided by the Health and Safety Executive, and from the Skills for Care board were approached and asked to take part in the interviews. Follow-up emails and phone calls were used to maximise response.

A total of 40 telephone interviews were undertaken with a broad cross-section of employers and workforce leads (see Table 1 below) from single residential care homes to national organisations providing a range of services to different groups and a PA agency. A copy of the questionnaire is in Appendix I.
Table 1: Profile of interviewees

<table>
<thead>
<tr>
<th>Sector</th>
<th>Supported living</th>
<th>Residential care</th>
<th>Domiciliary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent sector</td>
<td>Learning disability/ autism</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Mental health</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Older people/ dementia</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Public sector</td>
<td>Adult services</td>
<td></td>
<td>9</td>
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<tr>
<td>Other</td>
<td></td>
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<td>4</td>
</tr>
</tbody>
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$N=40$

The interviews were analysed to identify common themes and particular points of view and experience, particularly with reference to the people using the services and the type of service, as these appeared to be key variables in terms of practice and experience.
2. Experience of incidents of violence and abuse

2.1 Scale of the problem and trends

There was considerable variation in interviewees’ views about the scale of the problem of violence and abuse against social care and support staff and whether or not incidents were a common problem in their organisations. For some abuse and/or violence against social care and support staff was a constant factor, while others could identify few, if any, examples in their organisation. Most interviewees did not think it was a common problem, but it was an issue of concern for many. The individuals using care and support services and the setting were often relevant to the extent and nature of the problem, possibly reflecting different perceptions of what counts as violence or abuse.

Among small care homes for older people, including people with dementia, the incidents reported were mainly focused on particular individuals, often one or two were identified over recent years. Interviewees from larger organisations providing care to older people tended to have had more experience of such incidents. One interviewee from a large provider of care for older people commented that violence and abuse against social care and support staff was the ‘number one incident we record, more than slips and falls’.

There was a concern among some interviewees working with older people that the problem of violence and abuse against social care and support staff was increasing as people were coming to residential care with increasingly advanced levels of dementia:

‘It is increasing as the client group is getting older – so the condition is more progressed’.

Older people’s residential care provider

However, some interviewees involved in care for older people with dementia did not think that violence and abuse of social care and support staff was increasing.

Among providers of services to people with learning disabilities and autism, most reported that violence and abuse was widespread, although a couple of providers reported that it had reduced as a result of staff training and positive behaviour support in one case, and as a result of the organisational approach in the second:
‘Generally, it’s been managed pretty well within this organisation, but mainly as a result of the kind of ethos that’s been produced through the training organisation that supports us.’

Autism residential care provider

This provider reported teaching staff about autism, using the SPELL framework\(^2\): ‘all of our staff have lots of training in that, in all of those components, an evidence-based framework...it starts at induction and then it gets developed as they progress.’ The organisation also involved the in-house health and Safety advisor to work with staff on risk assessment and management on-site. An interviewee from a third organisation was unsure of the overall trend, but thought it might be reducing as a result of preventive training:

‘Because we now give staff preventative skills in order to reduce the conflict in the first place and to manage those behaviours, the actual incidents are getting less and less.’

Local authority

There was limited mention of violence against social care and support staff among organisations working with people with mental health problems – apart from one organisation working with people with personality disorders. This may reflect the relatively low number of such organisations in the sample.

Local authority interviewees with a perspective of a range of individuals gave varied answers about the scale of violence and abuse in their organisation and whether or not it was increasing. One public sector interviewee commented that the issue was high on the agenda at present, but did not think levels of violence and abuse were increasing. Another interviewee commented that although the number of incidents was fairly steady, the nature of incidents was becoming more severe.

Among those responsible for domiciliary care, violence and abuse was not thought to be a common problem in services for adults, and there was no perceived trend in incidents. In one instance, this was ascribed to the ‘more friendly set-up’ and minimum visits of an hour, along with earlier staff involvement in the individuals’ life cycle of care.

Interviewees from across service types mentioned a number of factors affecting the incidence of violence or abuse:

\(^2\) SPELL is a framework for understanding and responding to the needs of children and adults on the autism spectrum developed through evidence based. The framework is useful in identifying underlying issues, reducing the disabling effects of the condition and providing a cornerstone for communication.
• Verbal abuse and aggression has increased from relatives and carers, possibly due to: a weakening of respect for care and support staff; tensions between what individuals in need of care and support want and what families want for them; the impact of budget constraints and the greater likelihood that staff will have to refuse requests for some services.
• Increases due to changes in profile of people in need of care and support: more advanced levels of dementia, people with autism – ‘more difficult to manage’.
• Reductions in levels of violence and abuse as a result of staff training and other preventive work – particularly in relation to learning disability and complex needs, but also dementia – ‘in our organisation, once people have had training and follow our ethos, incidents do reduce’.

2.2 Risk factors and risk assessment

A range of risk factors were mentioned by interviewees, mainly related to the nature of support required by those using services. In particular, dementia, learning disability and complex needs, autism and people whose behaviour challenges were reported to be more likely to abuse or be violent to social care and support staff. In learning disability and autism, especially among younger adults, interviewees reported risks to staff due to the frustrations of the individual in being unable to express their needs effectively, or having a lack of appropriate activities. Age, gender and ethnic origin were not mentioned as risk factors, although one interviewee mentioned using men to work with some individuals with a previous record of assaults on staff could reduce the likelihood of further incidents.

Unsurprisingly, ‘hands-on’ staff - those working in front-line and care roles were most likely to experience incidents, although reception, cleaning and catering staff could also be at risk. Lone workers were also perceived as at particular risk. Personal care activities for people with dementia, and transition points for people with autism – for example, where moving to a new service or the arrival of a new member of staff, were cited by interviewees as potential triggers or risk points for violence or verbal abuse.

Risk management was a priority for the majority of organisations across all sectors. Many of those contacted mentioned staff focused risk assessments. Interviewees frequently described regular individual risk assessments which were then incorporated into care plans as part of their standard procedures. This was reported across different groups: people with dementia, learning disabilities, mental health and ‘challenging behaviour’. Many often reported having ‘flagging’ systems on databases for high risk areas or individuals. Local authority respondents and those responsible for people working with people in their own homes mentioned risks to social care and support staff working alone in the community, and having ‘lone worker’ support and policies in place to reduce risk in this area.
A number of interviewees commented that risks could be reduced through an appropriate approach. Organisations approaching services with a person-centred approach would ensure their individuals were supported and cared for by the appropriate member for staff:

“They work in a person-centred way and therefore ensure people are supported by the appropriate people, for example, if the service user would prefer a male carer, they try to do that”.

Autism and complex learning disability care provider

This approach appears to have a dual effect: reducing the risk to the staff member, as well as reducing the frustration of the individual using care and support services.

2.3 Impact
The impact of violence or abuse on staff and organisations was explored in the interviews. Most interviewees reported varying degrees of impact on staff, from ‘affects staff morale’ in residential care for older people, to ‘traumatic’, and ‘can be catastrophic….staff don’t feel valued’ in residential care for people with learning disabilities. Local authority interviewees mentioned ‘stress’ and ‘burn-out after four to five years’ and higher levels of sickness and turnover. One provider of residential care to people with learning disabilities and autism reported a 28% staff turnover in the last year. Clearly, in many organisations and particularly those providing services to people with learning disabilities and autism, violence and abuse against social care and support staff can affect levels of retention and staff sickness:

‘Occasionally, people leave, they say I’m not paid enough to get hit’.

Older people’s residential care provider

One interviewee providing a supported living service observed that verbal abuse and threats could have as great an impact as physical abuse: one individual had ‘burnt out three staff in a very short space of time’ with ‘calculated verbal aggression’.

Some interviewees reported that staff accept violence and abuse against them as caused by the individuals’ condition:

‘Staff understand it’s because of the clients’ condition.’

Domiciliary care provider

‘Staff know it’s due to the client group.’

Learning disability and autism residential care provider
‘Staff see it as part of the condition not the person themselves being a problem. If you know them, you know what to do to calm them down.’

Advocacy organisation

Interviewees echoed the online survey in comments about how staff frequently saw abuse and violence against them as part of the job:

‘Staff have accepted they are here to be abused. Staff don’t feel protected.’

Learning disability residential care provider

A few interviewees said that the impact of abuse and violence on staff was small, with some smaller residential homes and a larger provider service reporting good staff retention and low sickness leave rates. They attributed this lower impact on staff as due to a supportive approach and an effective training programme:

‘Generally speaking it’s been managed pretty well within this organisation, but mainly as a result of the kind of ethos that’s been produced through the training organisation that supports us.’

Learning disability and autism service provider

Training often involved induction to enable staff to understand the individuals’ illness or condition, factors that might lead to an incident, and how to deal with one if it occurred. Some interviewees reported that their organisations provided ongoing or refresher courses, while others provided further input following a specific incident which had led to the identification of a training need.

Where staff were fully aware of the challenges of the group and condition, some thought that this reduced the negative impact and had a protective effect:

‘For someone with dementia, they haven’t the ability to react by walking away. If staff understand this, then they can cope with the situation much better.’

Older people’s residential care provider
3. Staff and organisational response

The interviews explored how organisations respond to violence and abuse against their social care and support staff, and included questions about the support available to staff, and how the learning from incidents of abuse is shared.

3.1 Reporting

The participants were asked if staff were encouraged to report incidents of violence and abuse and if so, what type, and by what method. A large majority across all sectors reported that social care and support staff are encouraged and supported to report violence and abuse against them from induction onwards, with many having policies and procedures to capture and record incidents:

‘Encourage all staff to complete incident and accident and ABC chart, including behaviours - to identify triggers.’

Older people residential care provider

‘Yes – absolutely. Have to record for care plans and use as trigger for risk assessment process and identification of issues and training needs.’

Older people residential care provider

‘Yes – daily diary completed by all staff – report any incidents.’

Learning disability and autism service provider

Many indicated the importance of reporting for the organisation as a whole (including near misses), in order to identify patterns of behaviour and trigger factors. This seems to be common across all sectors and organisations. In one supported living service, the interviewee reported that it was a disciplinary offence for a member of staff not to report an incident: ‘you have to report everything’.

The method of reporting was varied, with smaller provider organisations more often having hard copy methods of reporting such as accident books, incident forms, ABC charts and handover forms. Larger organisations across all sectors had both paper recording and electronic recording systems in place. Classification of violence and abuse varied – some distinguishing between physical and verbal, others using a broader range of categories or levels with different codes for different types of incident. This is explored further in section 5 on monitoring and review.
All types of incident appear to be encouraged to be reported by those interviewed, although one organisation did not record racist abuse, and other interviewees said it was very rare or had not been reported. Some interviewees reported no incidents of cyber bullying occurring or being reported, and this was evenly consistent across sectors. There was one reported instance of cyber bullying between staff. Staff on staff issues also were mentioned by a few interviewees: ‘Things leak out into work.’

Under-reporting was a concern for some of those interviewed. For example, verbal abuse was reported occasionally as being seen as ‘part of the job’ in groups where capacity was an issue, and some racist comments from people living with dementia being viewed as ‘part of the condition’. This was also reported in services for people whose behaviour challenges:

‘…still elements of under-reporting, especially in services where high levels of challenging behaviour, people accept it as part of the job. Without training, they don’t know what they should do about it’.

Local authority

Many interviewees highlighted the significant role of the manager in relation to recording incidents and supporting staff. The support and approach of the manager was seen as a key element for staff to feel able to report incidents, and also type of incident. Many reported managers being encouraged to have an ‘open door’ policy to reporting incidents, and staff being aware through the manager that there is an expectation for reporting, so that learning can occur as a result. There was often mention of a culture of openness.

### 3.2 Organisational reaction

The reaction of social care organisations following an incident of abuse or violence against staff appears to vary considerably, largely depending on the nature and seriousness of the incident. There are some common approaches reported, such as:

- reviews of risk assessments
- debriefing
- supervision and offer of counselling
- completion of incident forms and/or accident forms
- investigations of incidents
- completion of RIDDOR reports, if appropriate
- inform CQC, if appropriate.
Many interviewees said that their organisations had processes aimed at identifying any trigger factors in order to avoid repetition of an incident:

‘We take them through a process of reflection to see if they can identify any relevant triggers to avoid it [the violence or abuse] happening again.’

Older people’s residential care provider

Interviewees frequently mentioned that the manager would refer to policy, and it would depend on the type of incident as to the response:

‘If physical – meet on site and remove. If verbal – it depends on the staff member.’

Domiciliary care provider

‘I always say to staff to explain and then come back when calmer – if verbal abuse. Physical aggression – we take more seriously and make clear to residents that it is unacceptable.’

Older people residential care provider

Physical abuse was generally viewed as a more serious issue than verbal abuse, and therefore the response is more reactive, for example, removing the carer from the individual using care and support services, or removing the care package, or in the most serious incidents, reporting the incident to the police. Quality assurance, health and safety and positive behaviour support teams (or departments) were all mentioned as potentially involved following an incident.

For local authorities, reporting to Health and Safety leads, and Human Resources was mentioned. Only one interviewee indicated that the staff member reporting the abuse may be ‘challenged’ for the details of what triggered the incident, stating that following some high profile instances of reported abuse by staff, this was required.

However, a few interviewees commented that some staff saw violence, and verbal abuse in particular, as part of the role, and that despite reporting incidents, the organisation did not always respond effectively.

3.3 Support available to staff

Interviewees were asked about what support their organisations made available to staff following an incident. Supervision and debriefing were the most commonly reported methods for supporting staff, and this applied across organisation size, type and sector. However, the frequency of supervisions ranged between once a month in one learning
disability and autism provider, to four times a year with an older people’s residential care provider.

Larger providers and local authorities generally provided more in the way of support. For example, one large provider illustrated a range of approaches:

‘The general approach is one of prevention, but then if things do happen, it’s about using agreed de-escalation – low arousal techniques to deal with the incident itself, and after the incident a very detailed debriefing and reporting process...Supervision at two levels: by the external organisation that we use, and internal supervision by the service manager and cascaded down through the structure.’

Learning disability and autism service provider

Larger provider organisations mentioned buying in independent counsellors to provide confidential support for staff who required it, usually for a set amount of time or sessions; Employee Assistance Programmes; and occupational health support. If an incident resulted in sick leave, some organisations mentioned a phased return to work, or ensuring the staff member was not involved in the care of the individual involved through changing site or shift patterns:

‘Have had to move staff to another service, because if the person we’re supporting doesn’t like them, you can’t leave them [there].’

Learning disability service provider

Smaller providers tended to have more limited support available, reflecting more limited resources:

‘There’s peer support, network of support in the home, management support, and if necessary external support if it becomes a safeguarding concern.’

Older people’s residential care provider

‘Staff have to be interviewed to find out how they dealt with it, and if she [the client] has the capacity to deal with it. And then arrange training if necessary – Management of Aggression, Dignity in Care etc. And give them the opportunity to look at how they feel and how they could manage better.’

Older people’s residential care provider

Preventive work and support from positive behaviour support teams was mentioned mainly by interviewees from learning disability and autism service providers.
Public sector interviewees mentioned Human Resources and counselling availability through Occupational Health departments. One local authority interviewee mentioned the training of managers to respond:

‘Managers are trained to identify stress and this could trigger a stress action plan which involves and the support of Human Resources and Occupational Health, access to a counselling service. They look at risk factors, a learning case conference and learning log, which can then be acted upon.’

Local authority

Peer support was reported by some interviewees, and seen as of particular value for care and support staff working alone in domiciliary care or supported living services, who might be particularly isolated:

‘We do two things: debrief and solutions circles, for example, you get other team leaders in a room – and you have two minutes to describe what’s happened and what the problem was without interruption, and then people write down notes and then go round the room and have everybody’s point of view on it.’

Supported living service

3.4 Action towards perpetrators

The procedures following an incident towards the perpetrator vary depending on the severity and frequency of the behaviour. According to interviewees, the response tends to involve a risk assessment and review of what may have triggered the abuse, followed by a review of the care plan, and possibly the placement itself. In some provider organisations working with people with learning disabilities, and those working with people with dementia, interviewees mentioned the possibility of moving people in need of care and support to more appropriate placements (which might involve requesting the placement local authority in relocating them), or asking them to leave if the violence was recurring. However, both these courses of action appeared to be relatively uncommon.

‘We have zero tolerance to aggression. The last resident we transferred out of this home was aggressive – would try to punch – so referred back to social worker and asked for her to be moved. But first looked to cover every area of care to ensure that we were caring for her properly. Some people need an EMI place.’

Older people’s residential care provider

Where an individual lacks mental capacity, interviewees pointed out that there is little point in taking any action towards the perpetrator beyond trying to identify the triggers and prevent repetition:
‘When we’re caring for people with dementia with no insight, the [zero tolerance] policy becomes unworkable.’

Older people’s residential care provider

With others, one interviewee mentioned preventive work to raise respect for staff among people in need of care and support:

‘Depends on the individual – some young people probably wouldn’t make sense of a standard procedure. Tend to avoid that kind of language as it invites people to make judgements about intention.’

Learning disability and autism service provider

For severe and serious cases of physical abuse by individuals with capacity, the majority of those interviewed would report the incident to the police.

3.5 Involvement of other agencies

The involvement of other agencies in the sharing and debriefing appears to be rare. Examples of the involvement of the police appear to be infrequent in this role, although the majority of interviewees said they would involve the police if necessary. However, one provider of residential care services to people with learning disabilities commented that the police ‘did not have a great understanding of the client group’.

Interviewees from provider organisations mentioned involving the local authority in the process where an alternative placement was required. Other possible agencies or professions that might be involved following an incident against social care and support staff included: GPs, community psychiatric nurses, social workers, local authority intensive support team, independent advocates and other health professionals; and referrals to a similar range of other professionals, such as the GP or social work team to review the care and services for the individual.

3.6 Learning from experience

The majority of those interviewed reported some form of structured approach to learning from incidents, and these included:

- staff meetings and handovers
- team meetings
- regional forums
- action learning sets
- shared scenarios
- incident analysis
- clinical governance reporting
• reports to health and safety committees.

Staff and team meetings were the most widely mentioned methods: ‘Most teams would have a team meeting where they would discuss but it depends on confidentiality’ (Local authority). Team meetings and peer support were identified as particularly important for lone workers.

Larger organisations tended to have a variety of methods for sharing learning from incidents of violence or abuse against staff:

‘Incidents are dissected, analysed and understood. The learning is disseminated through committees. Staff group meetings – managers cascade the learning through their teams.’

Older peoples’ service provider

Some organisations linked these approaches to training and development, and some mentioned having a ‘lessons learnt’ approach within the organisation which encourages openness. In smaller organisations, it appears that learning is frequently more informal.
4. Learning and development materials

4.1 Range

The survey identified a wide range of materials and the interviews also revealed a variety of learning and development resources in use. Some organisations have different levels or types of training for different types of staff. According to one interviewee from a learning disability residential care provider, all staff received 10 days training a year; while in other organisations, interviewees expressed concern that training budgets were at risk.

Across all sectors, there are generic training courses which are used through in house and external training in areas, such as:

- communication
- personal safety
- lone worker training
- risk assessment
- safeguarding
- medication
- managing challenging behaviour/aggression
- crisis prevention
- non-violent crisis intervention
- conflict resolution
- de-escalation and breakaway
- physical intervention.

Training in risk assessment was not provided in all interviewees’ organisations, although in one organisation, five staff were qualified to deliver risk assessment training at Level 2. Another provider emphasised that his organisation did not provide any training in physical restraint, while another interviewee commented that there had been:

‘A lot of debate recently about breakaway training and what we should do, because the local authority hasn’t got agreement on what good practice would look like.’

Local authority

Local authorities and local health trusts were mentioned by a number of interviewees as useful training providers, along with in-house and peer training arrangements:
‘Challenging behaviour for older people’s services – quite a range of dementia training from [xx] Council and the local NHS trust.’

Local authority

Other sources of information that were mentioned that could be used in training included: Skills for Care materials, the Health and Safety Executive website, BILD and the Challenging Behaviour Foundation.

Many organisations use specific training approaches, or training specific to different groups of people using care and support services, for example: dementia care and positive behaviour support for people with learning disabilities.

PROACT-SCIPr-UK was widely mentioned by interviewees working in learning disability services. It uses a positive behaviour support approach – preventive and proactive, and involves an initial four day course with an annual one day refresher:

‘Proact-Scipr gives staff confidence in managing situations. At induction, it’s mandatory, with refreshers.’

Learning disability residential care provider

Non-Abusive Psychological and Physical Intervention (NAPPI) training was also mentioned. In one supported living service, a member of staff had been trained to deliver this in-house. Another interviewee from a residential care provider reported that they had been advised to do NAPPI training, but found that it was not suitable for working with a frail, older people.

Other courses and materials commissioned from external providers which were mentioned by interviewees were:

- SPELL framework, a framework developed by the National Autistic Society to work effectively with autistic spectrum conditions
- Suzy Lamplugh training courses and workshops, materials to promote safety at work
- Accredited dementia training through City and Guilds
- Redcrier training, providing training for the care sector
- Gemma Jones Model of care for people with dementia.

In-house courses and sometimes externally provided courses tend to be delivered on induction, some are mandatory, and may then be repeated if considered appropriate after an incident or review:
‘All our staff have high levels of training at induction and after...Quite a lot of stuff on risk assessment and risk management training and risk reduction – quite a lot of this is at the point where it is likely to happen.’

Learning disability and autism service provider

‘Dementia training – all front line staff have mandatory training – Skills for Care common induction programme which touches on violence and aggression. A four day programme that all front line staff do. Includes experiential learning to help them understand the frustrations of individuals.’

Older peoples’ residential care provider

Most interviewees expressed a preference for face-to-face training rather than elearning. It is perceived as more effective and more appropriate, particularly where staff may have literacy or language problems.

Many expressed the need for further training options and in particular, accredited courses.

4.2 Effectiveness

The effectiveness of training courses and resources was explored in the interviews. Many interviewees stated that the resources used were effective; but, few could explain how this was evaluated. However, one interviewee had clear evidence that training and the implementation of a proactive and preventive approach had reduced the number of incidents of violence and abuse against staff:

‘Evidence from our figures that it’s incredibly successful, have seen a steady decrease in injuries and incidents.’

Learning disability and autism service provider

Another interviewee commented:

‘Anecdotally there seems to be much less aggressiveness because of it [PROAC SCIPr].’

Learning disability residential care provider

Interviewees working with different groups mentioned a need for more materials and guidance on control and restraint:

‘Not enough training available on how to manage restraint.’

Older peoples’ residential care provider

‘More needed around control and restraint.’

Violence against social care and support staff: Analysis of interviews
A local authority interviewee also mentioned a gap in the area of personal safety:

‘There isn’t any clear national guidance on this – but not sure if there can be. There needs to be something. Local authorities are looking for this – you know what bad practice looks like, you know what you shouldn’t be doing, but it’s a very woolly area. We’re fortunate that we don’t have more serious incidents to be honest.’

Local authority

Another interviewee was unsure of how effective generic courses are:

‘As effective as any theoretical course is, specific training is better.’

Older people’s residential care provider

While another local authority interviewee commented that training was ‘a help, but you learn from experience.’

4.3 Views on a national approach to training

A large majority of those interviewed were in favour of a nationally agreed approach to supporting and training social care and support staff in managing violence and abuse, although both in the field of dementia and learning disability – there was a view that the approach would need to be tailored to different groups of people using care and support services:

‘Depends on different sectors and different types of clients.’

Older people’s residential care provider

Interviewees mentioned the value of having a national framework for organisations and trainers to work from, as well as the role it could play in raising awareness and making staff feel valued:

‘Good practice guidance would be beneficial. Empowering people not to accept abuse. It would be stronger coming from a national perspective.’

Older people’s residential care provider
‘Having standards is a good framework that any organisation can work around. Raising awareness of individual and corporate responsibility is really useful. Would also raise the profile of personal safety – which is often an afterthought. It’s common sense not common practice.’

Local authority

‘Yes – we would know the standards needed.’

Learning disability residential care provider

‘Yes – might be a good idea to have a standardised approach.’

Mental health residential care provider

‘Yes, for staff to feel protected and valued. Needs to be practical to show how to react.’

Learning disability residential care provider

A number of interviewees (particularly from local authorities) mentioned the plethora of training courses available and difficulty of identifying which were effective:

‘I spent a lot of time trying to sort the training. When I spoke to some of the trainers, they said “Oh, this is fine, this’ll meet your needs”. And it wasn’t till I said, “No, there’s no way they’re doing that sort of thing”. And eventually, I got to speak to somebody who said, “We’ve got a course exactly for you client group and we’ll take out some of the physical holds”.’

Older peoples’ residential care provider

Accredited or approved training was seen as a potentially helpful move:

‘Yes – benefits in having a framework which would help trainers - an accredited approach would be good. Finding training can be difficult. Approved training would be helpful.’

Local authority

‘Yes – not sure how it could be framed, but there is a need for some sort of framework or guidance that could be adapted locally. There are so many training providers out there now and they are all offering something different. It’s just really hard to know and a lot of them are just cashing in on what’s being going on recently. And you’re not even sure it’s what you want.’

Local authority
Another interviewee mentioned the role of a framework of standards for training in ensuring that staff are receiving the minimum level of training, while also providing a framework to measure the effectiveness:

‘Could have an accredited programme so can measure quality of it.’
Older people’s residential care provider

However, this interviewee echoed a concern shared by others that there would be resource implications:

‘Need to have central resources if everyone has to do it.’
Older peoples residential care provider

One interviewee working with people with learning disability and autism thought that there should be the same principles and standards applied to staff and individuals in need of care and support:

‘At the moment different standards are applied to people…it should be the same for all of us and the same safeguards.’

A couple of interviewees thought a national framework would be particularly useful in relation to personal assistants and direct employment. There was a concern about the lack of guidance and regulation in this area:

‘With service user employers, there is no regulation for direct payment employers – it’s wholly their responsibility. No-one is policing how they are employing, training and treating staff. It would be a great benefit to PAs.’
Personal support agency

A number of interviewees, although in favour of the idea of a national framework, wondered how it would be developed in practice:

‘Yes – how you would do it, I don’t know. It will depend on the sector you are working with. Couldn’t be a blanket one.’
Older people residential care provider

For those who expressed doubts about a national approach, the reason was most commonly also based on this concern:

‘I don’t know, an individual approach may be better’
Older people residential care provider
5. Monitoring

5.1 Methods

All interviewees’ organisations had methods for recording incidents of violence or abuse, although the type and level of detail varied considerably. There was some understandable overlap with responses to questions about reporting methods. For smaller residential provider units, the recording was more likely to be on daily care charts for the individual, and incident and/or accident forms or books. Although interviewees reported that reporting was encouraged, there was variation in what was recorded:

‘Incident reports, accident reports, post incident forms, flow chart behaviour report.’

Older people residential care provider

‘Would record it like an accident or incident and report up to service manager and senior management team.’

Personal support agency

‘ABC charts to get a picture of what happened. Incident logs written in daily notes, body maps of injuries, witness statements, standard procedures.’

Learning disability residential care provider

Some used spreadsheets to record data and enable analysis of the type and triggers of incidents. In larger provider organisations, interviewees often mentioned a range of recording methods and systems including: individual charts, hard copy reporting, and electronic reporting systems which was collected and reviewed at both the local and higher strategic level:

‘Done at local level and reported up the line. We have a special system for recording that.’

Learning disability and autism care provider

Local authorities had a systematic approach to recording incidents, having IT systems flagging risk levels and incidence and Health and Safety departments to review and analyse the information:

3 The Antecedent Behaviour Consequence (ABC) Chart is a form to note the setting, time and frequency of behaviours, what happened just before a particular behaviour, a description of the behaviour itself, and the consequence of the behaviour. The ABC Chart enables carers to focus on the origin of a particular behaviour.
Violence against social care and support staff: Analysis of interviews

‘We do [monitor] within the organisation through the Health and Safety group – incidents of violence and aggression are reported on a quarterly basis and we would expect partner organisations to have good systems in place.’

Local authority

In this local authority, reviews were then fed into a ProACT SCIP board, chaired by the operations manager.

5.2 Effectiveness

The majority of interviewees thought that the systems in place were effective, although the level of detail captured by different systems, and the kinds of incidents clearly varied across organisations. It is also worth noting that these assessments of effectiveness were self-perceived not tested. The recording of incidents on individuals’ charts was considered effective as a way of ensuring the all carers are aware of any incident, trigger or situation, in particular, in areas of learning disability and dementia care:

‘Charts and accident reports work well as they can identify triggers, are easily accessible, highlight any incidents.’

Older people residential care provider

Electronic methods and databases were also generally thought to be effective, as they can be easily analysed and trends identified within larger organisations:

‘Easily accessible and up to date and highlights incidents.’

Learning disability residential care provider

‘Very effective, now captures information immediately.’

Learning disability service provider

However, one interviewee commented that his organisation’s system had too many free text fields which hindered analysis, and a second commented on the limited capabilities of their recording system.

For smaller organisations using hard copy incident/accident books, some indicated that it was effective only in recording an event; and analysis of the detail was not easily accessible.

There was also a concern that not all staff were able to report incidents easily, where they work in the community. In addition, information detailing risk was not accessible easily to all those who might need to know:
‘There is an additional box on the computer or red flag. Not everyone has access to this information, so some care workers (for example, outreach workers) may have to go back to ask for information.’

Local authority

5.3 Review and follow-up

The review of data varied through organisations: from weekly and quarterly to annual reviews. On the whole, organisations providing services to people with learning disabilities appear to conduct reviews and follow-up actions with greater frequency than those working with older people with dementia:

‘Data analysed weekly and with behaviour profile every 3 months (or as necessary)...Changes to plans or care provided as necessary.’

Learning disability and autism service provider

‘Review incident forms monthly and action to address any problem, then having to put resources in place, review after say 3 months. If no improvement, then call multi-disciplinary team including GP and social worker. If still no improvement, then take decision about where to go from there.’

Older people’s residential care provider

‘Audited six monthly by national office. National office support and investigate.’

Domiciliary care provider

‘Reviewed annually and independently.’

Supported living provider

Frequently, interviewees mentioned reviewing data to establish any trends in incidents, type or trigger, in order to alter care regimes or approaches to care:

‘Monitor as they come in. If it’s the same person then look at what’s happening and get other agencies involved, for example, mental health.’

Older people’s residential care provider

‘Directors are involved in a hands-on way. Aggression is reported to them to develop the environment and care plans.’

Learning disability and autism residential care provider

‘Monthly, quarterly, annual for performance review and training. Led to learning module, training material and focussed training.’

Older people residential care provider
Many reported ‘lessons learnt’ processes following reviews, where this is fed back into the organisation. However, some interviewees were unaware of the effects of the reviewing of data and how this shaped the strategic direction of the organisations response to incidents of violence or abuse:

‘There is a lessons learnt approach, but I am not sure how it is acted on strategically.’

Local authority

‘Advisers would speak to managers and lessons learnt.’

Learning disability service provider

‘Local reviews feed into corporate level review panel which meets three times a year. Leads to ‘lessons learnt’ which are circulated.’

Older people’s residential care provider

Larger organisations were able to look at implications of trends for the wider organisation in terms of general staff training and other issues. Single care homes and smaller providers, tended to focus on the individuals and any implications for their care in particular.

One interviewee from a local authority expressed concern that feedback to staff on lower level incidents did not always take place.

5.4 Views on a national approach to monitoring

A majority of interviewees were in favour of a national recording and monitoring system for violence and abuse against social care and support staff, although there were a significant minority who expressed doubts. Those in favour had a number of reasons for supporting the suggestion:

- To assess the scale of the problem

‘Would give people an idea of how many incidents.’

Local authority

‘If we don’t monitor, how do we know what’s happening.’

Learning disability residential care provider

‘To see trends and causes.’
Violence against social care and support staff: Analysis of interviews

Domiciliary care provider

‘Would show if more work needed. At the moment we have no way of knowing what’s going on at any one time.’

Personal support agency

• To raise awareness

‘Yes it would allow others to understand what care staff experience. For example, CQC don’t want to know what’s happening to the staff. It would make us realise the challenges of care staff.’

Learning disability residential care provider

‘Useful to see how much social care staff have to cope with.’

Domiciliary care provider

• To encourage reporting

‘To indicate the importance and give credence of issues – if held centrally. Stop it being ‘part of the job’ and help to develop a standards framework.’

Local authority

‘Set up correctly, many workers are terrified of reporting any incident, so they would feel anonymous.’

National organisation

• To monitor the impact of austerity budgets on care services on the incidence of violence and aggression against social care and support staff:

‘Many social care staff are on minimum wage – perhaps it would be a trigger for more resources and training for them. Concern that training is of the first things to get cut back – and a danger that it could result in increased levels of violence and aggression.’

Learning disability and mental health residential care provider

However, there were a number of concerns about any kind of national recording and monitoring system, mainly around the resources required and the difficulties of designing something that would actually work. Any system would need to be ‘clear and consistent’. Some thought that the specific nature of each incident made it too difficult to design a system that would work:
‘It’s too complex to capture.’

Older people’s residential care provider

‘People’s perceptions of what violence is varies, how it is reported could hinder things.’

Learning disability and mental health care provider

‘Danger of time inputting and if not used, falls into disrepute. Can become overly complex. How important is it? Data are always valuable, but need for balance and feedback.’

Older people’s residential care provider

This last comment raises also a shared concern among some interviewees about the purpose of a monitoring system:

‘As long as it is purposeful. Public perceptions can differ.’

Local authority

There were also doubts about how accurately incidents would be recorded as perceptions of what does, and what does not, constitute violence or abuse vary from person to person.

Of those interviewed who did not think a national system would be useful, there was a view among some working with people with autism and learning disability that the focus on violence was inappropriate, as it implied intention. Where capacity is an issue or the condition of the individual in need of care and support may be affecting their response to carers, the focus should be on the way staff are trained to respond, rather than the response of the individual in need of care and support.

‘No, when you measure, you don’t do anything about it. It would be better to maintain the training and evaluate the effectiveness of that rather than the violence itself. Also, it depends what boxes people tick.’

Learning disability and autism residential care provider
6. Barriers and facilitators

6.1 Enablers of effective response to violence and abuse

Interviewees were asked about factors that enabled an effective response to violence and abuse against social care and support staff. Across different groups, three key factors were identified: supportive management, clear procedures and guidance, and training:

‘Support for people who experience this – a strong message from the organisation.’

Domiciliary care provider

‘Supportive management who are pro-active and have a firm grasp on frontline care and support, not sat in their ivory towers.’

Local authority

‘Good management support – if you feel you are being supported to take actions to deal with the situation.’

Personal support agency

‘Clear process in place.’

Learning disability and autism residential care provider

‘Clear guidance. Encourage staff to report.’

Older people’s residential care provider

‘Training can be very powerful – making sure the information is available to people. Empowering them to report things and record things....Managers need to be proactive – can be very enabling of their staff.’

Local authority

‘Training by far. In terms of recognising the signs and having good assessment in place, and knowing how to respond. Through ongoing training to ensure people don’t respond instinctively and pull away and cause real harm to service users.’

Learning disability and autism service provider

While interviewees tended to refer to ‘training’, they were often talking about a wide variety of learning and development activities.
Local authority interviewees, in particular, underlined the importance of openness as an enabling factor:

‘Openness, team skills, policy and procedure. Respect service users and encourage autonomy.’

Local authority

A couple of interviewees mentioned that careful matching of staff and individuals using care and support services could help to reduce or prevent incidents of violence and abuse:

‘That’s the trouble in the care sector, you have random people thrown together and expect them to get on.’

Supported living service

Other key aspects identified by interviewees from across the sectors included the following:

- transparency in dealing with any incidents and the response
- good peer support and supervision
- being proactive instead of reactive
- sound and applicable procedures and policies in responding to incidents
- organisational culture
- no blame culture
- open door policy
- values based leadership
- high staffing levels
- an underpinning philosophy that it is not ‘part of the job’
- clear communication with all agencies and individuals concerned
- easy access to outside agencies.

6.2 Obstacles to effective response to violence or abuse

Barriers to an effective response by organisations were also similar across sectors and groups. The most commonly mentioned barrier was that violence or abuse is seen as ‘part of the job’, and tolerated by staff and organisations:

‘Care givers make excuses for the client – part of the job.’

Domiciliary care provider

‘Some staff think it’s part of the job.’
Allied to this, was an issue around what staff perceive as violence or abuse, which could be tackled by having clear definitions of what is and is not abuse:

‘Clear definitions from organisations about what is abuse, it’s not just about physical violence.’

Sometimes this is also affected by emotional involvement with the carer or their perception of the individual’s condition, so that the care worker puts up with violence or abuse.

Interviewees also mentioned a reluctance of some staff to report problems because of job security and fear that they may not be seen as competent. This was linked with staff who have ‘zero hours’ contracts, who may be concerned that they will not be offered work if they report or complain.

Some interviewees identified obstacles in terms of lack of staff understanding how to work with different groups and the need for training:

‘First of all, is there a reason why someone is behaving like that? Is the way we deal with it just going to compound problems?..In a lot of incidents, the threats are due to mental illness – and some actions can make it worse.’

The cost of training was mentioned as a factor which could deter employers:

‘Can’t work out why NAPPI and other training are so expensive. Why do they charge so much for it? It puts the employer off.’

Other issues identified by interviewees as barriers to an effective response included:

- ineffective induction programmes for new staff and lack of training in responding to violence and abuse, so that people don’t know what they can and can’t do
- ineffective communication about policies and procedures
- fear of retribution and blame of staff
• lack of support and information from other agencies, resulting in inappropriate referrals of care and placements
• budget freezes and reductions means there is a decrease in the workforce, resulting in less support and less time.

6.3 Views on sharing and disseminating good practice
All of those interviewed were in favour of sharing and disseminating good practice on preventing and responding to violence and abuse against social care and support staff, although there were potential commercial sensitivities among some providers:

‘Definitely useful, small organisations are fragmented and isolated.’
National organisation

‘Yes, finding out and sharing would be useful…the issues are the same across nursing, residential care and domiciliary care.’
Supported living provider

‘Sharing good practice is really useful for example, when working with managers from other areas, its useful to share different approaches.’
Local authority

‘Very good idea. Why reinvent the wheel if someone’s already done a good job.’
Older people’s residential care provider

Interviewees valued the sharing of knowledge, case studies, scenarios, and information about effective training. There was a common view that learning from other organisations was an important element of responding to abuse and violence, of all types, and would be valuable in supporting care and support staff. For smaller private sector organisations, the response was also very positive and the availability of good practice resources would be valued.

However, one interviewee expressed caution regarding the use of the term ‘best practice’ and the need for a sound evidence base:

‘Often what people think is best practice is not evidence based, there should be a stronger evidence base, showing what has been done and what the outcomes have been.’
Learning disability and autism care provider

There were many (sometimes conflicting) suggestions for the most effective methods of disseminating good practice. Interviewees commented that some methods were not
accessible to all staff, and therefore what was suitable would vary. There was some concern that the use of web-sites and on-line learning would not be accessed by some staff due to lack of internet access and, even lack of ability to read English.

Other suggested methods included:

- Skills for Care web-site and area networks
- HSE web-site
- SCIE web-site
- NASCIS web-site
- (as part of) CQC Compliance Standard
- Suzy Lamplugh web-site
- a dedicated national website
- internet discussion forums
- networking and national conferences
- Community Care magazine
- learning forums
- open discussions
- multi-agency training
- managers forum
- learning disability partnership boards.

The challenge of effective dissemination of good practice was recognised by some interviewees – partly because of the fragmented nature of the provider market, and partly due to different learning styles:

‘Getting the message out to staff in small care homes is a challenge.’

National agency

‘There is a huge workforce which is invisible, they rely on the employers, and the onus is on the local authorities to communicate information.’

National agency

‘Really hard. It depends how people learn. For some a forum or informal get together to look at real life examples would be useful. Other people wouldn’t learn that way and might find analytical data useful. Opportunity to have both.’

Personal support agency
7. Conclusions

The interviews add depth to the understanding of violence and abuse against social care and support staff obtained from the electronic survey, conducted as the second stage of this project. It is clear that there is overall agreement among employers and workforce leads in social care that violence and abuse is an on-going and important issue for staff. However, there did not appear to be strong evidence from the interviews that violence and abuse against social care and support staff was increasing, apart from as a result of growing numbers of people with dementia. While the experience of violence and abuse varies across different types of service working with the range of groups, it appears that most people working in social care will have some experience of violence and abuse, even though they may not always perceive it as such.

The impact on staff varies: from time out, to the much rarer need to attend hospital or leave employment. From the interviews, the impact appears to depend in part on the severity of the violence or abuse, and in part on the nature of the organisational response. Aggressive abuse can be as upsetting for staff as physical assaults. Supportive management; effective training in prevention and responding to violence and abuse; clear policies and procedures – all have a part to play in enabling staff to feel able to report an incident, cope with one when it occurs, and reducing the likelihood of future problems.

The approach to reporting, recording and training staff varied across organisations and sectors. Larger organisations tended to have more extensive arrangements in place. For people with learning disability, there was frequently a focus on the condition of the individual and the importance of training staff effectively. For those working with older people with dementia, there was often a concern to recognise trends before taking further action. Enabling the identification of trigger factors was a common aspect of recording mechanisms, although levels of detail differed. The most forceful approach was one organisation where staff faced disciplinary action for not reporting incidents, underlining the importance of reporting and recording for the whole care team and wider organisation.

Concerns were raised regarding staff employed by individuals in need of care and support to work in their own homes through direct payments. This growing group was seen as potentially particularly vulnerable.
The importance of training was widely acknowledged by interviewees, particularly to reduce or prevent incidents, but also to help staff cope with violence and abuse when it occurred. A few interviews had statistical or anecdotal evidence that violence and abuse had reduced as a result of training and changes in organisational ethos or culture.

A number of interviewees mentioned the difficulty of finding appropriate, affordable and effective training. Overall, a nationally agreed approach to supporting and training staff was seen as a potentially helpful development, although such an initiative would need to take account of differences in what is appropriate to different groups.

A national recording and monitoring system was also cautiously approved by many of those interviewed, as a way of assessing the extent of the issue and raising awareness of the challenges faced by many social care and support staff. However, there were concerns that putting such a system into operation would be challenging and not without resource implications.

There was also widespread support for sharing and disseminating good practice, through the web and local or regional forums and networks

In conclusion, violence and abuse against social care and support staff is an important and complex issue. There is a worry among some that the use of these terms connotes blame and responsibility which is not appropriate to people who may lack mental capacity and insight into the consequences of their actions. Interviewees often mentioned that staff perceived violence and abuse as 'part of the job', and therefore not susceptible to change. However, it seems that open and supportive organisational cultures, effective training for staff and managers, and clear and consistent approaches can prevent and reduce the incidence of violence and abuse against social care and support staff.
8. Appendix 1 - Telephone Questionnaire

Preamble

When you recently completed an electronic survey for the Institute of Public Care, you kindly agreed to take part in a telephone interview to help us find out more about violence and the social care workforce, as part of a project with Skills for Care for the Department of Health.

This interview will take no more than 45 minutes and with your permission, will be recorded. It is confidential. Your name and any identifying characteristics will not appear in any of the write-up. All recordings will be destroyed at the end of the project.

Taking part in the interview is voluntary, so can I check that you are willing to be interviewed?

Consent: Yes / No

If there is any question that you do not wish to answer or you wish to stop the interview, just let me know.

Your organisation’s experience

1. Firstly, is violence or abuse against social care and support staff a common problem in your organisation?

   Probe: Could you explain a little more fully?

2. Are there any particular types of: work, staff, group, or setting that experience and report more incidents of violence and abuse than others against social care and support staff in your organisation?

   Probe: What do you think is the reason for this?

3. What has been the impact of incidents of violence on social care and support staff?

   Probe: How many have left in the last year as a result of an incident?
4. Do you think incidents of violence or abuse are increasing or decreasing towards your social care and support staff?

Probe: Why do you think so?

Staff and organisational response

We would like to find out how organisations currently respond to violence or abuse against their social care and support staff.

5. Are social care and support staff encouraged and supported to report any incidents of violence or abuse in your organisation?

Probe: What kind of incidents? In what way?
Probe: What about incidents of racist abuse?
Probe: And what about incidents of cyberbullying?

6. How does your organisation react when an incident involving violence or abuse against a member of staff occurs?

Probe for details: including different actions for different types of incident

7. What support is available for staff following an incident of violence or abuse?

Probe for details: including different support for different types of incident, eg debrief after incident, eg regular supervision sessions.

8. Are the police or any other agencies involved in sharing and debriefing post incidents with staff?

Probe for details: including different actions for different types of incident

9. Does your organisation encourage staff to share and learn from experiences when incidents occur?

Probe for details

10. Is there an organisational procedure which follows an incident of violence or abuse towards staff which is applied to the perpetrator?
How materials are used or not used, and could they be improved

We are interested in finding out what materials are used and effective for employers and staff preventing or responding to violence and abuse against social care and support staff.

For Question 11 – refer to response to electronic survey where available – and begin by saying: You said you use X, Y and Z...

11. Are there any training, materials or courses that your organisation uses to help social care and support staff prevent or respond to violence and abuse against them?

Probe: Ask for details, Who gets/goes on them? How frequently? Is it reviewed with staff?

Probe: Ask if anything on risk assessment and risk management? Frequency etc?

12. Are these effective in supporting and guiding staff?

Probe: Could you explain why you said yes/no? Eg, staff don’t know about them, not available to all staff etc?

Probe: How could they be improved?

13. Do you think there should be a nationally agreed approach to supporting and training social care and support staff in managing violence?

Probe: Why do you think that?

Views on reporting systems

14. Do you have a method of recording incidents of violence and abuse in your organisation?

Probe for details

15. How effective is it?
Probe: Why do you think that?

16. How often are the data reviewed?

17. What actions arise from reviewing this data?

18. Do you think a national recording and monitoring system would be useful?

 Probe: Why do you think that?

Barriers and facilitators to responding to violence against social care and support staff

19. What do you think are the main obstacles to responding effectively to violence or abuse against social care and support staff in your organisation?

Probe: Anything else? (repeat till no more suggested)

20. What do you think are the main enablers of responding effectively to violence or abuse against social care and support staff in your organisation?

Probe: Anything else? (repeat till no more suggested)

21. How useful do you think it would be to share good practice on preventing and responding to violence against social care and support staff with other organisations?

22. What would be the best way to disseminate good practice across the sector?

23. Do you have any further comments or suggestions?

Thank you very much for taking part.